Program Evaluation Summary
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Sheridan Correctional Center Therapeutic Community: Year 6

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The Sheridan Correctional Center was re-opened in January 2004 as a prison fully dedicated to providing adult male inmates with substance abuse treatment and other rehabilitative programming through a modified therapeutic community (TC) design. The Illinois Criminal Justice Information Authority supported a process and impact evaluation of the program, and this *Program Evaluation Summary* summarizes findings from January 2004 through June 2010.

The impetus to have Sheridan focus specifically on the substance abuse treatment needs of inmates was fueled by a dramatic increase in the state's prison population, high rates of recidivism, and limited access to substance abuse treatment services within Illinois' prison system and following an inmate's release back into the community under mandatory supervised release (MSR).

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Sheridan is one of 27 adult prisons operated by the Illinois Department of Corrections (IDOC). Although substance abuse treatment services were available to inmates within Illinois' prison system prior to Sheridan, the programs were small and served only a fraction of those in need of services. Less than 2,000 substance abuse treatment beds were available throughout IDOC facilities for adult males, and about one-third of those were within the 600-bed, minimum-security Southwestern Illinois Correctional Center (SWICC) in East St. Louis. SWICC opened in 1995 and has operated as a fully dedicated substance abuse treatment facility ever since. The SWICC program was enhanced in fiscal year 2006 to also include a specialized methamphetamine treatment unit, more vocational services, and mandatory aftercare upon release for all graduates. All other treatment beds were distributed across different correctional centers in Illinois, operating as small, specific treatment housing units in a larger traditional prison setting.

The Sheridan Correctional Center is a medium-security prison housing adult male inmates who were convicted of a felony offense and sentenced to IDOC, and met the criteria for inclusion in the treatment program. Located in Sheridan, 70 miles southwest of Chicago, the center was rated to house 950 inmates. An additional housing unit was built in 2006, and renovations of existing housing units were made so that by December 31, 2008, Sheridan had a rated capacity of 1,300 inmates. Due to budget and staffing limitations, all beds were not filled until spring 2010.

The National Institute on Drug Abuse defines therapeutic communities as "residential [programs] that use a hierarchical model with treatment strategies that reflect increased levels of personal and social responsibility.

Table 1
Sheridan admissions, exits, and existing population from January 2004 to June 2010

	Number	Percentage of total admissions*	Percentage of total exits*	Median length of stay
Total admissions	6,680	100%		
Number incarcerated on 6/30/2010	949	14.2%		
Exits**	5,731	85.8%	100%	
Successful exits***	4,328		75.6%	382 days
Disciplinary removals	1,069		18.7%	138 days
Non-disciplinary removals	325		5.7%	50 days

*Percentages may not equal 100% due to rounding.
**Five inmates who died at Sheridan and four inmates with other extraordinary circumstances resulting in their release were included in the total exits but not within the specific sub-categories.
*** Includes 4,162 discharged to mandatory supervised release and 166 released to an IDOC Adult Transition Center.

Peer influence, mediated through a variety of group processes, is used to help individuals learn and assimilate social norms and develop more effective social skills." At Sheridan, this is accomplished through the provision of individual and group treatment delivered by a contractual service provider. During the earlier years of operation, services were provided by the Gateway Foundation. Since October 2006, WestCare has been the treatment provider.

Sheridan inmates receive a variety of other services, including educational programming, job and vocational training, and anger management and parenting skills classes. Upon release from Sheridan, all participants are required to participate in substance abuse aftercare services, usually outpatient treatment, and also receive clinical case management services from Treatment Accountability for Safe Communities (TASC), job referral and placement services through the Safer Foundation, along with supervision by IDOC parole agents under MSR.

Sheridan eligibility

Unlike other prison-based TCs in the United States, which often limit eligibility to only those convicted of drug law violations or driving under the influence, or only serve probation or parole violators, the criteria for inmates to participate in Sheridan is quite inclusive. Indeed, during the planning phase of Sheridan in 2003, initial "pipeline" studies performed by Authority researchers and IDOC determined that to keep Sheridan operating at a level that would maximize access to the services (around 950 inmates), the eligibility criteria could not be too restrictive. After a number of different iterations of potential target populations, the following final criteria were adopted:

1) Participants must be identified as in need of treatment based on a brief drug use and treatment need screen (Texas Christian University Drug Screen II), administered at an IDOC Reception and Classification Center, and a subsequent comprehensive drug assessment (the Addiction Severity Index, or ASI) performed at Sheridan.

2) Participants must be projected to serve nine to 36 months. Originally, the requirement was that inmates be projected to serve between six and 24 months in prison, based on the general research literature regarding treatment effectiveness and treatment dose. This was changed in the fall 2006 to nine to 24 months, and again in 2010 to nine to 36 months, as a result of evaluation findings that indicated inmates who spent less than nine months at Sheridan showed recidivism rates that were not much lower than those of inmates who did not receive treatment. Because the length of stay for parole violators or inmates with outstanding warrants/detainers cannot be accurately predicted, they are excluded from participating in the Sheridan program.

3) Inmates serving a sentence for murder or a sex offense, or have a murder or sex offense conviction in their criminal background, are ineligible.

4) Participants must be eligible for placement in a medium security facility and free of mental health issues that cannot be managed at Sheridan.

5) Participants must volunteer for the program.

6) Inmates who previously participated in the Sheridan program are ineligible.

