Does Prison Substance Abuse Treatment Reduce Recidivism?

Performance Audit Report

Iowa Department of Corrections' Licensed Substance Abuse Programs

May 25, 2007

Iowa Department of Management
Performance Audit Program

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The Iowa Legislature has given the Iowa Department of Management (IDOM) authority to implement a system of periodic performance audits in consultation with the Legislative Services Agency, Auditor of State and executive branch agencies.

The performance audit is a key component of the Iowa Accountable Government Act. Its purpose is to evaluate agency performance, including program effectiveness, based on performance measures, targets and supporting data.

In response, IDOM has created the consultative Performance Audit Program designed to improve state agencies' ability to achieve and demonstrate key results by offering relevant and practical solutions to performance challenges.

Report Highlights:

- ⇒ 59.6% of offenders with substance abuse needs are released without treatment.
- ⇒ 12.1% of offenders treated for substance abuse problems are convicted of new offenses within 12 months of release.
- ⇒ Substance abuse treatment reduces new conviction recidivism by 2.4%.
- ⇒ Less than 50% of substance abuse interventions reduce both new conviction and total recidivism.
- ⇒ Programs had little effect on prison population, operational cost savings, and overall crime reduction.
- ⇒ Mental health issues, community support, and implementation of evidence-based practices can significantly influence outcomes.

Inside this Report:

Executive Summary

The Iowa Department of Corrections faces a growing prison population expected to quickly exceed current capacities. Additionally, nine out of every ten offenders have a history of alcohol or drug problems – often both. Research suggests that alcohol and drugs lead to criminal behavior, which lead offenders right back to prison – creating a vicious circle and placing a financial and societal burden on the state. However, research also shows that substance abuse treatment can minimize criminal behavior, and offers a way to shut the revolving prison door.

Substance abuse programming attempts to change offender thinking patterns and behavior in order to facilitate re-entry back into the community, lessen substance abuse relapse and reduce recidivism. Yet nearly 60% of offenders with identified needs are not treated, and many lacking treatment are high risk. Additionally, the percentage of offenders returning to prison varies significantly from program to program – and some programs can not show they have reduced recidivism when compared to offender groups with substance abuse problems and receiving no treatment at all. All of which minimize the effect substance abuse programming has in curbing prison population growth and reducing crime.

The Department of Corrections intends to reduce recidivism through evaluation of program fidelity and implementation of evidence-based practices. Many of the programs are already structured to accommodate continuous improvement centered on desired outcomes. Population characteristics and the type and level of community support can also significantly influence recidivism. All of which call for the department to:

- ⇒ Enhance community support and other re-entry initiatives to reinforce desired behaviors in the community where offenders face situations that can lead to relapse and criminal behavior; and
- ⇒ Develop planning, evaluation and service delivery approaches that support integrated substance abuse programming across the prison and correctional system, and enable internal benchmarking of "best practices."

Background

The National Institute on Drug Abuse (NIDA), one of the federal government's lead agencies for substance abuse research, describes drug addiction as a complex illness, characterized by "compulsive, at times, uncontrollable drug craving, seeking and use" ("Drug Abuse Treatment" 9). In 2004, 83% of state prisoners had used illegal drugs, and 53% met the DSM-IV[1] criteria for drug dependence or abuse (Mumola and Karberg 1). The Department of Corrections' (DOC) findings are similar. 90% of offenders within the prison system have a history of alcohol or drug problems, and roughly 60% have had problems with both drugs and alcohol (Prell "Substance Abuse" 5). The statistics make Drugs/Alcohol the top priority need of offenders within prison (DOC "Strategic Plan" 19).

"Overtime, an individual's ability to choose not to take drugs diminishes, and continued use persists regardless of medical, psychological, and social consequences."

Alcohol and Drug Use and Abuse Can Lead to Criminal Behavior

Drug use can lead to addiction, negative behaviors, and many health related problems. Even experimental use can quickly grow into an addiction depending on individual vulnerabilities. Over time, an individual's ability to choose not to take drugs diminishes, and continued use persists regardless of medical, psychological, and social consequences. Methamphetamine, Marijuana and Cocaine were identified as the three most prominent drugs used/abused by offenders in Iowa's prison system (Prell "Substance Abuse" 5). Short-term effects of such drug use include: impaired motor function and judgment, and bizarre, erratic and violent behavior in high doses (such as with cocaine). Long-term effects include: addiction, mood disturbances, irritability, aggressive and violent behavior, paranoia, hallucinations, and health-related problems (NIDA "Cocaine" 4-5, "Marijuana" 5, "Methamphetamine" 5).

Aggressive and violent behaviors and other drug effects can lead to criminal offenses. Illegal drug use was found to increase the odds of committing any crime sixfold (NIJ "Adult Patterns"). According to Mumola and Karberg, nearly a third of state prisoners nationally were under the influence of illegal substances at the time of their offense, and over half had taken drugs within the month of their offense (2). There is also an association between drug use and re-occurring crime. 21% more state prisoners dependent on or abusing drugs also had at least three prior sentences to probation or incarceration when compared to other inmates (Mumola and Karberg, 1).

[1] Criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV).

Treatment Can Reduce Criminal Behavior

Substance abuse is a recognized dynamic risk factor[2], altering the need can increase the likelihood of changing the criminal behavior and closing the revolving prison door (National Institute of Corrections 5; Bonta "Risk-Needs" 23). Long-term use of drugs can temporarily and permanently alter brain anatomy and chemistry. The alterations persists long after drug use (months to years) making it extremely difficult for addicts to quit on their own (NIDA "Drug Abuse Treatment" 14; "Treatment for Criminal Justice Populations" 1). This makes drug addicts high risk for relapse even after prolonged periods of abstinence, suggesting the need for treatment even with longer prison sentences.

DOC intends to impact and reduce recidivism of offenders through evidence-based programming ("Strategic Plan" 5, "Performance Plan" 1, "Self-Assessment" 15, 19, 38). According to NIDA, substance abuse treatment has the potential to support this effort. They state, "Treatment offers the best alternative for interrupting the drug abuse/criminal justice cycle" ("Treatment for Criminal Justice Populations" 13).

"...evaluations generally support the use of substance abuse programming as a means to reduce drug use and criminal behavior."

Recent meta-analyses of treatment program evaluations generally support the use of substance abuse programming as a means to reduce drug use and criminal behavior. A meta-analysis conducted by Prendergast et al. concluded that treatment programs, as practiced in the United States, are effective at reducing drug use and crime (66).[3] The average effect sizes for drug use and crime were both positive indicating "on average, clients who participated in treatment had better outcomes than did those who received no treatment or those who received minimal treatment" (61).[4] Effect sizes were translated to reflect a 15% higher success rate on drug use outcomes, and a 6% higher success rate on crime outcomes for treatment groups (63).[5] Prendergast's study helped dismiss claims that drug treatment was not effective, and refocus on the question of how can treatment be improved, and better address the needs of clients.

An analysis by Mitchell, Wilson, and MacKenzie focused more closely on the subject of this audit –

[2] Dynamic or changeable risk factors are also known as criminogenic needs and serve as predictors to criminal behavior.

[3] Meta-analysis conducted on 78 drug treatment studies conducted between 1965 and 1996. However, only 25 of the studies had crime outcome information. The analysis compared those who received drug treatment to those who received minimal or no treatment. 59% of the studies assigned participants randomly or quasi-randomly.

[4] Effect size is an index that measures the magnitude of a treatment effect.

