Program Evaluation Summary
Vol. 3, No. 1 October 2004

Impetus and implementation of the Sheridan Correctional Center Therapeutic Community

By David E. Olson, Ph.D., Rebecca Juergens, and Steven P. Karr

The increase in Illinois' prison admissions and population during the past 15 years has been fueled in large part by sentences for drug law violations and high rates of return to prison, both of which are significantly related to the prevalence of substance abuse problems among those entering and exiting prison. However, despite this trend, resources have not been available to adequately meet the treatment needs of Illinois' prison population. By 2003, roughly 35,000 adults were admitted to and released from prison in Illinois, and Illinois' prison population stood at nearly 45,000 inmates (Figure 1). In response to this situation, and a desire to improve public safety by reducing recidivism among drug-involved offenders, Gov. Rod R. Blagojevich announced during his 2003 State of the State address his goal of reopening the Sheridan Correctional Center as a prison that could serve as a national model for how to safely and effectively manage these offenders while incarcerated and following their release back into Illinois' communities. The Sheridan Correctional Center is a medium-security prison located about 70 miles southwest of Chicago.

Following this announcement, criminal justice and social service policy makers, practitioners, and researchers from Illinois and across the nation were brought together by the Governor's Office to develop what could be one of the largest and most comprehensive prisons in the country devoted to substance abuse treatment and inmate reentry, including both institutional and post-release programming. The outcome of this yearlong planning process culminated in the reopening of the Sheridan Correctional Center as a fully-dedicated Therapeutic Community (TC) on Jan. 2, 2004, when the first 50 inmates were admitted to the facility. In general, Therapeutic Communities are "residential [programs] that use a hierarchical model with treatment strategies that reflect increased levels of personal and social responsibility. Peer influence, mediated through a variety of group processes, is used to help individuals learn and assimilate social norms and develop more effective social skills" (National Institute on Drug Abuse, 2002). By the end of June 2004, almost 900 inmates were at Sheridan, and it is projected that the first large cohorts of participants will be released during Fall 2004.

Illinois Criminal Justice Information Authority

120 S. Riverside Plaza, Suite 1016
Chicago, Illinois 60606

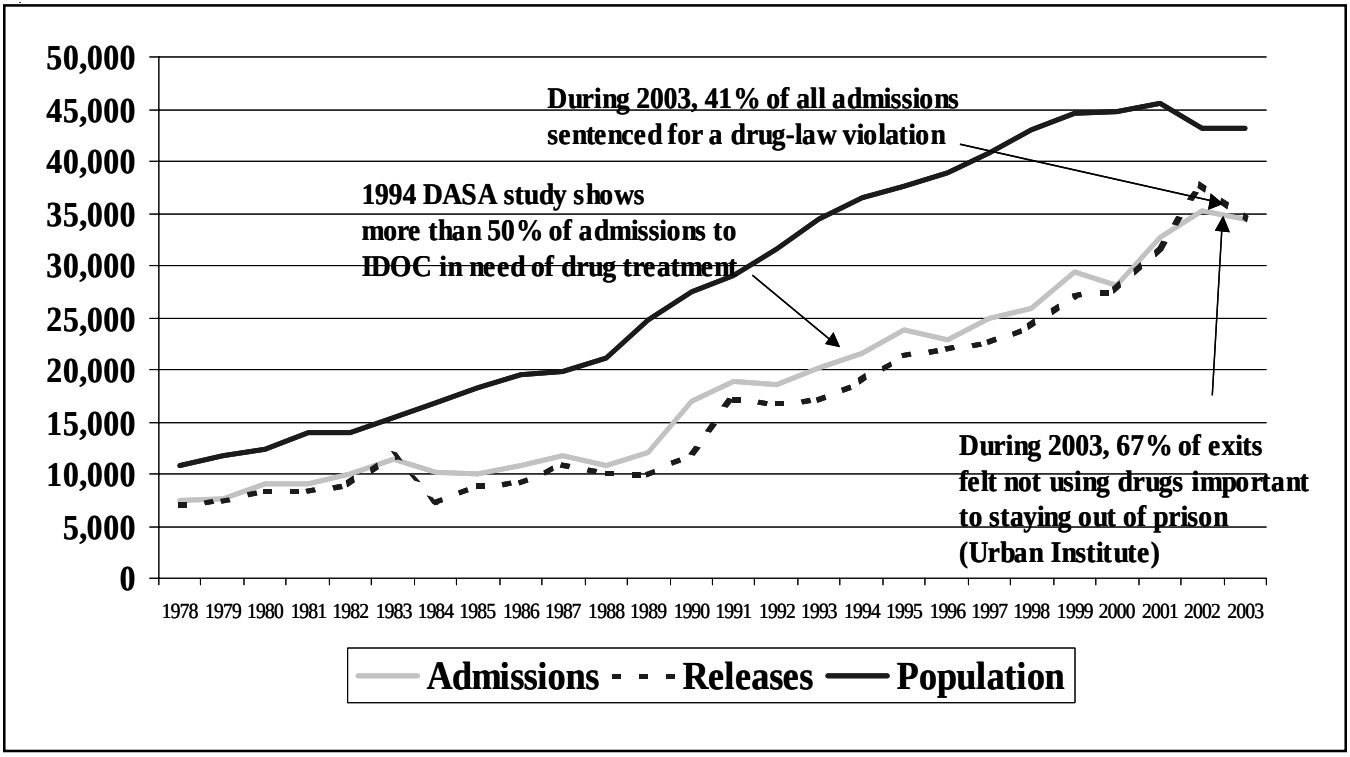
Phone: 312-793-8550, TDD: 312-793-4170,
Fax: 312-793-8422
website: www.icjia.state.il.us

Program Evaluation Summaries are derived from program evaluations funded or conducted by the Authority. The full evaluation reports are available from the Authority.