Table 2
Participant characteristics, January 2004 to June 2010*

Characteristic	Sheridan admissions
Average age	31.8 years
Race	
Black	66.4%
White	24.4%
Hispanic	8.9%
Marital status	
Married	15.6%
Single	84.4%
Children	
None	32.9%
One or more	67.1%
Education level	
No high school diploma or GED	56.5%
At least a high school diploma or GED	43.5%
Gang affiliation	
Yes	60%
No	40%
Prior prison sentence	
None	35.7%
One	24.5%
Two or more	39.8%
Average total prior arrests	20.5
Average prior arrests for drug law violations	5.1
Primary substance of abuse	
Alcohol	27%
Marijuana	29%
Cocaine	17%
Heroin/opiates	22%
Other	5%
Age at first drug or alcohol use	
Under 15	59.1%
15-16	21.3%
17 or older	19.6%
Prior treatment admissions	
No prior treatment	47.4%
One or two prior admissions	35.9%
More than two prior admissions	17.7%

*Percentages may not equal 100% due to rounding.

Participant characteristics

During the first six-and-a-half years of operation (January 2004 through June 2010), 6,680 inmates were admitted to the Sheridan Correctional Center program. On June 30, 2010, 949 inmates were residing at Sheridan (*Table 1*). Of outgoing Sheridan participants, 4,328 had completed the prison component of the program and were released to MSR or an adult transition center. Another 1,069 inmates were removed from Sheridan for disciplinary reasons and sent to another facility. About one-third of them had refused to participate in treatment programming, while the other two-thirds were transferred for violating other IDOC rules.

Only 325 inmates were removed from Sheridan for non-disciplinary reasons (less than 6 percent over the six-year period), including identification of mental health issues that interfered with ability to participate in the program, outstanding warrants or detainers that were either going to require the inmate to appear in court frequently or face deportation following completion of a sentence, too much or too little time to serve to meet program eligibility requirements, inmates who were later determined to have a criminal history that prohibited their participation in Sheridan, and serious medical conditions or safety concerns related to being housed with specific inmates.

Half of the non-disciplinary removals occurred within 50 days of admission to Sheridan. Closer inspection of these data revealed that time periods between admission and transfer for non-disciplinary removals substantially decreased over time due to improved screening and identification of inmates who were not appropriate for Sheridan as the program has evolved.

During the period studied, most of those admitted to Sheridan were black, with an average age of 32 years old (*Table 2*), and were primarily sentenced to prison from Cook County (Chicago) and other urban areas of the state for drug and property crimes. Cook County not only accounted for the largest number of admissions to prison in Illinois, but accounted for more than one-half (52.3 percent) of the 6,680 admitted to Sheridan. The next largest group of inmates admitted to Sheridan were sentenced out of Winnebago County (Rockford), followed by the suburban counties bordering Cook—DuPage, Will, Lake, and Kane counties. Individuals from Cook, DuPage, Kane, Lake, Will, and Winnebago counties accounted for 71 percent of Sheridan admissions. The remaining 29 percent of Sheridan admissions came from 73 other counties, primarily in northern Illinois. A higher proportion of inmates admitted to Sheridan from Cook County

(primarily Chicago) were black (81 percent) than those from the rest of the committing counties combined, as 50 percent of those admitted to Sheridan from outside of Cook County were black.

Although most Sheridan participants were single and had never been married (84 percent), 67 percent had children. Upon admission to Sheridan, 43 percent were high-school graduates or had received a GED. Most Sheridan inmates were unemployed prior to incarceration, and only 27 percent were employed full-time prior to incarceration. Even more illustrative of the limited formal employment experiences among those admitted to Sheridan is the fact that 63 percent had never previously held a job for more than two years.

Clear evidence of an extensive prior history of involvement in criminal behavior and the justice system also existed among Sheridan participants. Sheridan admissions had, on average, almost 21 prior arrests with charges for drug law violations, property crimes, and crimes of violence, such as robbery, battery, and assault, and 94 percent had five or more prior arrests. Of those admitted to Sheridan during the period examined, 66 percent had served previous prison sentences in IDOC.

Participant substance abuse histories were quite lengthy and varied, but prior exposure to substance abuse treatment was limited. Upon admission to Sheridan, 47 percent of the participants had never before participated in substance abuse treatment. Primary substances of abuse also varied, with 29 percent reporting marijuana, 27 percent reporting alcohol, 22 percent reporting heroin/opiates, and 17 percent reporting cocaine as their primary substance of abuse. Further, 50 percent indicated that they abused multiple substances, and 11 percent reported previous intravenous drug use.

Despite the growing concern regarding methamphetamine production and use in Illinois, particularly in rural communities, Sheridan has not seen a large number of admissions where this drug was cited by the participants as their primary substance of abuse. Less than 2 percent of those admitted to Sheridan reported amphetamine or methamphetamine as their primary substance of abuse. Part of this could be influenced by the fact that the majority of admissions to Sheridan were from northern Illinois where methamphetamine has not had a large impact, unlike the more rural jurisdictions in central and southern Illinois (Bauer, 2006). Further, since October 2006, Illinois' Southwestern Correctional Center has operated a specialized methamphetamine treatment unit where many of those identified as in need of methamphetamine treatment are sent.