[5] Binomial effect size display (BESD) equivalent was used to determine the success rates.

incarceration-based substance abuse treatment programs. They conclude that incarceration-based programs are "modestly effective in reducing recidivism".[6] In the study, the general recidivism odds-ratio favored the treatment group over the comparison group in 83% of the 65 evaluations having at least one measure for post-release offending.[7] The general recidivism rate is translated to be 7% lower for treatment groups. Far fewer of the independent evaluations reviewed in this study assessed post-release drug use. The meta-analysis results for drug use outcomes were not found to be statistically significant (12, 17).[8] In a study of substance abuse programs within the federal prison system, Pelissier et al. further support the use of substance abuse programs within correctional settings. They concluded that inmates receiving in-prison residential treatment were less likely to be re-arrested than untreated inmates within the first six months after release (329).[9]

"Programs are intended to change offender thinking patterns and behaviors in order to...reduce recidivism."

Prison Programming

The DOC attempts to address this problem through the provision of substance abuse programming to offenders through 15 licensed programs in eight institutions.[10] In SFY 2006, the licensed substance abuse programs collectively had the capacity to serve 2,014 offenders. In SFY 2007, the DOC budgeted $3.1 million for the delivery of licensed substance abuse programs ("Budget Details" 2).

Although the substance abuse programs were often developed independently at the institutional-level, they all share a common purpose. Most employees, managers and stakeholders believe that the programs are intended to change offender thinking patterns and behavior in order to facilitate re-entry back into the community, lessen substance abuse relapse, and reduce recidivism (Performance Audit –

[6] The meta-analysis was based on 53 unique studies reporting the results of 66 independent evaluations with interventions conducted between 1980 and 2004. Two-thirds of the studies were post-1996. The scope was the review was experimental and quasi-experimental evaluations of incarceration-based drug treatment programs for juveniles and adults that utilized a comparison group (no or minimal treatment).

[7] General recidivism included re-arrests, re-convictions, and re-incarcerations.

[8] The odds-ratio compared the odds of an event occurring in comparison group to the odds of it occurring in the treatment group. The mean odds-ratio for the general recidivism was 1.37, re-arrests 1.40, re-convictions 1.43, and re-incarcerations 1.22. An odds ratio of 1 implies that the event is equally likely in both groups. Results greater than one indicates that the recidivism event is more likely to happen in comparison group, values less than one would make it less likely to occur. All were found to be statistically significant.

[9] Male and female treatment subjects were drawn from 20 different prisons of medium, low and minimum security levels. Comparison subjects were drawn from over 30 prisons. Both groups were limited to those released to supervision.

[10] Programs conform to the licensure standards outlined in 641 *Iowa Administrative Code* Chapter 156.

Manager Interviews, Employee Survey, and Stakeholder Survey). However, how the programs fulfill this purpose differs:

⇒ the level of treatment varies among the licensed programs, four are inpatient residential programs, one is an intensive outpatient program, and the remaining programs are outpatient;

⇒ the minimum program duration generally ranges from 12 to 40 weeks (however, one program is significantly longer – spanning an 18 month period);

⇒ the hours per week spent in or intensity of program activities vary among programs, and in many cases are dependent on individual case plans; and

⇒ the number of offenders per staff person also varies significantly from six offenders for every staff person to 40.

However, the programs do share some common ground with 11 of the 15 programs using curriculums specifically incorporating cognitive and cognitive-behavioral therapies. One program also uses a gender specific curriculum designed to help women recover from substance abuse. Two programs' curriculums are eclectic – drawing from a variety of sources.

Although the programs are attempting to lessen substance abuse relapse and criminal behavior, it is important to note they can not control the results – but can only hope to influence them. Many other factors can affect their ability to do so, and as time passes the programs' degree of influence diminishes. Figure 1 reflects the relationships among program activities and desirable results, as well as factors that can influence results.

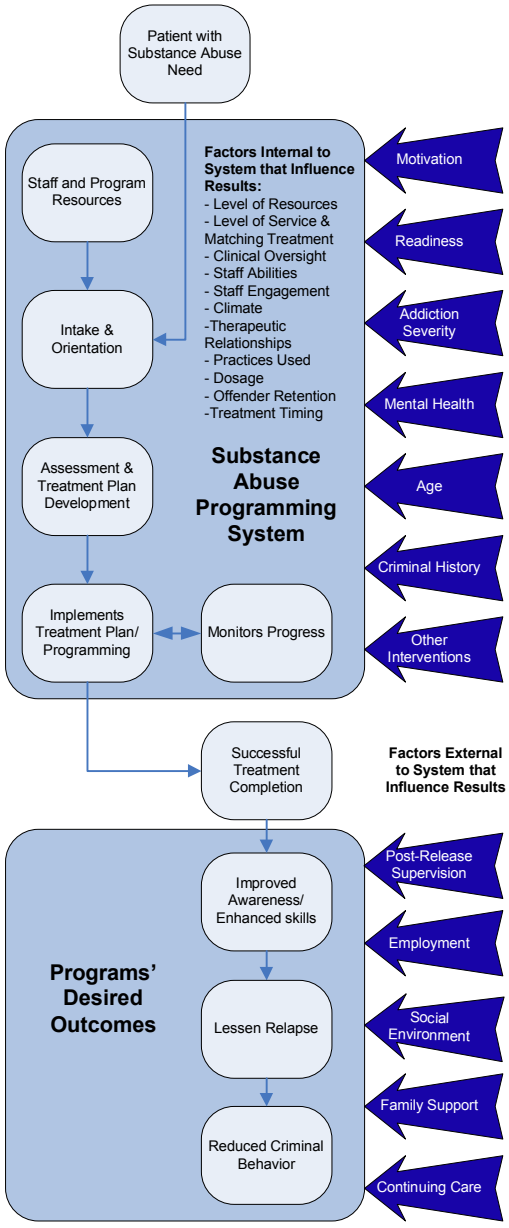

Figure 1: General Logic Model for the DOC's Substance Abuse Programs.

Audit Scope, Objectives and Methodology

The performance audit focused on the licensed substance abuse programs available to offenders in prison. Substance abuse programs were selected, since substance abuse is the top criminogenic need among offenders within Iowa's prison system.[11] The use of evidence-based practices is also a key strategy embraced by DOC to reduce offender recidivism, which can influence the means for which treatment is delivered. The offender population was set using offenders released between October 1, 2004 and December 31, 2005. The timeframe was limited because of availability of substance abuse intervention data in Iowa Corrections Offender Network (ICON).

The follow-up period to capture recidivism information was one year. Two recidivism measures were used: new conviction resulting in prison or community supervision; and new conviction or return to prison for any reason (i.e. total recidivism rate). Exit or release was based on release from prison due to end of sentence or entrance into community supervision.

The performance audit's purpose, developed as part of Iowa's Accountable Government Act, is to evaluate agency performance, including program effectiveness, based on performance measures, targets and supporting. In accordance with the program's legislative purpose, the following objectives were established to evaluate the effectiveness of licensed substance abuse programs within DOC:

Objective 1: What percentage of offenders with a history of substance abuse is released without treatment?

Objective 2: Are the DOC's licensed substance abuse programs effective at preventing offenders from being reconvicted for new offenses and returned to the correctional system? What are the consequences of the programs being effective or ineffective and why?

1) Condition – What are the recidivism rates for offenders successfully completing licensed substance abuse programs 12 months following release from prison?
2) Criteria – How do the 12 month recidivism rates of offenders successfully completing the substance abuse program compare to:
   a) offenders from the same institution with a history of substance abuse, but received no treatment;
   b) offenders who started the same program, but did not successfully complete it; and
   c) offenders from the same institution without a history of substance abuse?

[11] Criminogenic needs are attributes of an offender that when changed can reduce the probability of criminal behavior.