For more information about this or other publications from the Authority, please contact the Authority's Criminal Justice Information Clearinghouse or visit our website.

Printed by authority of the State of Illinois, October 2004.

Figure 1
Trends in Illinois' adult prison admissions, releases, and population



This *Program Evaluation Summary* describes the impetus for the Sheridan Correctional Center TC, the planned design and operation of the program, and the characteristics of the nearly 900 participants at the Sheridan Correctional Center on June 30, 2004. Future *Program Evaluation Summaries* will provide updates from the process and impact evaluation, which is being led by staff from the Authority and the Illinois Department of Corrections (IDOC), and also involves a consortium of state agencies and service providers, researchers from area universities, and nationally recognized experts with experience developing and evaluating prison-based treatment programs.

Program impetus

Illegal drugs have contributed dramatically to the growing admissions to, exits from, and population of, prisons in Illinois and across the country in two ways over the past 15 years. First, since the late 1980s, sentences to prison in Illinois for state drug law violations increased from fewer than 1,500 before 1986 to more than 15,000 by 2003, driven primarily by increases in arrests and to some degree by changes in sentencing practices and policies. By 2003, 41 percent of the more than 35,000 adults admitted to prison in Illinois were convicted of a drug law violation (Figure 1). Second, drug *use* is associated with the crimes committed by the majority of those sentenced to prison, regardless of the specific type of crime for which they were convicted. For example, while 41 percent of all adults admitted to Illinois' prison system during 2003 were convicted of a drug law violation, it is estimated that roughly 70 percent of those sentenced to prison, regardless of their conviction offense, were "regular" drug users and in need of drug treatment prior to their incarceration (Cho, Johnson, Kelly-Wilson, & Pickup, 2001; Visher, La Vigne & Farrell, 2003).

In addition to fueling prison sentences handed down by the courts, drug abuse, as well as illegal possession and sale of drugs, also plays a significant role in the recidivism and return to prison for many of those released in Illinois. Based on a sample of more than 2,400 adults released from Illinois prisons during 2000 (Olson, Dooley & Kane, 2004), 33 percent were rearrested for a drug law violation or returned to the IDOC because they tested positive for an illegal drug while on mandatory supervised release, or parole, in Illinois. All told, 75 percent of adults released from prison and tracked for the study over a three-year period were rearrested for a new crime, with roughly one-third due to the

possession or sale of illegal drugs. Similarly, recidivism research conducted by IDOC, which specifically examined those returned to prison, revealed that more than 54 percent of the inmates released during 2000 were returned to prison within three years, which is the highest recidivism rate ever documented by the IDOC (Jones, et. al., 2004). Among those releasees with histories of substance abuse, the recidivism rates were even higher. Finally, the relationship between drug use and the risk of returning to prison is also recognized by prison inmates in Illinois. Based on a survey of soon-to-be-released adult male prison inmates in Illinois by the Urban Institute, 67 percent felt that "staying away from drugs will be important to staying out of prison in the future."

Despite the substantial relationship between drug use, prison admissions, and recidivism, the degree to which substance abuse treatment has been historically integrated into correctional programming has been limited in Illinois and the rest of the country. Evidence of this can be seen in a national survey of prison inmates in 1997, which found that fewer than 20 percent of inmates identified as being regular drug users prior to their incarceration participated in drug treatment while incarcerated (Mumola, 1999). A similar pattern is evident in Illinois, where it is estimated that fewer than 20 percent of regular drug users in need of treatment actually participate in one of the roughly 2,500 drug treatment slots in IDOC.

Other national research reveals that the number of prisons "focusing" on intensive substance abuse treatment was low (Stephan & Karlberg, 2003), and those fully dedicated to substance abuse treatment were even more rare. A June 2003 Authority telephone survey of state correctional systems, and follow-up interviews with staff at specific prisons in the country, revealed that only 12 of the more than 1,300 state-operated prisons in the U.S. were fully dedicated (all inmates participating in treatment) to substance abuse treatment for a general prison population (excluding parole/probation violators).

However, those involved in the planning for the Sheridan Correctional Center recognized early on that providing prison-based substance abuse treatment programming is only the beginning of the process to address the criminogenic risks/needs of those participating in the program. In addition to substance abuse, many of the inmates targeted for the program were also expected to have other needs, including those that will need to be addressed during the period of time following their release from prison. For example, based on a survey conducted in 2003 of soon-to-be-released adult male inmates by the Urban Institute, it was revealed that 62 percent reported that they would need help finding employment, 29 percent needed assistance in finding a place to live, 26 percent wanted help accessing treatment, and 43 percent needed help finding counseling services. Many of these needs were correlated with the inmates' expectations about being able to stay out of prison in the future. Inmates who were concerned about being able to find a job or a place to live were quite pessimistic about being able to stay out of prison (Olson, Travis, Visher, & La Vigne, 2003).

Evolution of the program

Following Gov. Blagojevich's 2003 announcement, numerous working groups were established to develop the Sheridan program, including an interagency workgroup, a policy advisory committee, workgroups to design the institutional and post-release aspects of the program, an evaluation advisory committee, and a workgroup comprised of community and faith-based organizations to ensure the inclusion of community capacity in the planning for Sheridan. This was the first time that many of the organizations included on these workgroups were formally asked to be involved in the development of correctional programming in Illinois. The *Sheridan Interagency Work Group* was formed and included representatives from all of the state agencies to leverage and integrate existing state resources to more effectively support successful reentry of former inmates. Agencies involved were IDOC, the Illinois Department of Human Services, which includes the Divisions of Alcoholism and Substance Abuse and Mental Health, Illinois Department of Public Health, Illinois Department of Public Aid, Illinois Department of Employment Security, Illinois Department of Children and Family Services, Illinois Department of Commerce and Economic Opportunity, the Authority, and the Governor's Office.