Beyond the extensive prior substance abuse history, 55 percent of Sheridan participants had also been previously hospitalized for medical problems (excluding drug overdoses), and 33 percent of Sheridan participants had been hospitalized multiple times. The average number of prior hospitalizations (excluding drug overdoses or drug detoxification) among all Sheridan admissions was two. A sign of the exposure to violence experienced by Sheridan participants is the fact that 8 percent had been previously hospitalized as a result of gun-shot wounds. In addition, 27 percent of those admitted to Sheridan were also identified as having a chronic medical condition, and 19 percent were taking prescription medications for medical conditions.

Although many prison-based TCs in the United States target only those convicted of specific drug law violations, most often drug possession, Sheridan program planners recognized that only considering an inmate's conviction offense would exclude a substantial number of people in need of treatment. Sheridan houses inmates serving time for convictions ranging from felony-level DUI, and drug sale and possession, to burglary, robbery, and battery. In aggregate, the largest single offense category for admissions to Sheridan was for drug law violations (42 percent), followed by property crimes (32) and violent offenses (24 percent) (*Table 3*).

Of all Sheridan admissions, only 6.5 percent were the result of a Class X felony conviction, primarily for armed robbery and drug sale/delivery offenses involving 15 grams or more of cocaine or heroin. Those sentenced to prison for a Class X felony—the most serious felony class other than murder—are required under Illinois law to be on MSR upon release from prison for three years. Illinois law specifies that those released from prison after serving a sentence for a Class 1 or 2 felony must be supervised on MSR for two years, and 72 percent of those admitted to Sheridan fell into these two felony classes. Finally, 22 percent of Sheridan admissions were convicted of Class 3 and 4 felonies, and those inmates were required to undergo one year of MSR post-release.

More than half of those admitted to Sheridan were eligible for Earned Good Conduct Credit (EGCC), which cuts time off of a prison sentence by participating in substance abuse treatment programs (in addition to traditional day-for-day good conduct credits and Meritorious Good Conduct credit for which almost all inmates at Sheridan are eligible). Inmates receiving EGCC for Sheridan par-

Table 3
Most prevalent holding offenses of Sheridan participants, January 2004 to June 2010*

	Number	Percentage of total**	Percentage within category**
Drug law violation	**2,826**	**42.3%**	100%
Sale/delivery of a controlled substance	1,617	24.2%	57.2%
Possession of a controlled substance	813	12.2%	28.8%
DUI	253	3.8%	9%
Sale/delivery/production of cannabis	121	1.8%	4.3%
Other	22	0.3%	0.8%
Property crimes	**2,174**	**32.5%**	100%
Burglary	1,216	18.2%	55.9%
Theft	461	6.9%	21.2%
Motor vehicle theft	316	4.7%	14.5%
Forgery/deception/fraud	144	2.2%	6.6%
Other	37	0.6%	1.7%
Violent crimes	**1,620**	**24.3%**	100%
Firearm possession by convicted felon/ other weapon offenses	446	6.7%	27.5%
Assault battery	405	6.1%	25%
Robbery	379	5.7%	23.4%
Armed robbery	283	4.2%	17.5%
Other	107	1.6%	6.6%
Other	**60**	**0.9%**	100%
Total	**6,680**	**100%**	

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

ticipation had higher rates of successful completion than those who were ineligible for this time credit. In addition, EGCC reduced the length of incarceration, thereby more quickly freeing up bed space at the facility.

More than 259,872 days of EGCC were earned by those who graduated from the program during the first six state fiscal years of operation (FY05 through FY10). This EGCC time is equivalent to 119 years of reduced incarceration per year. Given the average annual cost of $23,394 to house an IDOC inmate, the reduced incarceration resulting from EGCC for substance abuse treatment programming is valued at $2.78 million annually, or $16.7 million during the first six state fiscal years of operation. An additional 119 participants are able to enroll in the Sheridan program each year due to the bed space made available through EGCC.