3) Effect – How does this impact corrections' population growth and operational costs?
4) Causes –
   a) Do the following variables significantly influence recidivism rates:
      i) Co-occurring mental health problems,
      ii) Length of time between treatment and release,
      iii) LSI-R score, and
      iv) Participation in community aftercare?
   b) How does program management, structure and staffing influence recidivism rates?

Substance abuse needs were identified by LSI-R, Iowa Risk, Custody Classifications, or Jesness Assessments. Treatment groups' institution and location were defined by location where treatment was concluded, which may differ from an offender's release location. Comparison groups' institution and location were based on offenders' location at time of release – for offenders comprising these groups.

Comparisons were made by reviewing the difference in recidivism rates between the treatment group and the comparison groups at the same institution or location. The recidivism rates from the comparison group were subtracted from the recidivism rate of the treatment group to determine the difference. Negative values reflect positive results – the expectation is that treatment groups will have a lower recidivism rate.

Causes were reviewed primarily by controlling for the specific variable of interest to see if a pattern emerges in recidivism rates. Where patterns emerged at the department-wide and institutional levels, population characteristics were reviewed at the program level if possible. Differences in population characteristics between treatment group and comparison group were examined specifically for co-occurring mental health problems, LSI-R scores, and offender demographics. Length of time between treatment and release, and participation in community aftercare were reviewed for each treatment group at the institution and program level where possible.

The review of program management, structure and staffing was limited since many offenders received treatment two to three years ago. Observations made during the audit, may not be representative to how the program operated at the time offenders in the data set were treated. Additionally, previous evidence-based program assessments were conducted roughly two years prior to the offenders receiving treatment, and they were limited to five of the 15 programs. These evaluations are also limited to a specific point in time, and may not adequately reflect how the offenders in this data set were treated.

The variables were compared to differences in recidivism rates for each program to identify those which appear to affect the difference. The data collection methodology for the performance audit is provided in Appendix A. The data was

supplemented with policy and procedure manual reviews, manager interviews and employee and stakeholder surveys.

What percentage of offenders with a history of substance abuse is released without treatment?

Lack of treatment resources was one of the most pressing issues noted by managers, stakeholder and employees alike. Budget and staffing reductions and available treatment space limit DOC's ability to provide substance abuse treatment to many of the offenders in need (Performance Audit – Employee Survey, Stakeholder Survey; Howard and Phillips; Dick and Comp; Dursky et al.; Bagby; Austin and Kelly). Of those released from prison between October 1, 2004 and December 31, 2005, slightly less than 60% of the offenders with substance abuse needs had not received substance abuse treatment, as shown in Figure 2. North Central Correctional Facility had the largest percentage of offenders with substance abuse needs released without treatment at 85.4% and Clarinda Correctional Facility the fewest at 36.6%, as shown in Table 1.

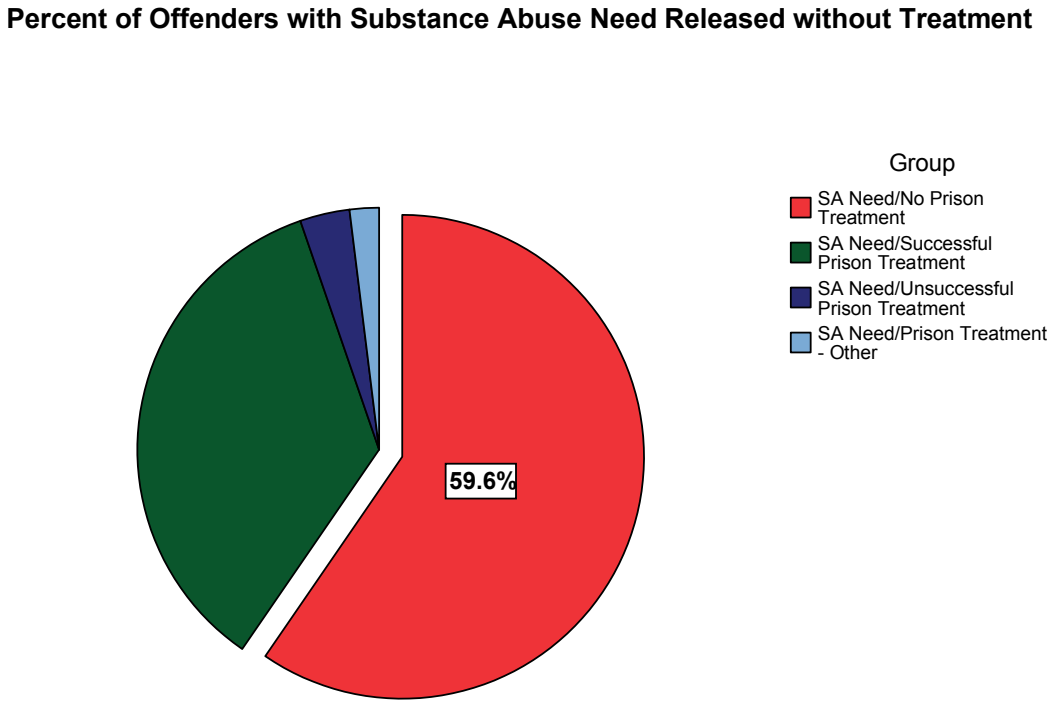

Figure 2: Percent of Offenders with Substance Abuse Need Released without Substance Abuse Treatment.

% of Offenders with Substance Abuse Needs Released without Treatment by Institution

Institution	SA Need /No Prison Treatment	SA Need /Successful Prison Treatment	SA Need / Unsuccessful Prison Treatment	SA Need /Prison Treatment - Other	Total
Anamosa State Penitentiary	53.2%	39.1%	4.7%	3.0%	100.0%
Clarinda Correctional Facility	36.6%	52.5%	9.1%	1.8%	100.0%
Fort Dodge Correctional Facility	60.4%	34.5%	3.5%	1.6%	100.0%
Iowa Correctional Institution for Women	56.7%	36.8%	4.7%	1.8%	100.0%
Iowa Medical & Classification Center	81.3%	13.5%	3.1%	2.1%	100.0%
Iowa State Penitentiary	82.4%	13.7%	1.1%	2.8%	100.0%
Mount Pleasant Correctional Facility	43.8%	51.5%	1.2%	3.4%	100.0%
North Central Correctional Facility	85.4%	13.1%	.9%	.7%	100.0%
Newton Correctional Facility	64.0%	33.1%	1.6%	1.3%	100.0%
Total	**59.6%**	35.1%	3.3%	2.0%	100.0%

Table 1: Percentage of Offenders with Substance Abuse Needs Released without Treatment by Institution.

Are the DOC's licensed substance abuse programs effective at preventing offenders from being reconvicted for new offenses and returned to the correctional system?

The DOC's licensed substance abuse programs have a new conviction recidivism rate of 12.1% and total recidivism rate of 26.6% at twelve months following release for the time period reviewed. Overall, these programs slightly reduce new conviction recidivism department-wide, but do not effect the total recidivism rate. As the data is disaggregated to the institution and intervention level, it demonstrates not all institutions' performance is the same, and that not all interventions (i.e. substance abuse programs) are equally effective at reducing recidivism.

Key findings:

⇒ 12.1% of offenders released after successful completion of substance abuse treatment are convicted for new offenses within 12 months; 26.6% return for either new offenses or technical violations.

⇒ New conviction recidivism rates range from 3.4% to 21.1% for substance abuse programs; total recidivism rates range from 7.1% to 41.7%.

⇒ Department-wide substance abuse treatment slightly lowers new conviction recidivism by 2.4%, but not total recidivism.