There was also a *Policy Advisory Committee*, which included representatives from various community-based treatment agencies, social service organizations, civic groups, the Chicago Mayor's Office, Illinois General Assembly and Congress, and a group of national experts on correctional issues and institutional treatment programs. A *Sheridan Evaluation Advisory Committee* was also formed, and continues to provide feedback and input into the design of the process and impact evalua-

Table 1
The Sheridan process

Day one at IDOC Reception & Classification Center	First week at Sheridan Correctional Center	First month
•Screening of all admissions for substance abuse problems using Texas Christian University's (TCU) Drug Screen II by Treatment Alternatives for Safe Communities (TASC) •Identification of Sheridan criteria-eligible admissions •Explanation of Sheridan program to eligible inmates in need of treatment, acceptance by inmate, inmate's signature of Sheridan "contract" •Recommendation to IDOC's Transfer Coordinator's Office (TCO) of Sheridan-eligible inmates	•Participants transferred to Sheridan Correctional Center from the Reception and Classification centers •More in-depth assessment by Gateway staff •Assessment of employment skills, experiences and needs by Safer Foundation •Identification of treatment needs and plans developed by Gateway with input from IDOC, TASC and Safer Foundation	•Orientation to Therapeutic Community (TC) concepts and treatment readiness programming by Gateway •Additional testing for educational needs by IDOC School District •Inmates successfully pass a test on TC concepts and are transferred out of the orientation unit and into smaller living units/"families" •Individual review of treatment plan with Sheridan participant and Gateway counselor

Remainder of time Months 2 - 24 depending on sentence	Pre-Release	Post-Release
•Substance abuse treatment, including encounter groups, cognitive self-change groups, and group and individual counseling •Educational programming, vocational training, institutional employment/ correctional industries •Job preparedness workshops; job shadowing and evaluations; resume development; interview skill building •Specialized programming: anger management, parenting skills, and family reunification	•Multi-disciplinary discharge staffing involving Gateway, TASC, Safer, IDOC's Placement Resource Unit (PRU), and Parole beginning at 120 days prior to release •Development of an aftercare plan, including treatment, education/ vocational, housing, employment and other needs •Identification/recommendation to the Prisoner Review Board (PRB) of mandatory supervised release (MSR) conditions/requirements	•Through TASC, PRU and Parole, referral to various services, including transitional housing, continued clinically-appropriate treatment, and educational/vocational programs •Through Safer, job placement, coaching, and employment retention services •Parole supervision to ensure compliance with MSR conditions •Linking former Sheridan inmate with Community Support and Advisory Council members

tion being performed. Together, these groups identified the appropriate target population for the program, developed the operational goals of the Sheridan program, identified the types and amount of services needed, ensured that the best practices were identified and included in the plan, developed detailed operational guidelines for the program, and designed a process and impact evaluation that would provide timely information regarding the Sheridan program to policy makers and practitioners. Since many of those involved in the design and implementation of the Sheridan program also have broader interests in correctional policy and inmate reentry, these groups will be reconstituted during the fall of 2004 into the Governor's Task Force on Community Safety and Re-Entry Management, which will continue to identify, develop, and recommend effective reentry programs and policies for the state.

Target population

One of the first discussions that took place among members of the Policy Advisory Committee before the Sheridan Correctional Center opened was on who should be targeted for participation in the Sheridan program. To help make the determination, Authority staff conducted telephone interviews with staff at prisons in the U.S. identified as being fully dedicated to substance abuse treatment to determine their target populations. From these interviews it was concluded that most had very specific target populations (drug law violators, DUI offenders, or parole violators), specific lengths of stay (six months or less, nine to 12 months only), and most served minimum security populations. During the planning phase for Sheridan, numerous admission criteria were explored. With each set of criteria, a pipeline study was performed to determine if the criteria would produce the numbers of admissions needed to ensure full utilization of Sheridan program resources and institutional capacity.

The planning groups recognized the need to not base admission solely on the conviction offense, which may be misleading, but rather on an objective substance abuse assessment. The group also thought it important to accept not only inmates with the ideal length of time to participate (nine to 12 months), but also those with relatively short projected lengths of time to serve (six to eight months), as they tend to have the fewest opportunities to access treatment while experiencing the highest recidivism rates. Individuals with 13 to 24 months of incarceration also were accepted with the intention of providing access to a broader array of educational and vocational opportunities while in the facility.

Through refinement of the criteria and reanalyses of data for the pipeline study, a final set of participant criteria were agreed upon. They include: male inmates, projected to *serve* six to 24 months within IDOC, appropriate for a placement in a medium security institution, and identified through an objective assessment to be in need of substance abuse treatment. The only specific inmates excluded from Sheridan are those serving a sentence for murder or criminal sexual assault and those identified as having a severe mental illness. Based on these criteria, it was estimated that roughly 8,000 inmates admitted to Illinois prisons per year would be eligible for Sheridan. However, the Sheridan program is voluntary, which is consistent with other effective prison-based TC programs, so it wasn't expected that all eligible inmates would be willing to participate.