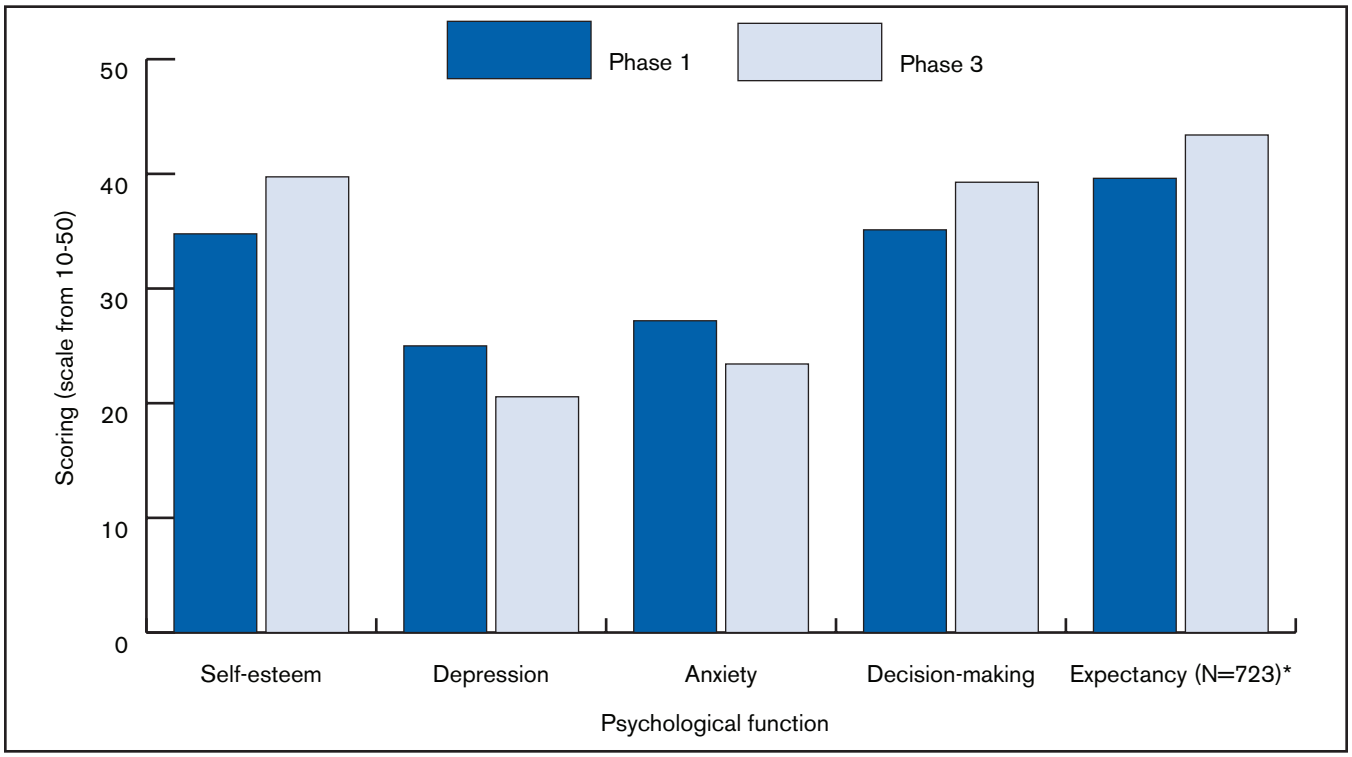
Sheridan progression

In addition to various assessments and the development of a comprehensive, multidisciplinary treatment plan, Sheridan participants undergo an orientation phase during their first month at the facility. During orientation, inmates are provided with basic drug education, an overview of the TC philosophy and program rules, and other motivational activities and exercises to get them prepared for their treatment and participation in the program. During this phase, inmates will also begin to get involved in educational and vocational programming and take on various responsibilities around the institution.

Following successful orientation phase completion (Phase 1), which requires inmates to pass an exam showing that they understand the TC philosophy and basic issues regarding their drug abuse, inmates are placed into smaller housing units and "families," where they begin their regi-

Figure 1

Participant psychological functioning scale changes from Phase 1 to Phase 3 (N=1,334)



*Likelihood of refraining from drug use. Client scoring in this category was initiated in May 2008.

men of intensive, daily substance abuse treatment (Phase 2). Each inmate at Sheridan is required to participate in group treatment five days per week for a minimum of 15 hours per week. This programming includes didactic groups, process groups, encounter groups, cognitive restructuring program groups, aggression management and domestic violence groups, behavior management, TC structures and responsibilities, and support groups (Illinois Department of Corrections 2006).

Inmates are identified as being in either AM or PM groups, meaning that half of the inmates at Sheridan are participating in intensive drug treatment in the morning, while the other half is involved in various educational, vocational, or job assignments. After a lunch hour, the groups then shift. The beginning and end of each day involves group meetings, and inmates are also provided with time in the evening to participate in recreational programming and complete assignments related to their treatment programming. The schedule remains the same Monday through Friday. Visitation with friends and family members is only allowed on the weekends.

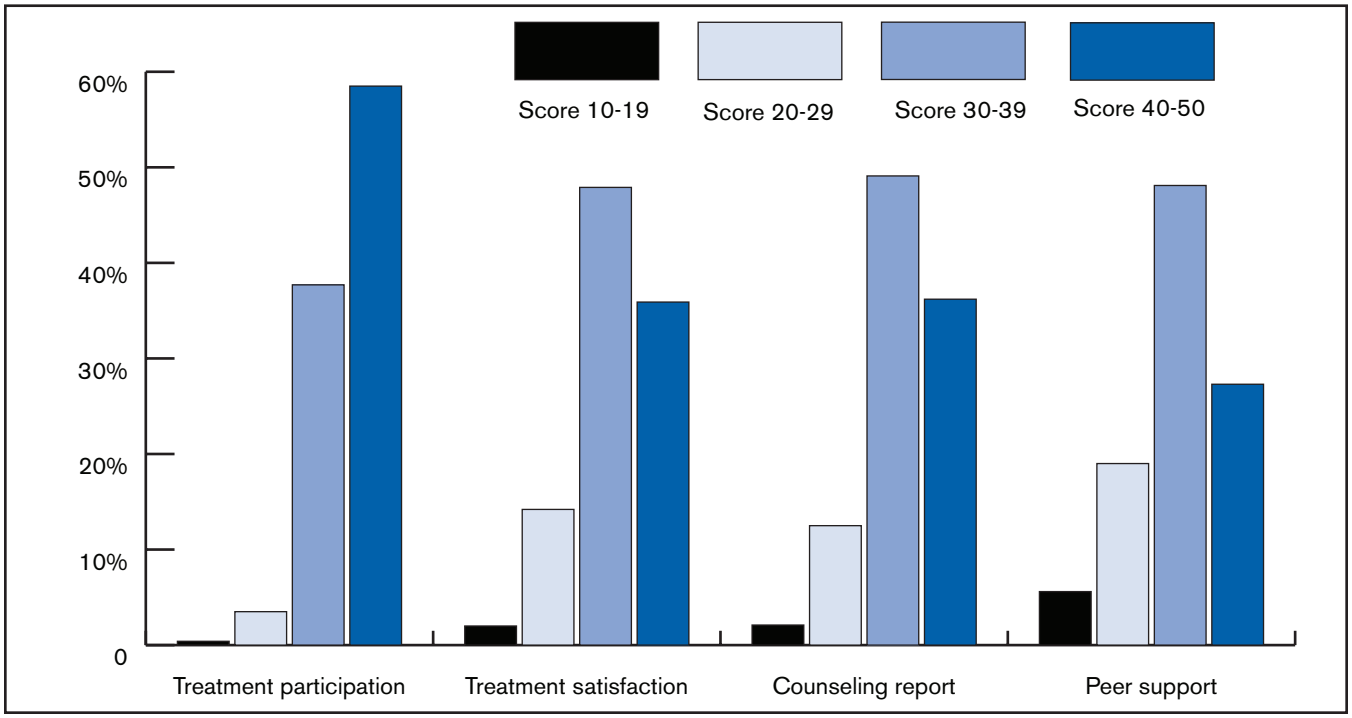
Once an inmate has completed Phases 2 and 3 (additional intensive treatment within the facility), they enter Phase 4, which focuses primarily on the development of job and vocational skills, but still involves daily participation in the therapeutic community and frequent group treatment programming. To enter Phase 4, participants are required to complete a minimum of 12 months at the Sheridan Correctional Center, demonstrate leadership within their treatment group and the facility, and be active participants of the therapeutic community.