⇒ Substance abuse treatment lowers new conviction and total recidivism in three out of eight institutions – Newton Correctional Facility (NCF) and Iowa State Penitentiary (ISP) have the best overall performance.

⇒ In eight out of 17 substance abuse interventions, substance abuse treatment lowers both new conviction and total recidivism. PSD and IFI at the Newton Correctional Facility stand out among the group.

12.1% of offenders with successful substance abuse treatment are convicted for new offenses within 12 months of release, and 26.6% return for either new offenses or technical violations.

As shown in figure 3, the new conviction recidivism rate for offenders successfully completing treatment was 12.1% 12 months following release from prison. Among institutions, new conviction recidivism rates ranged from 5.1% (Iowa State Penitentiary) to 16.2% (Anamosa State Penitentiary). The total recidivism rate for this population was 26.6% department-wide. Fort Dodge Correctional Facility had the highest total recidivism rate at 38.7% and Iowa State Penitentiary the lowest at 15.4%. New conviction recidivism rates for programs, as shown in figure 4, ranged from 3.4% (PSD at Newton Correctional Facility) and 21.1% (Violator's Program at ICIW). Total recidivism rates ranged from a low of 7.1% (STAR) to 41.7% (TC at Anamosa State Penitentiary).

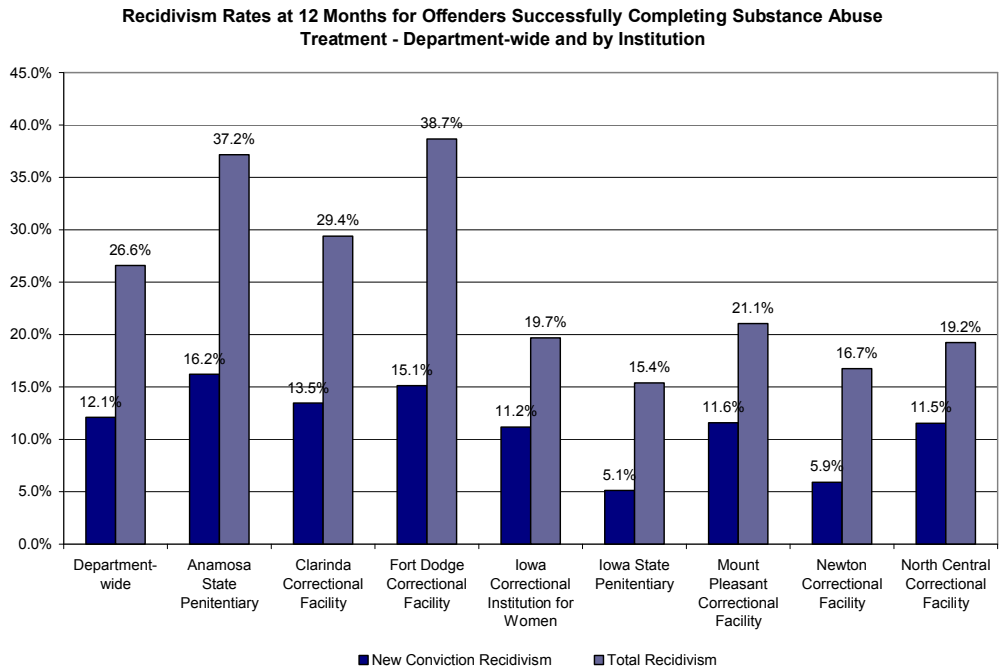

Figure 3: New conviction and total recidivism rates of offenders successfully completing substance abuse treatment 12 months subsequent to release both department-wide and by institution. Data for figure provided in Table 2 and Appendix B.

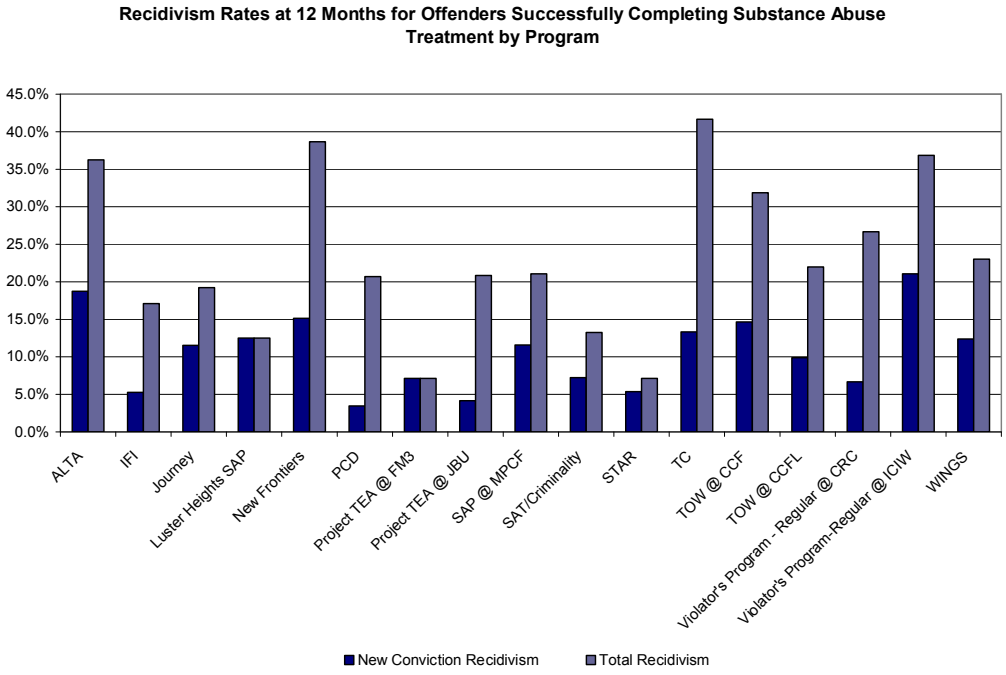

Figure 4: New conviction and total recidivism rates of offenders successfully completing substance abuse treatment 12 months subsequent to release by program. Data for figure provided in Appendix C.

Department-wide substance abuse treatment slightly lowers new conviction recidivism, but not total recidivism.

Within the prison system, new conviction recidivism rates were 0.3% lower for offenders successfully completing substance abuse treatment programs compared to offenders with substance abuse needs receiving no treatment in prison. The difference in new conviction recidivism rates associates Department-wide successful substance abuse treatment with a 2.4% reduction in recidivism for new convictions[12]. However, the total recidivism rate for offenders successfully completing substance abuse treatment is 0.5% higher than those offenders with substance abuse needs and no treatment within prison. Although fewer offenders with successful substance abuse program completion were reconvicted for new offenses, more returned to the correctional system due to technical violations. Collectively, DOC's substance abuse programs did not demonstrate success for either new convictions or total recidivism rates or when compared to offenders released with no substance abuse needs. See Table 2 for additional information.

Substance abuse treatment reduces new conviction recidivism for those with substance abuse need by 2.4% department-wide.

Recidivism Rates by Comparison Group

Comparison Group		Did Not Recidivate	Recidivism Rates		
			New Convictions	Technical Violations	Total
No SA Need	Count	659	94	90	184
	%	78.2%	11.2%	10.7%	21.8%
SA Need/No Prison Treatment	Count	1893	314	321	635
	%	74.9%	12.4%	12.7%	25.1%
SA Need/Successful Prison Treatment	Count	1095	180	216	396
	%	73.4%	12.1%	14.5%	26.6%
SA Need/Unsuccessful Prison Treatment	Count	95	22	24	46
	%	67.4%	15.6%	17.0%	32.6%
SA Need/Prison Treatment - Other	Count	63	9	11	20
	%	75.9%	10.8%	13.3%	24.1%
Total – General Population	Count	3805	619	662	1281
	%	74.8%	12.2%	13.0%	25.2%

Table 2: Recidivism Rates by Comparison Group.