Identifying and enrolling participants

During the course of program development, the various workgroups and committees created a blueprint for how inmates would be identified, assessed, oriented, treated, prepared for release/reentry and assisted while in the community following their release. The result of this planning is summarized in Table 1, which provides an overview of the steps involved and the types of services and activities that will take place for the typical Sheridan inmate.

Carrying out the Sheridan initiative

Because of the unique nature of the Sheridan Correctional Center, it was the desire of senior-level IDOC officials to have those who believed in the TC model manage Sheridan. IDOC sought eligible candidates for the positions of warden, assistant warden of operations and assistant warden of programs from within the department and nationally. The warden is a Certified Criminal Justice Addictions Professional, and the two assistant wardens are Certified Alcohol and Drug Counselors. Together, the three individuals have a combined 61 years of correctional experience. This experience and perspective of the management staff is critical given that a large body of research on the effective implementation and impact of prison-based treatment programs emphasizes the commitment and dedication of management to the program and its goals. To ensure that this understanding and commitment to the mission of the program is also held by the line staff of the Sheridan Correctional Center, careful selection of staff took place, and extensive training was provided to staff both prior to the opening of the facility as well as since it has become operational. Parole officers who will be involved in the post-release supervision and management of Sheridan participants have also undergone immersion training and will have programs, interventions, and graduated sanctions available to support the successful reentry of participants while ensuring accountability and public safety. A number of contractual service providers were also selected through a competitive bidding process, including the Gateway Foundation to provide the substance abuse treatment at the Sheridan Correctional Center, Treatment Alternatives for Safe Communities (TASC) to provide clinical case management services, including the initial screening/assessment for treatment need,

Table 2
Participant characteristics by primary substance of abuse

Primary Substance of Abuse	Average Age	Non-White	Cook County	High-school Grad/GED	Full-time Employment	Daily Poly Drug Use
Heroin	34.6	81%	67%	45%	28%	58%
Cocaine	34.0	76%	44%	46%	42%	65%
Marijuana	26.2	80%	42%	34%	35%	44%
Alcohol	34.2	61%	45%	48%	49%	36%
Total	31.8	74%	48%	43%	38%	52%

planning for release, including the linking of participants to needed community-based services, and assisting parole staff, and the Safer Foundation to provide institutional programming to address inmate employment needs and to provide participants with assistance following their release in obtaining employment that provides both a living wage and that is likely to lead to opportunities for career advancement. To achieve this, the employment readiness, adult basic education and vocational training programs being developed at Sheridan are also innovative, with a focus on skills needed for jobs in high-growth sectors of the economy likely to hire ex-offenders and developed in partnership with numerous organizations, including Illinois Valley Community College, the Illinois Manufacturing Foundation, and the National Homebuilders Association.

Given the identification by research and those involved in the various planning workgroups of the importance for community partnerships and capacity to assist those returning from prison back to the community, a number of initiatives were launched to support communities where Sheridan inmates were likely to return. For example, IDOC coordinated a series of community capacity building and training workshops across the state. Also, a proposal by faith-based, community and civic organizations in parts of the state with large numbers of released inmates to form and pilot Community Support and Advisory Councils (CSACs) was supported, and these CSACs will not only assist returning inmates but will also provide short and long-term recommendations on how to better address the needs of the formerly incarcerated. Finally, community-based service providers that may work with participants following their release have been given immersion training at the Sheridan Correctional Center so that they can better understand the program and its participants. In total, more than $45 million has been set aside for the Sheridan program in state fiscal year 2005, which includes both the institutional and post-release components of the program.

Participant characteristics

The following provides an overview of the characteristics of the 890 inmates at the Sheridan Correctional Center on June 30, 2004, and is based on detailed information collected during the initial screening for program eligibility, the assessment performed on each participant by Gateway, analyses of participant criminal history records, and other administrative data collected by the IDOC.

Committing county

Consistent with the projections, 48 percent of the Sheridan participants were sentenced to IDOC from Cook County. Due to the time and additional staff needed to implement the recruitment process, admissions to the IDOC through the Northern Reception and Classification (R&C) Center at Stateville have been the focus of Sheridan recruitment, and thus there have been relatively few admissions to Sheridan from counties in the central and southern part of Illinois. This will change as the other two male R&C centers in the state at Graham and Menard have now fully implemented the recruitment and screening for Sheridan-eligible inmates. Combined, 68 percent of the current Sheridan participants were sentenced from the Cook (Chicago) and surrounding collar county region (Lake, McHenry, Kane, DuPage, and Will counties).

Inmate demographics

The majority of those admitted to Sheridan so far have been African-American (65 percent) and the average

age of participants is 32 years (Table 2). Overall, 68 percent of those admitted to Sheridan were single (never married), 43 percent had completed high-school/ had a GED and 38 percent were employed full-time prior to their commitment to IDOC. When the participants were grouped by their primary substance of abuse, some differences emerged. For example, those identified as heroin abusers tended to be older (average age of 35), than marijuana abusers (average age of 26). Similarly, 67 percent of the heroin abusers were from Cook County, compared to 42 percent of the marijuana abusers.

Extent and nature of substance abuse

Based on the TCU Drug Screen, which asks interviewees to identify the drug that causes them the worst problem (primary substance of abuse), there appear to be four distinct and fairly large groups of Sheridan participants: cocaine abusers (27 percent), marijuana abusers (28 percent), alcohol abusers (18 percent) and heroin abusers (21 percent). Five percent of the Sheridan participants identified other substances, such as methamphetamine and hallucinogens, as their primary substance of abuse.