Changes in social and psychological functioning and criminal thinking patterns

The primary goal of the Sheridan Correctional Center TC is to reduce offender substance abuse and involvement in criminal activity through the provision of treatment that improves the psychological and social functioning of participants, reduces their criminal thinking patterns, and provides them with educational and vocational programming and experiences that will improve their chances of success upon release from prison.

To gauge the degree to which Sheridan participants have changed their ways of thinking about their criminal activity, and how their psychological and social functioning changed during the course of program participation, participants complete a series of self-administered assessments at each program phase change. These surveys,

Figure 2
Client evaluation of treatment at Phase 2*



*Scores ranged from 10 to 50.

developed by the Texas Christian University Institute for Behavioral Research, are used extensively in treatment programs serving criminal populations for program evaluation purposes and to monitor client progress and needs.

The psychological functioning assessment gauged five different dimensions of psychological functioning, including: self-esteem, depression, anxiety, decision making, and expectancy (likelihood of refraining from drug use). The scales produced through these assessments resulted in scores ranging from 10 to 50 (*Figure 1*). The social functioning assessment completed by participants provided quantitative assessments of three dimensions of social functioning: hostility, risk taking, and social support. Six dimensions of criminal thinking, including entitlement (sense of ownership and privilege, misidentifying wants as needs), justification, power orientation (need for power, control and retribution), cold-heartedness, criminal rationalization, and personal irresponsibility were also measured at phase changes.

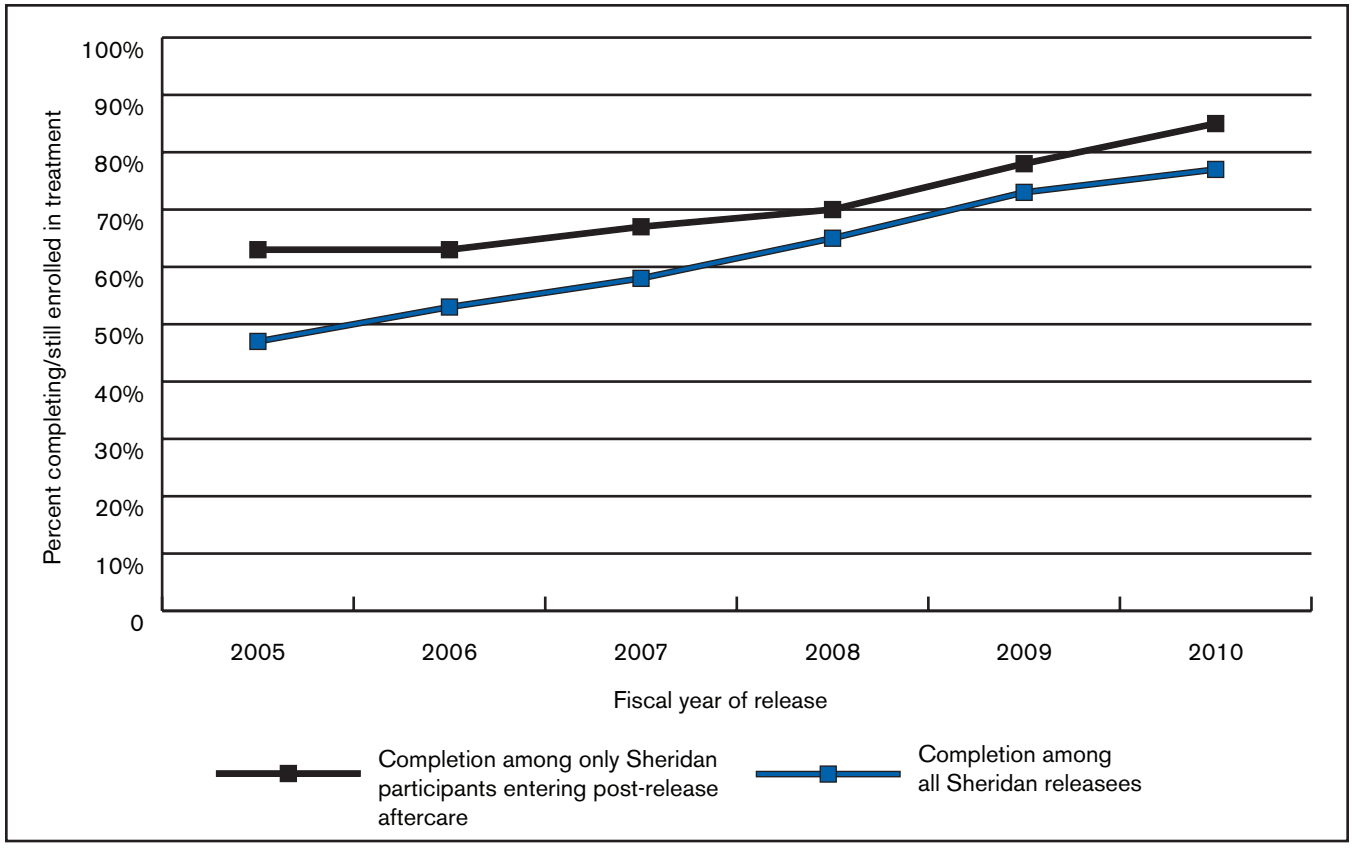
The assessments revealed that as participants matriculated through the Sheridan program phases, levels of psychological and social functioning improved, criminal thinking patterns decreased, and participants had very positive views of their treatment and high levels of rapport and support from their counselors and peers. Improvements were seen across all measures of psychological and social functioning, and criminal thinking patterns as participants matriculated from Phase 1 (orientation) to Phase 3 (completion of intensive treatment within the facility). The surveys also indicated levels of hostility and risk-taking were reduced, and the level of social support increased. For example, the scale measuring depression decreased from an average of 25 at the beginning of Phase 1 to 20 at the beginning of Phase 3.