[12] % change = ((12.4%-12.1%)/12.4%) X 100

In three out of eight institutions, substance abuse treatment lowers new conviction and total recidivism.

NCF and ISP were the only institutions to show success for both new conviction and total recidivism when compared to the substance abuse need/no prison treatment and no substance abuse need comparison groups. North Central Correctional Facility (NCCF) also reflected improvement relative to new conviction and total recidivism, but only when compared to the substance abuse need/no prison treatment group.

Five of the eight institutions with licensed substance abuse programs had 0.5 to 7.9% lower new conviction recidivism rates for offenders successfully completing substance abuse treatment compared to offenders within the same institution with substance abuse needs, but no treatment within prison. As a result, within the NCF, ISP, Fort Dodge Correctional Facility (FDCF), NCCF, and Clarinda Correctional Facility (CCF), substance abuse treatment can be associated with a 3.4 to 57.2% reduction in new conviction recidivism depending on the institution. Figure 5 provides additional information. Three of the five institutions (NCF, ISP, and NCCF) also demonstrated lower recidivism rates for offenders successfully completing substance abuse treatment compared to offenders from the same institution with no substance abuse needs, see Figure 6. Iowa Correctional Institution for Women (ICIW), Anamosa State Penitentiary (ASP), and Mount Pleasant Correctional Facility (MPCF) had higher rates of new conviction recidivism for offenders successfully completing substance abuse treatment compared to offenders with no substance abuse need and those with substance abuse need/no treatment.

Only NCF and ISP have lower new conviction and total recidivism rates among those successfully completing treatment regardless of comparison group evaluated.

The review of total recidivism rates reflected similar results. Five of eight institutions with licensed substance abuse programs have lower total recidivism rates for offenders successfully completing substance abuse treatment compared to offenders from same institution with substance abuse needs. NCF, NCCF, ISP, ICIW and MPCF had total recidivism rates ranging 1.2 to 12.4% lower for offenders with successful substance abuse treatment than those with a substance abuse need and no treatment, as shown in Figure 7. Within the five institutions, successful substance abuse treatment can be associated with a 5.4 to 42.6% reduction in total recidivism depending on the institution. Additionally, ISP, NCF, and NCCF had lower total recidivism rates than offenders from

the same institution with no substance abuse needs, as shown in Figure 8. CCF, ASP, and FDCF had higher total recidivism rates for offenders successfully completing substance abuse treatment compared to either offenders with no substance abuse need or those with a substance abuse need/no treatment.

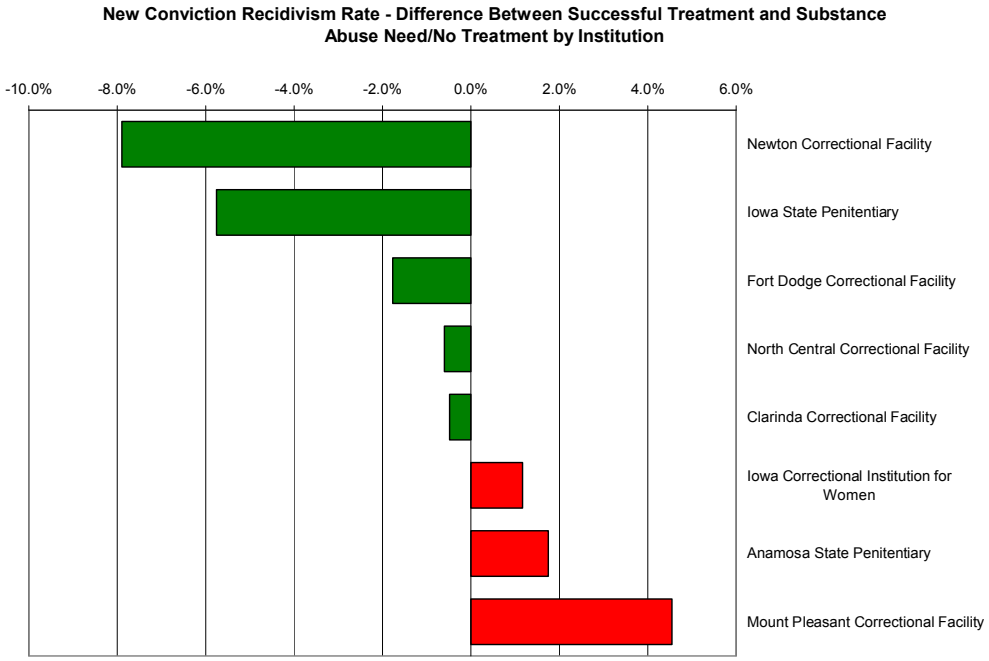

Figure 5: Reflects the difference between new conviction recidivism rates for offenders successfully completing substance abuse treatment and offenders with substance abuse needs without prison treatment by institution. Negative values correspond to positive results. Figure based on data provided in Appendix B.

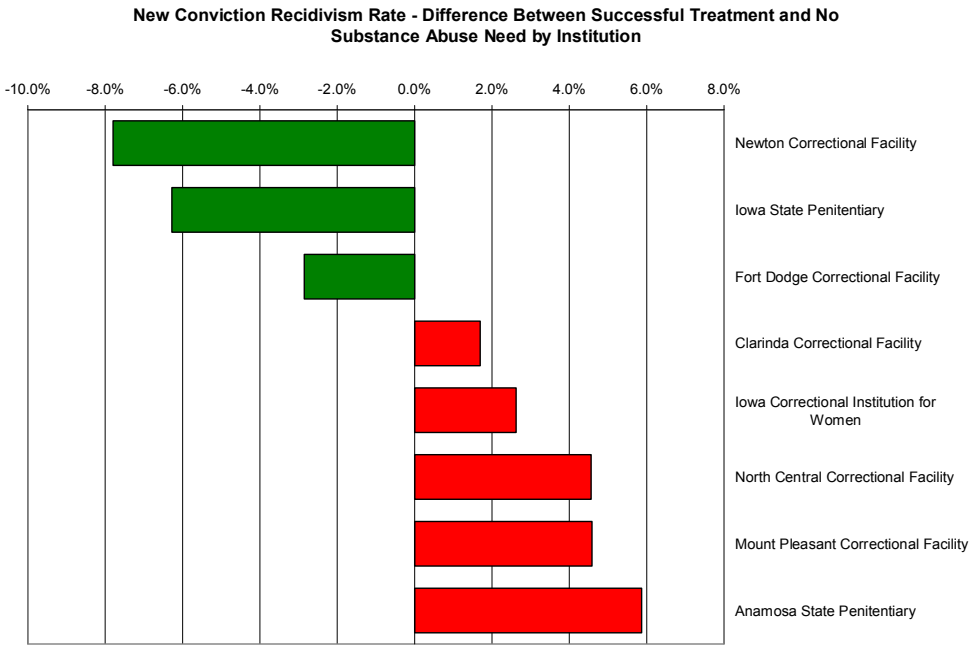

Figure 6: Reflects the difference between new conviction recidivism rates for offenders successfully completing substance abuse treatment and offenders with no substance abuse need by institution. Negative values correspond to positive results. Figure based on data provided in Appendix B.