When primary and secondary substance of abuse were combined to determine if the participants saw themselves as having a problem with each drug, it was evident that almost one-half (46 percent) identified themselves as having a problem with alcohol, 50 percent a problem with marijuana, 46 percent a problem with cocaine, and 25 percent a problem with heroin. Since participants could identify multiple drugs as causing them some problem, these percentages exceed 100 percent. In terms of the frequency of drug use, the majority of Sheridan participants, regardless of their primary substance of abuse, were using drugs—often multiple drugs—on a *daily* basis prior to their incarceration. For example, almost 100 percent of those who identified heroin as the drug causing them the most problems used heroin on a daily basis, and a large proportion of the heroin abusers (57 percent) also reported using cocaine on a daily basis as well. Among the cocaine abusers, 95 percent reported using it on a daily basis, and 65 percent also indicated daily use of other drugs, including alcohol, heroin and/or marijuana. Overall, 52 percent of the Sheridan participants indicated that they used more than one drug on a daily basis prior to their incarceration.

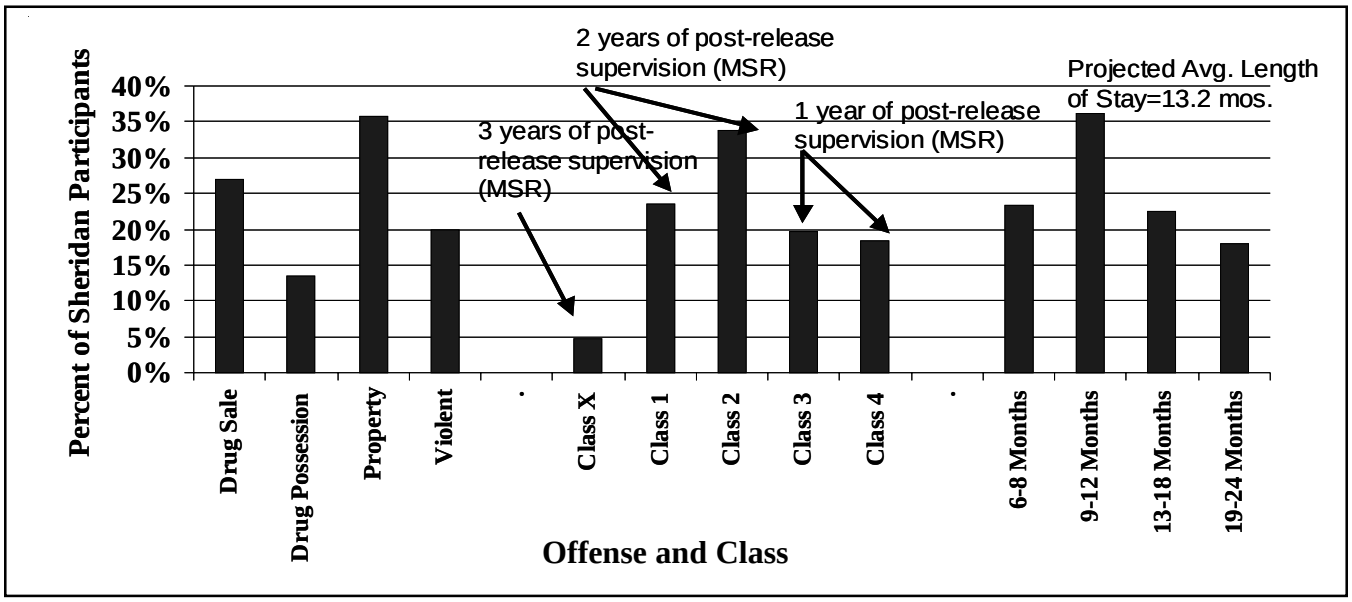
It is also evident that the majority (70 percent or more, depending on the primary substance of abuse) of Sheridan participants reported that they had spent less time at work, school or with friends so that they could use drugs. Almost one-half (42 percent) reported experiencing emotional/psychological problems due to their drug use, with those abusing cocaine and heroin reporting a higher prevalence of these emotional/ psychological problems (49 percent) than those identified as marijuana abusers (30 percent). Finally, almost 22 percent of all Sheridan participants reported experiencing health/medical problems due to their drug use. Those abusing cocaine and heroin reported a higher prevalence of these health problems than marijuana abusers. By examining the responses to specific questions on the TCU screening tool, it is possible to determine the severity of the substance abuse problem. Combining specific elements can produce a severity score, which has a possible range from 0 (no indication of drug abuse) to 9. A score of 3 is consistent with a clinical diagnosis of drug dependence. The average TCU Drug Screen score for the Sheridan participants was 7.3. Those who reported their primary substance of abuse as alcohol or marijuana had average scores of 6.7 and 6.4, respectively, while cocaine abusers had an average score of 7.8, and heroin abusers had an average score of 8.4.

Just over one-half (55 percent) of the Sheridan participants reported on the TCU Drug Screen that they had previously received drug treatment, but there were some differences across the identified primary substances of abuse. For example, 61 percent of those that identified alcohol as the drug causing them the worst problems had been in substance abuse treatment previously, as were 66 percent of the heroin abusers. On the other hand, 41 percent of the marijuana abusers had ever received substance abuse treatment. Part of this difference may be due to the older ages of the alcohol and heroin abusers.

Holding offense and class, and prior criminal history

Consistent with projections made during the planning process, the majority of Sheridan participants were sentenced to the prison for drug law violations or property offenses (Figure 2). Specifically, 27 percent were sentenced to the IDOC for drug sale/delivery, 14 percent for drug possession, 3 percent for DUI, 17 percent for burglary, 13 percent for theft/forgery, and 6 percent for other property crimes. Combined, these drug and property offenses accounted for 80 percent of

Figure 2
Conviction/holding offense, felony class and time sentenced



the admissions to Sheridan. In addition, roughly 20 percent of the current Sheridan participants were sentenced to IDOC for violent crimes, primarily robbery and assault/battery. However, regardless of their holding offense, all were identified as drug dependent based on a clinical assessment.