Another set of questions gauged the Treatment Engagement Process by asking participants to indicate how strongly they agree or disagree with 36 statements in an effort to construct measures of treatment participation, treatment satisfaction, counseling rapport, and peer support *(Figure 2)*.

The majority of participants who completed Phase 2 had positive views of their treatment participation, treatment satisfaction, counselor rapport, and peer support. Almost half had a score of 30 to 39 on the treatment satisfaction scale, and an additional 36 percent had a score of 40 to 50. The mean score on the treatment satisfaction scale at the completion of Phase 2 was 36, indicating satisfaction with treatment. Also, 85 percent of Phase 2 completers

Figure 3

Rates of treatment completion/still enrolled among all releasees and releasees entering aftercare



scored counselor rapport at 30 or higher, with a mean score on this scale of 36.

Program completion and release to the community

The length of time an inmate spends at Sheridan is determined exclusively by the length of the prison sentence imposed by the court, minus jail, good conduct, and any other statutorily allowable credit. As such, an inmate can successfully complete the institutional phase of Sheridan without completing their treatment's clinical components. However, because every inmate released from Sheridan is required to be on MSR for a statutorily determined length of time, those released from Sheridan are required to participate in aftercare, or continue their treatment in the community if it is deemed necessary by administrators.

Prior research has consistently found that aftercare enhances positive outcomes of prison-based and other intensive residential substance abuse treatment programs, including additional outpatient treatment, participation in support groups, and relapse prevention programs. All inmates released from Sheridan are required as a condition of MSR to participate in some type of treatment, the nature of which is determined by the multidisciplinary team that meets prior to the release of each inmate. Inmates are referred by TASC to a program that is accessible and appropriate for their particular needs. Intake assessments for these community-based referrals are scheduled prior to the inmate's release, and usually take place within two weeks post-release.

During the first six-and-a-half years of operation, data from IDOC indicate that 4,328 inmates successfully completed the institutional phase of Sheridan and were given either MSR or sent to an adult transition center in the community. TASC does not provide post-release clinical case management to individuals discharged to a transition center. This left 4,162 Sheridan releasees eligible for post-release services through June 30, 2010.

During the period examined, 4,098 eligible releasees had at least one referral to some type of aftercare service. Intensive outpatient treatment accounted for the single largest category of referrals among those released from Sheridan, followed by traditional outpatient, recovery

home, half-way house, and residential treatments. Of the 4,162 Sheridan participants given MSR, 3,529 were given at least one referral for outpatient treatment services (85 percent).

Of those receiving referrals, 87 percent actually entered treatment, while the remaining 13 percent did not enter any post-release treatment program. However, the percentage of releasees who participated in aftercare increased over time (*Figure 3*). Only 75 percent of the first cohort released from Sheridan in FY05 entered aftercare treatment, while a 90-percent treatment admission rate was seen among the cohort released from FY08 through FY10.

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

To determine program success, rates were calculated on those who were referred to treatment, and those who actually completed treatment. Of all participants who were referred to treatment, 61 percent successfully completed or were still enrolled in at least one aftercare program. When only Sheridan releasees who actually entered a recommended aftercare program upon referral were examined, 71 percent had successfully completed or were still enrolled in at least one aftercare program.

The overall proportion of Sheridan participants that completed or were enrolled in at least one aftercare treatment program steadily improved over time. Of inmates released from Sheridan during FY05 (the first cohort of releasees), less than 50 percent of those referred to treatment had completed or were still enrolled in aftercare. Of all releasees who entered aftercare, more than 60 percent completed or were still enrolled in FY05, compared to 70 percent among the FY09 releasees and 85 percent of the releases in FY10.