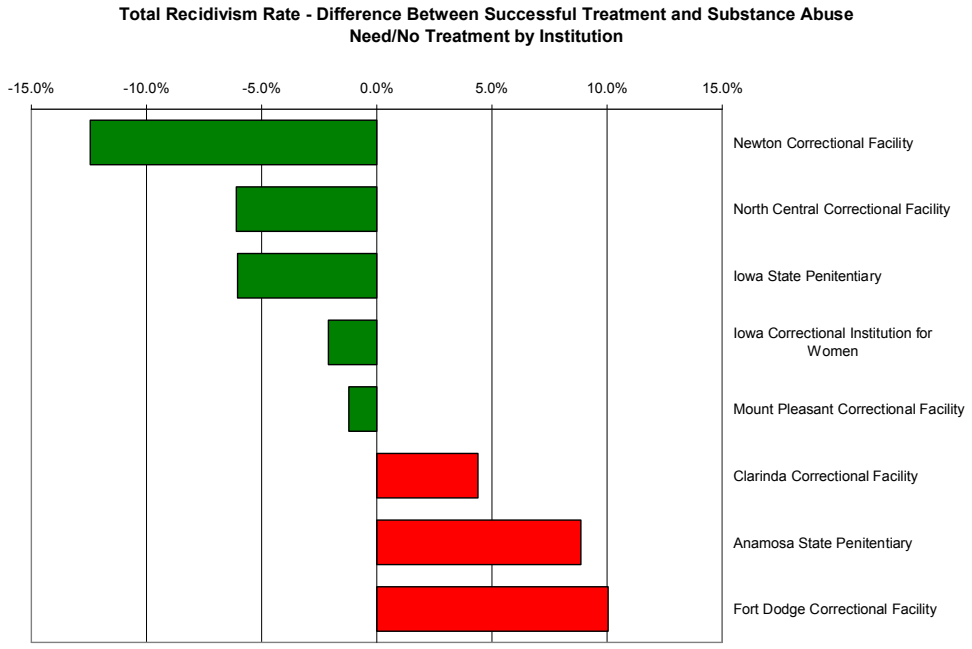

Figure 7: Reflects the difference between total recidivism rates for offenders successfully completing substance abuse treatment and offenders with substance abuse needs and no prison substance abuse treatment by institution. Negative values correspond to positive results. Figure based on data provided in Appendix B.

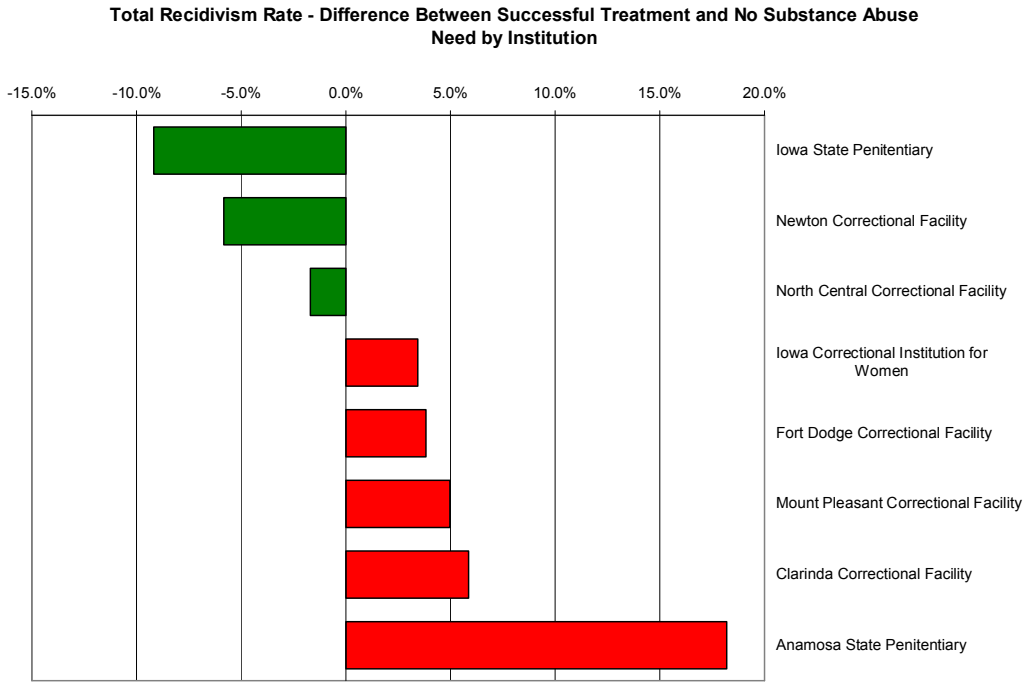

Figure 8: Reflects the difference between total recidivism rates for offenders successfully completing substance abuse treatment and offenders with no substance abuse need by institution. Negative values correspond to positive results. Figure based on data provided in Appendix B.

In eight out of 17 substance abuse interventions, treatment lowers both new conviction and total recidivism.

Only eight of the 17 substance abuse interventions reduced both new conviction and total recidivism rates, which include:

- ⇒ PCD (NCF),
- ⇒ IFI (NCF),
- ⇒ Project TEA (ISP – John Bennett Unit only),
- ⇒ Luster Heights SAP (ASP – Luster Heights),
- ⇒ STAR (ICIW),
- ⇒ SAT/Criminality (NCF – Correctional Release Center),
- ⇒ Journey (NCCF), and
- ⇒ TOW (CCF – Lodge only).[13]

12 out of 17 substance abuse interventions had 1.1 to 14.0% lower new conviction recidivism rates for offenders successfully completing substance abuse treatment compared to offenders at the same location with a substance abuse need, but receiving no treatment – as shown in Figure 9. Successful completion in substance

[13] TOW and Project TEA were reviewed at more than one location – accounting for 17 interventions compared to the 15 licensed programs previously noted. Project TEA at FM1 was excluded from the analysis for small population size – only one offender was released during timeframe reviewed.

abuse treatment was associated with a 1.1 to 80.2% reduction (depending on intervention) in new conviction recidivism. Three programs stand out – PCD and IFI at NCF, and Project TEA at the John Bennett Unit within ISP.

However, substance abuse interventions were slightly less successful with total recidivism. Ten out of 17 substance abuse interventions had 2.0 to 17.4% lower total recidivism rates for offenders successfully completing substance abuse programs compared to offenders at the same location with a substance abuse need, but no treatment – as shown in Figure 10. Successful substance abuse treatment, within the ten interventions, was associated with an 8.4 to 50.5% decrease in total recidivism rates. Four programs stand out among the programs provided by DOC – PCD and IFI at NCF, STAR at ICIW, and the Luster Heights Substance Abuse Program at ASP.

ALTA at ASP, and WINGS and Violator's Program Regular at ICIW did not reduce either measure of recidivism.