There appear to be more inmates at Sheridan sentenced for more serious offense classes than originally projected. Of the 890 inmates, 62 percent were sentenced for a Class X, 1 or 2 felony, while the projections estimated less than one-half would fall in this range. As a result, 38 percent of Sheridan participants are serving a sentence for the less serious offense classes (Class 3 and 4 felonies) than projected (54 percent). Given that more serious felony classes tend to receive longer sentences and longer periods of mandatory supervised release, this will make the average length of time participants are at Sheridan and on supervised release slightly longer than expected.

During the planning for Sheridan it was projected that the target population would have extensive criminal histories, and analyses of the criminal histories of those admitted to Sheridan confirms this is the case. Those admitted to Sheridan had an average of 1.4 prior prison sentences and 17 prior arrest charges, with prior arrests for various crimes, including drug law violations, property crimes and violent offenses. Those identified as heroin abusers had more extensive criminal histories, while marijuana abusers (who tended to be younger) had fewer prior arrests and convictions. For example, among those with heroin as their primary substance of abuse, the average number of prior arrests was 22, with an average of 10 prior convictions and 2.3 prior prison sentences.

Gauging motivation for the program

It appeared from the responses to specific questions on the TCU Drug Screen that the majority of Sheridan participants are highly motivated to enter treatment. More than 75 percent of all participants said it is "extremely important" for them to get treatment, with nearly 90 percent of those identified as cocaine or heroin abusers feeling this strongly.

A less direct but potentially more telling indicator of motivation is whether or not the participant is legally eligible for what is called earned good conduct credit (EGCC), which provides inmates with additional time off of their sentence for participation in treatment or vocational programming if they have not been sentenced to IDOC more than once before and if they have never received it before. Based on interviews by the research team, EGCC heavily influenced many participants' willingness to participate. In terms of eligibility for earned good conduct credit, 48 percent of the current participants are eligible. There appears to be a relationship between earned good conduct credit eligibility and primary substance of abuse. Among those identified as heroin abusers, a relatively small

proportion (33 percent) are eligible. On the other hand, among marijuana abusers, 64 percent are eligible for earned good conduct credit. This, in part, is likely due to the age and criminal history differences between the two groups, and therefore the likelihood that the marijuana abusers have not been in the IDOC multiple times. It may also be indicative of the high level of treatment motivation among the heroin abusers – since two-thirds of them still elected to participate despite that they are not receiving a reduced sentence.

Removals from Sheridan

There were 123 inmates, in addition to the population of 890 participants at the end of June 2004, who were removed from the program for a variety of reasons, including (from most frequent reason to least): refusal to participate, IDOC rule violations, and inappropriate for the program (projected length of stay in IDOC too long or too short, pending criminal cases/warrants, serious mental illness). The inmates who were removed from the program due to refusal to participate and rule violations were younger on average than inmates still in the program (28 versus 32 years old, respectively), more likely to be marijuana abusers (40 percent versus 28 percent) and less likely to be eligible for earned good conduct credit (31 percent versus 47 percent).

Exits from Sheridan

Based on who is currently at Sheridan, it is projected that the average length of stay at the facility will be 13.2 months, with about one-quarter serving six to eight months in the facility, 35 percent serving nine to 12 months, 25 percent serving 13 to 18 months and the remaining 15 percent serving between 19 and 24 months (Figure 2). About 300 participants are projected to be released from Sheridan by the end of December 2004. It is projected that 38 percent will be on mandatory supervised release (MSR) for one year, 57 percent will be on MSR for two years, and the remaining 5 percent will have three years of post-release supervision. These lengths of supervision are based on Illinois law and the felony class of the conviction offense.