Recidivism

The most frequently used measure to gauge the impact and effectiveness of rehabilitative programs is the reduction in recidivism, or reduced involvement in criminal behavior, by those who participate in the rehabilitative program. Accurately measuring an individual's involvement in crime is difficult as many crimes do not come to the attention of law enforcement. For this evaluation, measuring subsequent criminal activity involved analyses of official criminal history information, including return to prison.

To assess the impact of the Sheridan program on post-release recidivism (return to prison), the performance of the first 4,162 Sheridan graduates were compared to a sample of 8,078 inmates with similar characteristics and backgrounds released from other Illinois prisons during the same time period *(Figure 4)*.

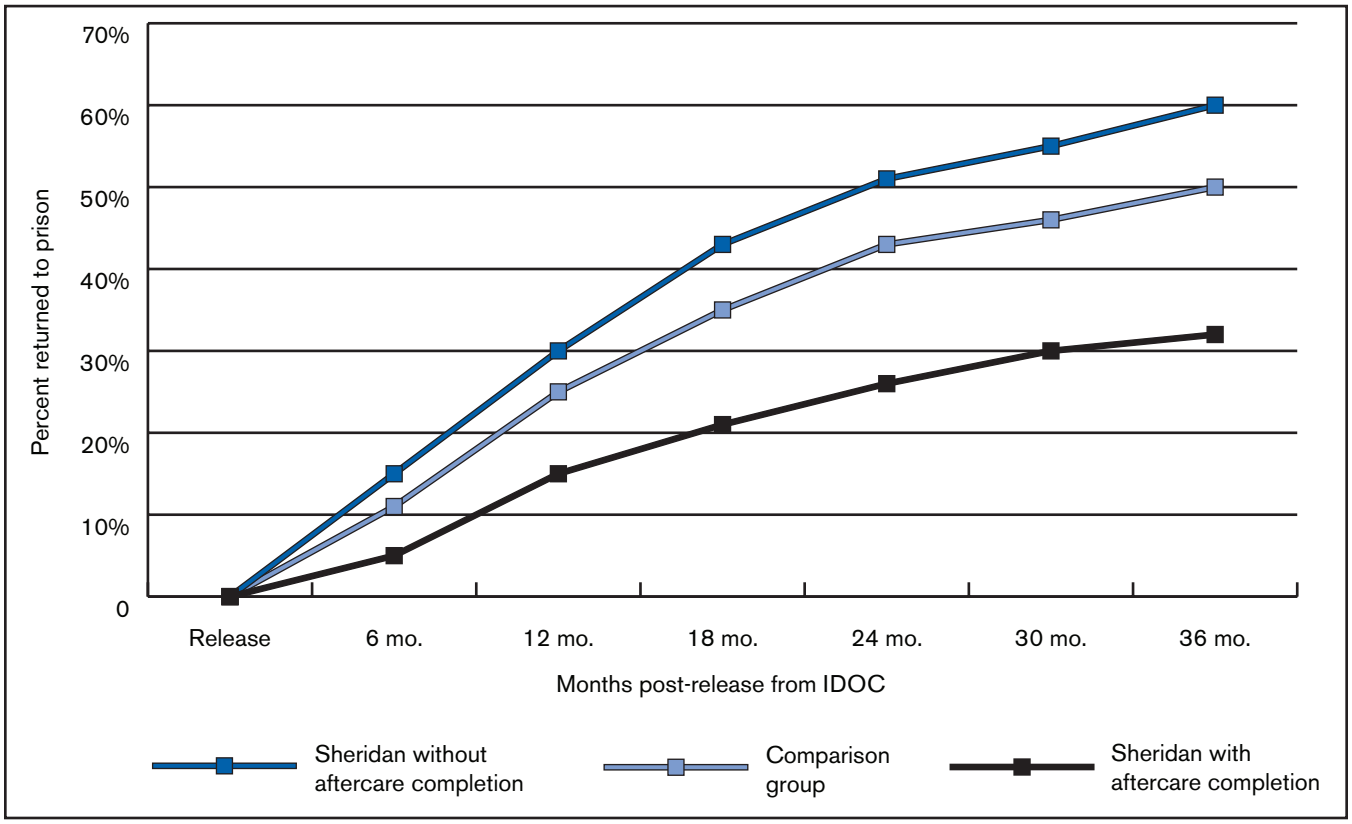
A second group of inmates also were identified and compared to the Sheridan graduates in terms of post-prison recidivism patterns. The second sample consisted of those who were removed from Sheridan Correctional Center due to rule violations and disciplinary problems. Between January 2004 and June 2010, 1,069 inmates were removed from Sheridan due to rule violations or disciplinary problems. Of them, 892 had been released from prison as of June 2010.

Because the Sheridan graduates and inmates included in the first comparison group were not exactly identical in terms of their demographic, socio-economic, and current offense characteristics, multivariate statistical analyses were performed to statistically control for the influence the differences may have on each group's overall recidivism rates.

Recidivism analyses revealed that Sheridan graduates had a 16 percent lower likelihood of being returned to prison for a new offense or a technical violation of MSR than the comparison group. After statistically controlling for the characteristics of the two groups, at three years post-release, 43 percent of Sheridan graduates had returned to prison, compared to 50 percent of the comparison group.