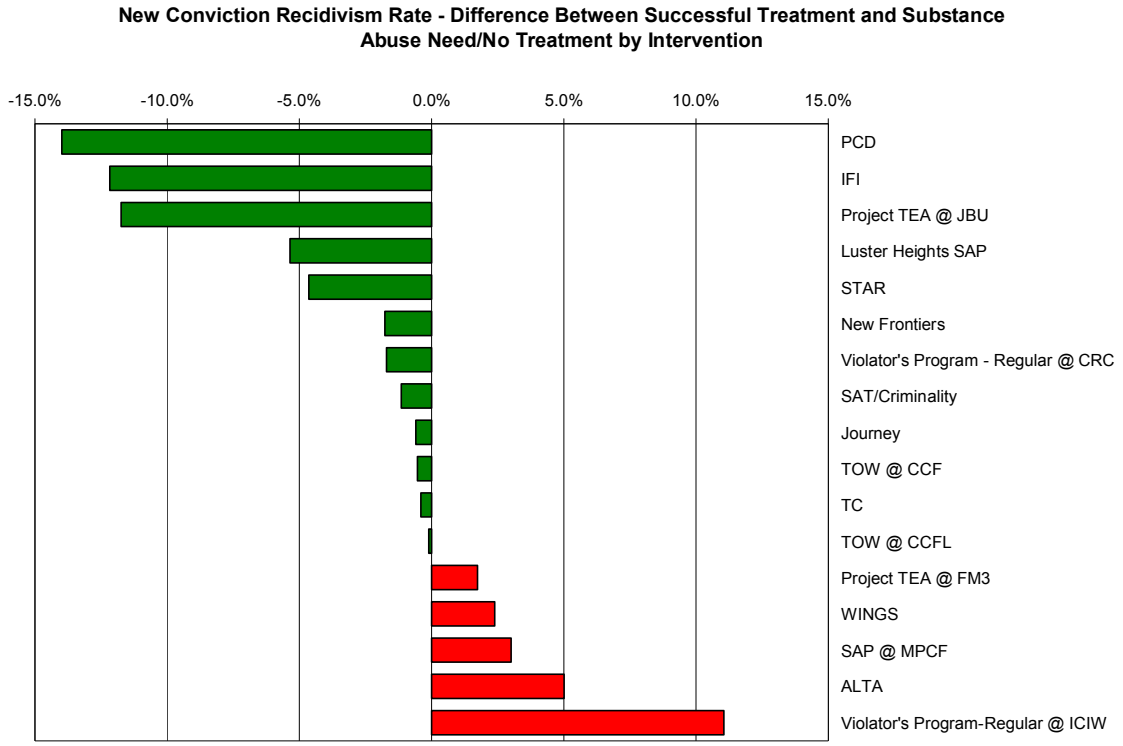

Figure 9: Reflects the difference between new conviction recidivism rates for offenders successfully completing substance abuse treatment and offenders with substance abuse needs and no prison substance abuse treatment by intervention. Negative values correspond to positive results. Figure based on data provided in Appendix C.

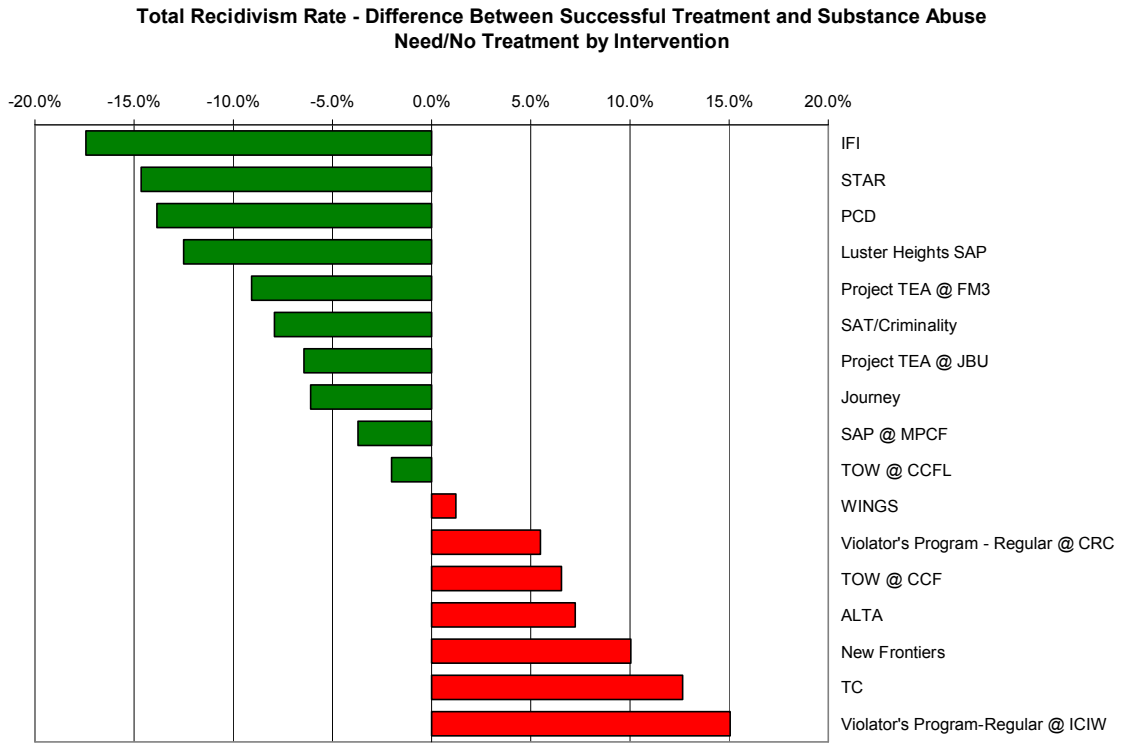

Figure 10: Reflects the difference between total recidivism rates for offenders successfully completing substance abuse treatment and offenders with substance abuse needs and no prison substance abuse treatment by intervention. Negative values correspond to positive results. Figure based on data provided in Appendix C.

What are the consequences of the programs' results?

There are a number of consequences associated with recidivism reductions, such as:

⇒ Reductions in the incarcerated offender population– or at least a reduction in the projected growth – which is stressing the existing prison infrastructure;
⇒ Cost savings associated with keeping offenders out of the prison system and/or correctional system; and
⇒ Societal benefits from reduced crime.

Key findings:

⇒ The substance abuse programs overall did very little to curb the growing prison population during the14-month review period.
⇒ Cost savings is not produced Department-wide, but institutions like NCF highlight potential with over $134,000 in saved operational costs one year following offender release.
⇒ Across the department, substance abuse treatment prevented less than five new offenses from occurring during the 14 month review period.

Overall, substance abuse programs did not curb the growing prison population.

The offender population in prison is expected to increase by over 31% in the next ten years, causing inmate capacity to be exceeded by 72% for females and 52% for males (Stageberg 3). Readmissions to prison are one of the factors influencing prison growth. The 2,086 readmissions occurred in state fiscal year 2006 and are expected to increase 20.8% over the next ten years (Stageberg 9). The readmission growth makes treatment interventions a key area of focus not only for recidivism, but as a strategy to help curb the prison inmate population growth. Unfortunately, because the total recidivism rate was not lowered through DOC's substance abuse programs (SA need/no treatment total recidivism rate was 25.1% compared to 26.6% for those successfully completing treatment – see table 2) – prison population growth should continue to grow at the same rate projected.

Cost savings was not produced Department-wide, but institutions highlight potential savings.

It costs $23,367 annually to house an offender in prison, and preventing one offender from returning to prison from parole or work release saves roughly $5,400 in incarceration costs (DOC "Quick Facts" 1; Prell "Population Growth" 13).[14] Although there was cost savings of over $8 million associated with offenders released during the timeframe reviewed who

[14] Annual costs estimated by taking the average daily cost and multiplying it by 365.

received treatment, cost savings were not greater than what would have been achieved if results were the same as the substance abuse need/no prison treatment group. Additional information is provided in table 3. However, ISP and NCF, where the best performance related to total recidivism was achieved, reflected cost savings from offenders released to community supervision of roughly $12,800 and $134,600. Total cost savings are likely to be much higher, since savings only reflect DOC operational costs – not the costs associated with the criminal justice system or other societal costs associated with crime. Return on investment could not be calculated, since recidivism rates were based on a 14 month release period. To calculate return on investments, recidivism rates would need to be established for the treatment period, since offenders could be released at different times.