Participant views of the program

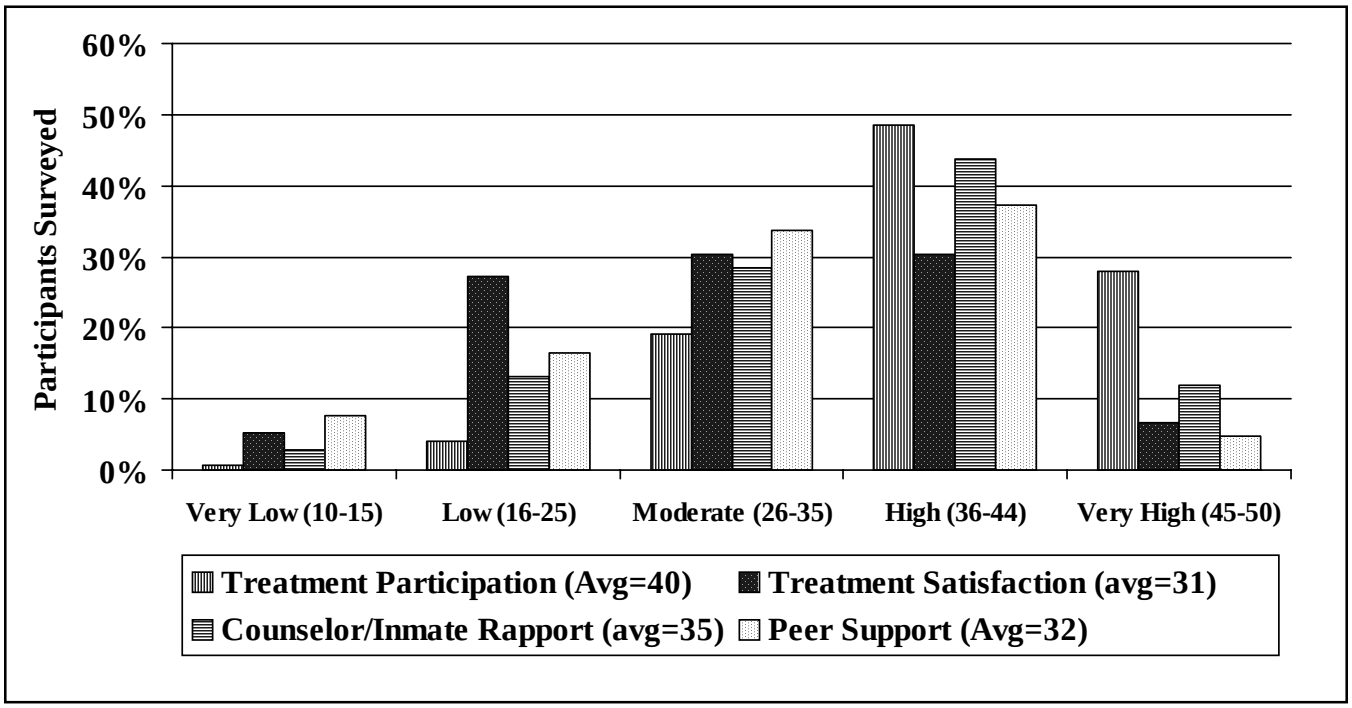
As part of the evaluation of the Sheridan Correctional Center TC, participants are asked to voluntarily complete a survey that inquires about their treatment participation and views of the program. The survey was designed by researchers at Texas Christian University specifically for incarcerated criminal justice populations and is called the Client Evaluation of Self and Treatment, or CEST. To date, 571 participants at Sheridan have completed the survey. In the CEST numerous questions ask about different dimensions of the program, which can be grouped into composite measures of treatment participation, treatment satisfaction, rapport between the client and counselor, and peer support.

The first set of questions examined here gauged treatment participation among the Sheridan inmates. This composite measure combines individual responses to 11 separate questions that are intended to measure the inmates' participation in the program, including being "willing to talk about your feelings," " learning to analyze and plan ways to solve your problems," "participating actively in your counseling sessions," and "making progress in your understanding of your feelings/behavior." From the responses to these questions it can be concluded that participation is high among those in the program, with an average score on the composite measure of 40 on a 10-50 scale (Figure 3).

Another dimension of the Sheridan program examined through the surveys was treatment satisfaction. Average participant responses to a number of the inquiries — "You get plenty of personal counseling at this program," "The treatment staff here are efficient at doing their job," " You are satisfied with this program"—could be described as "neutral" or "uncertain." However, when asked whether they agreed or disagreed with the statement, "This program expects you to learn responsibility and self-discipline," the average response was between "agree" and "strongly agree" (4.2 on a 1 to 5 scale).

Another aspect of the program examined through the responses to the survey questions was the degree of rapport between the program participant and their counselor. Research has consistently found a strong relationship between good participant/counselor rapport and successful treatment outcomes, and the surveys indicate that the program is on its way to achieving this. The composite score for "participant/counselor rapport" (based on 13 separate questions) averaged 35 on a 10-50 scale, with 56 percent of the participants indicating a high or very high degree of rapport.

Figure 3
CEST composite measures of treatment participation, satisfaction, counselor/inmate rapport and peer support among participants



Participants' view of peer support was measured in the survey through participants indicating the degree to which they agreed or disagreed with five statements, including, "Other clients at this program care about you and your problems," "Other clients at this program are helpful to you," and "There is a sense of family (or community) in this program." It appears that the average composite score in this area — 32 on a scale from 10-50 — is in the neutral/uncertain range. Part of this may be the result of a population at Sheridan from different parts of the state, with different substance abuse and criminal histories, varying education levels, and limited experience in a TC setting. It is important to note that these surveys reflect current views, which may change as participants are exposed to more programming.

Policy and practice issues identified

During the course of the planning and implementation of the Sheridan program, a number of policy and practice issues were raised. First, a large number of inmates coming into IDOC require substance abuse treatment, but serve relatively short periods of time. For example, among new court admissions released from IDOC in 2003, more than 13,000 spent fewer than six months in prison. In addition, IDOC has experienced a substantial increase in returns to prison of parole violators since the late 1990s, many of whom may also require treatment but cannot be easily placed into the program due to the uncertainty of their release date or their relatively short length of stay in an IDOC facility. Given this cycle of short prison stays, with few opportunities for *substantive* treatment or rehabilitative programming while incarcerated, the need to develop some type of community-based programming for these released inmates is critical to the long-term improvement in prison outcomes in Illinois. Through the Governor's Task Force on Community Safety and Re-Entry Management, these types of issues will likely be raised and addressed through interagency and intergovernmental coordination and collaborations with community-based organizations and groups.

Also, during the course of program implementation, the need to objectively gauge the extent and nature of substance abuse and treatment need among *all inmates* admitted to the IDOC was addressed. During the first three months of program implementation only those that indicated an interest in participating in drug treatment were given the TCU Drug Screen during the Reception and Classification process. In response to this gap, and a larger desire within the IDOC to document treatment needs, this screening for substance

abuse and treatment need will be given to all inmates admitted to the IDOC. In the future these efforts will assist in being able to better gauge the need for substance abuse treatment programming among IDOC inmates, as well as help prioritize treatment access for those identified with the most severe drug problems. As these screenings are performed, IDOC will utilize this information for decision-making on both the individual level and an agency and interagency level for strategic planning within IDOC and the Illinois Department of Human Services' Division of Alcoholism and Substance Abuse.