Further, when Sheridan graduates were separated into those who were still enrolled in or had completed aftercare and those that did not complete aftercare, the reduction in recidivism relative to the comparison group was

Figure 4
Standardized cumulative recidivism rate among Sheridan releasees and comparison group



even more substantial (*Figure 4*). Sheridan participants who had completed or were still enrolled in aftercare had a recidivism rate that was 44 percent lower than the comparison group. At 36 months post-release, 32 percent of Sheridan releasees who completed or were still enrolled in aftercare had returned to prison, compared to 50 percent of the comparison group.

Sheridan graduates who did not complete aftercare were 30 percent more likely to be returned to prison than the comparison group. Within 36 months, 60 percent of Sheridan graduates who did not complete aftercare returned to prison. A Sheridan graduate's failure to comply with aftercare is considered a technical violation of MSR, and increases the likelihood of return to prison relative to the comparison group, which did not have the same mandatory treatment requirements of MSR.

Post-release recidivism analyses of Sheridan graduates also included a comparison to inmates who were removed from Sheridan's treatment program for disciplinary reasons, primarily refusal to participate in the treatment program. All individuals in this group (referred to as "Sheridan removals") met the program's eligibility requirements, including being in need of substance abuse treatment and initially volunteering for the program. Using multivariate statistical analyses that again controlled for demographic, socio-economic, criminal history, and time served differences between the two groups, results indicated that the graduates from the institutional phase of the Sheridan program had a 25 percent lower likelihood of recidivism than those who were removed from or dropped out of the Sheridan program and were subsequently released from another Illinois prison.

Conclusion

The pre-operational target population identified for the program is being served, with those admitted to Sheridan having extensive criminal and substance abuse histories, and a substantial unmet need for treatment, and vocational and educational programming. With strong support from IDOC administrators, the Sheridan program has been implemented in a manner that has ensured the program's clinical integrity and availability of sufficient resources for needed services. As a result, IDOC has developed and implemented a process by which all adults admitted are screened to identify substance abuse treatment and information is integrated into an automated offender tracking system. A treatment waiting list for

inmates also was developed, and an increasing proportion of inmates were admitted to Sheridan from other institutions via the treatment wait list. During the first year of operation, less than 4 percent of admissions came from other prisons, but by 2007, nearly 25 percent of all Sheridan admissions came from other facilities via the treatment wait list.

In addition, the Sheridan Correctional Center has seen several significant operational accomplishments and improvements. They include a consistently low rate of referred inmates subsequently determined to be ineligible for the program, and quicker identification and removal of these inmates from Sheridan. Overall, less than 5 percent of all inmates admitted to Sheridan did not meet the eligibility criteria during the period examined. Also promising was a consistently low rate of inmates removed from Sheridan for disciplinary reasons despite the serious criminal backgrounds of the inmates. For every Sheridan inmate removed for disciplinary reasons, four others successfully completed the prison phase of the program.

During the course of program participation, inmates at the Sheridan Correctional Center improved their levels of psychological and social functioning and reduced criminal thinking patterns. The implementation of enhanced pre-release planning for Sheridan releasees involving a multidisciplinary case staffing team of institutional, parole, aftercare staff, and the inmate is also credited for program success.

In addition to these enhancements at the Sheridan Correctional Center, significant improvements to the post-release phase of the program were evident during the period studied. Aftercare referrals were consistent with pre-operational expectations, with all Sheridan releasees receiving referrals for either outpatient or residential treatment services. Other improvements include an increased rate of successful treatment admission among the Sheridan releasees, fewer releasees failing to show up for aftercare referrals, and a decreased length of time between an inmate's release and placement into aftercare treatment. The program also recorded an increased rate of successful aftercare treatment completion among the Sheridan graduates. Between FY05 and FY10, the proportion of Sheridan releasees successfully completing aftercare increased from 60 percent to 80 percent.

Earned Good Conduct Credits received by many Sheridan inmates for participation in treatment during the period studied translated into a savings of 714 years of incarceration, which equates to $16.7 million, or $2.78 million per year, in reduced incarceration costs.

In addition, as a result of the treatment services and aftercare received, Sheridan graduates had a 16 percent lower likelihood of returning to prison after three years in the community than a statistically similar comparison group of inmates released from other Illinois prisons during the same time period.

The largest reductions in recidivism—both in terms of re-arrest and return to prison—were evident among Sheridan graduates who successfully completed aftercare treatment. These releasees had a 44 percent lower likelihood of returning to prison after three years in the community than a statistically similar comparison group. Given that rates of aftercare treatment completion have improved substantially over the past year, it is likely that recidivism among Sheridan graduates will continue to drop.

Notes

[1]Annual cost per inmate is for FY08, and came from the Fiscal Impact Statement provided by IDOC to the Clerk of the Circuit Court pursuant to ICLS 5/3-2-9.

[2]Standardized rates represent the recidivism rates for the groups after statistically controlling for any differences between the groups in terms of offender age, race, marital status, education level, having children, gang membership, prior prison sentences, current conviction offense, current offense felony class, length of time served in prison, and the jurisdiction to which the inmate was released. The technique used to make these statistical controls was Cox Regression (multivariate survival analyses), which accounts for the slight differences between the groups in terms of their characteristics, as well as substantial differences in the time individuals included in the analyses were at risk for recidivism.

[3]The unstandardized recidivism rates (i.e., without making statistical adjustments to account for the slight differences in the characteristics of the Sheridan and comparison group) using survival analyses/life tables were 53 percent for the comparison group at 36 months and 49 percent for the Sheridan graduates at 36 months.

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