The last potential issue identified during the planning and implementation of Sheridan is that a large number of inmates eligible for Sheridan (and other treatment programs in IDOC) are ineligible to receive earned good conduct credit due to legislative restrictions. State law prohibits inmates convicted of certain crimes under Truth-In -Sentencing (TIS) laws, as well as those who either received earned good conduct credit in the past or who have been sentenced to prison more than once from getting EGCC. While most agree that the TIS offenders should have some restrictions on the opportunity to receive EGCC, the fact that the majority of admissions to IDOC are now prohibited from getting earned good conduct credit is something that Illinois' policy makers may want to reexamine. Since more than one-half of the inmates eligible for the program will not be able to get earned good conduct credit, the number of inmates who volunteer for the program may be affected. Among inmates admitted to Sheridan since it opened, 52 percent are eligible for earned good conduct credit. These figures, confirmed by interviews with Sheridan participants for the evaluation, suggest that for the majority of those who volunteer and are eligible for Sheridan, their eligibility for EGCC is one of the factors that influenced their decision to participate.

Conclusions

The preceding analyses confirm that the Sheridan Correctional Center is serving a population with extensive substance abuse and criminal histories, as well as educational and vocational deficits. It is also evident that many of the Sheridan participants will need to be engaged in programming and services following their release from the institution, since a large portion (nearly 60 percent) will be at Sheridan for a year or less. Based on observations made by the evaluation team during the course of program implementation, and interviews and surveys with program participants, it appears that many of the pieces of an effective TC program are in place and becoming routine at the Sheridan Correctional Center. Much of these early successes can be attributed to the extensive, coordinated and inclusive planning that was done during the year before Sheridan opened, and the continued monitoring of program implementation to ensure consistency with the program design. As participants from Sheridan begin to be released in larger numbers — with a projected 290 exits to mandatory supervised release by the end of December 2004 — the challenge will be the coordination and balance of participant needs, reintegration into the community, and public safety concerns. Further, given the comprehensive nature of the Sheridan program, this coordination will need to go beyond IDOC and the agencies providing programming to the Sheridan inmates, and will need to take into account how the program integrates with local law enforcement and other criminal justice system agencies.

Since the Sheridan program represents such a significant change from how inmates historically have been handled, and reducing recidivism takes time to accomplish and gauge, evaluators will continue to document the implementation and impact of the Sheridan Correctional Center program. Future reports will provide updates on characteristics of participants, the types of services being provided and the view of the program from the perspective of both the participants and staff. As participants from the program are released, evaluators also will monitor and assess the impact of the program across a number of different outcomes, including recidivism and employment rates, and access to community-based services.

References

Cho, Y., Johnson, T., Kelly-Wilson, L., & Pickup, L.: *Substance Use in Illinois: Prevalence and Treatment Need, 1990-2000*. Chicago, Illinois: Illinois Departemnt of Human Services, Office of Alcoholism and Substance Abuse, 2001

Jones, R.J., Olson, B.W., Karr, S.P., & Urbas, S.M.: *2003 Statistical Presentation*. Springfield, Illinois: Illinois Department of Corrections, 2004

Mumola, C.J.: *Substance Abuse and Treatment, State and Federal Prisoners*, 1997. Washington D.C.: Bureau of Justice Statistics, 1999.

National Institute on Drug Abuse, *Therapeutic Community - Research Report Series*, Washington D.C.: U.S. Department of Health and Human Services,

2002.

Olson, D.E., Travis, J., Visher, C., & La Vigne, N.: *Examining the Optimism/Pessimism of Soon-to-be-Released Prison Inmates*. Paper presented at the Justice Research and Statistics Association Annual Conference, San Francisco C.A., 2003.

Olson, D.E., Dooley, B., & Kane, C.M.: *The relationship between gang membership and inmate recidivism*. Chicago, Illinois: Illinois Criminal Justice Information Authority, 2004.

Stephan, J.J. & Karlberg, J.C.: *Census of State and Federal Correctional Facilities, 2000*. Washington D.C.: Bureau of Justice Statistics, 2004.

Visher, C., La Vigne, N., & Farrell, J.: *Illinois Prisoners' Reflections on Returning Home*. Washington, D.C.: Urban Institute, 2003.

Affiliations and acknowledgments

David Olson, Ph.D, is chairman and associate professor of Loyola University Chicago's Department of Criminal Justice, and a senior scientist at the Authority. Rebecca Juergens is a research analyst in the Authority's Research and Analysis Unit. Steven Karr is the manager of the Illinois Department of Corrections' Planning and Research Unit.

The evaluation team would like to thank all of those who have assisted in making this evaluation report possible, including the staff at the Sheridan Correctional Center, the program participants at Sheridan who have allowed us to interview them and who have completed surveys, and the various working groups, committees, and organizations involved in the development and operation of the Sheridan program.

ICJIA

Illinois Criminal Justice Information Authority

This project was supported by Grant #01-DB-BX-0017, awarded to the Illinois Criminal Justice Information Authority by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions contained within this document are those of the author and do not necessarily represent the official position or policies of the Illinois Criminal Justice Information Authority or the U.S. Department of Justice.

Criminal Justice Information Authority
120 S. Riverside Plaza, Suite 1016
Chicago, Illinois 60606
312-793-8550, TDD: 312-793-4170, Fax: 312-793-8422
www.icjia.state.il.us

PRESORTED STANDARD
U.S. POSTAGE
PAID
CHICAGO, IL
PERMIT NUMBER 4273