Cost Savings Comparisons

	Release to Community Supervision	Released from Correctional System	Total
Total Released - Treatment Group	1,334	157	1,491
Annual Cost Reduction Per Offender Remaining Out of Prison	$5,400	$23,367	
% of Treatment Group Remaining Out of Prison @ 12 months	72.8%	79.0%	
Cost Savings	***$5,243,400***	***$2,897,545***	***$8,140,945***
% of SA Need/No Treatment Group Remaining Out of Prison @ 12 months	72.3%	82.0%	
Cost Savings using SA Need/ No Treatment Group Percentages	*$5,211,610*	*$3,008,306*	*$8,219,916*
Difference	**$31,790**	**($110,761)**	**($78,971)**

Table 3: Cost savings comparisons using release totals from the substance abuse need/successful treatment group. Compared savings associated with non-recidivism rates of the treatment group with those that would have been achieved if the rates were the same as those of the substance abuse need/no treatment group. Savings for offenders remaining out of prison for less than one year was not calculated. Cost savings were calculated by multiplying total released by % remaining out of prison and by the annual cost reduction per offender.

Across the department, substance abuse treatment prevented less than five new offenses from occurring during 14 month review period.

Substance abuse treatment lowers new conviction recidivism rates – which benefits society. However, the benefit was relatively small. Recidivism rates were 0.3% lower among offenders receiving prison substance abuse treatment compared to those with a substance abuse need and no prison treatment. This amounts to slightly less than five new offenses. However, because of differing performance levels among institutions – some prevent more new offenses. At NCF (where the best performance related to new conviction recidivism was achieved), 13 new offenses were prevented.

If reconvicted, offenders completing substance abuse treatment had fewer property crimes as a percentage of total new offenses compared to those with substance abuse needs/no treatment. However, other crime types, including drug, were higher. Data was not available to make a comparison between initial convicting crime and new offenses committed which may reflect a greater societal benefit if treatment lowers the severity of the crimes committed.

New Offense Comparison

Convicting Crime Type		SA Need/Successful Prison Treatment	SA Need/No Prison Treatment
Drug	Count	33	55
	%	18.3%	17.5%
Other	Count	4	4
	%	2.2%	1.3%
Property	Count	41	80
	%	22.8%	25.5%
Public Order	Count	71	124
	%	39.4%	39.5%
Violent	Count	31	51
	%	17.2%	16.2%
Total	Count	180	314
	%	100.0%	100.0%

Table 4: Comparison between treatment group and comparison group (substance abuse need/no treatment) for those committing new offenses within 12 months of release. Percentages are expressed as a percentage within the convicting crime type for all new offenses committed.

What issues significantly influence program results?

Evaluating program effectiveness using outcomes is complicated. When changes to outcomes occur, programs are often unable to explain why. The cumulative effect of numerous events or situations influence results (in this case recidivism results) make it challenging to understand what is truly causing observed changes. Many times, changes simply cannot be attributed or attached to one particular cause, or the program's contribution is relatively small in comparison to other factors and makes it difficult to see how operational or strategic changes are impacting results, see figure 11.

Key findings:

- ⇒ Both new conviction and total recidivism rates were higher among offenders with mental health diagnosis – highlighting the challenge to effectively treat individuals with multiple needs.
- ⇒ Treatment should be made as close to an offender's release date, so new skills are retained before offenders face high risk situations – questionable data made this variable difficult to evaluate.
- ⇒ Offenders with higher risks had higher recidivism rates.
- ⇒ Additional support in the community whether it is through supervision or continuing substance abuse treatment lowers new conviction recidivism.
- ⇒ Older offenders were less likely to be reconvicted for new offenses, and incur technical violations.
- ⇒ African Americans had higher new and total recidivism rates than Caucasians and other minority groups – highlighting socioeconomic conditions/issues within communities African American offenders come from and return to.
- ⇒ DOC has yet to fully identify where evidence-based practices are being successfully implemented.
- ⇒ DOC does not consistently measure addiction severity, and responsivity factors reducing confidence that treatment approaches are best suited for individual offender characteristics.
- ⇒ 22.8% of offenders treated by the substance abuse program were classified in low to low/moderate risk category – whereas over 1,800 offenders with substance abuse needs and classified with moderate to high risks, and received no treatment while in prison. 500 of the higher risk individuals were released due to the end of their sentence leaving no other opportunity to provide treatment while in the correctional system.
- ⇒ Consistent system-level measures are needed to enhance DOC's ability to manage for results, and enable program comparisons.
- ⇒ More frequent recognition of quality work and ensuring adequate resources are available could enhance employee engagement.

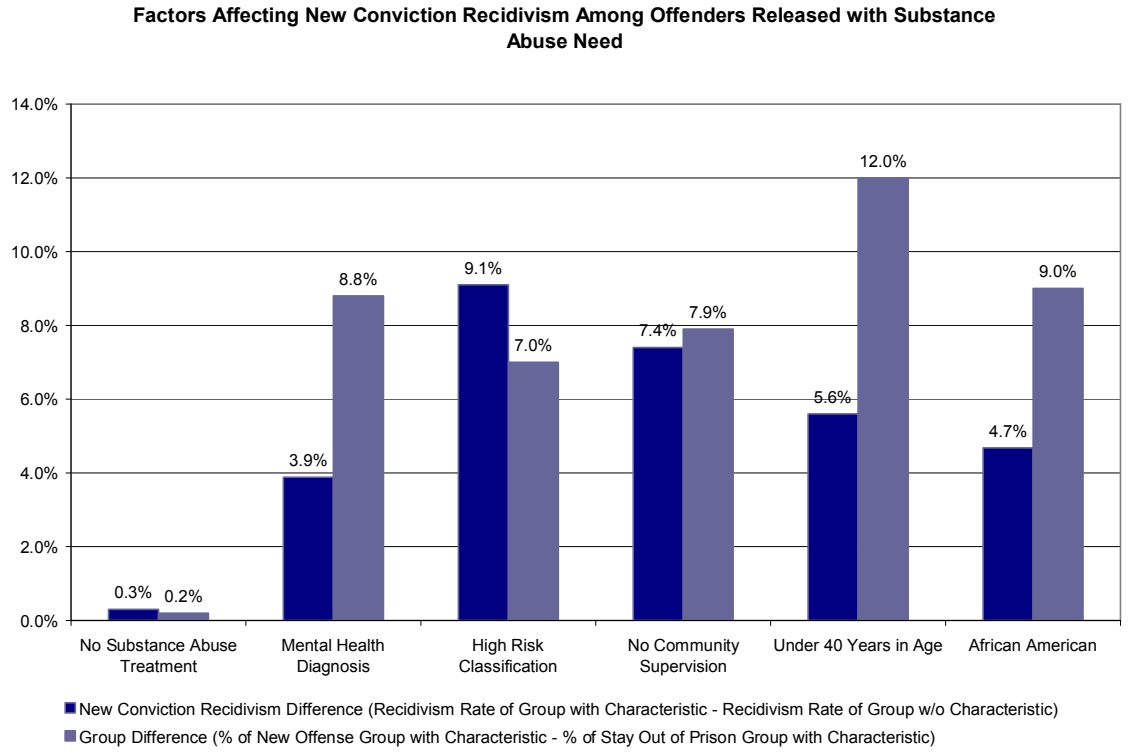

Figure 11: Factors affecting new conviction recidivism among offenders released with substance abuse need. The first series (dark blue) reflects the difference in new conviction recidivism rates (e.g. The new conviction recidivism rate for the group of offenders with a mental health diagnosis is 3.9% higher than offenders without a mental health diagnosis). The second reflects population differences in the percent of offenders exhibiting the characteristic between offenders reconvicted for new offenses and offenders who have not returned to prison (e.g. The group of offenders returned to prison for new convictions had 8.8% more individuals with mental health diagnoses than the group of offenders who remained out of prison). Group differences by program are reflected in Appendix D.

Both new conviction and total recidivism were higher among offenders with mental health diagnosis.

DOC institutions and the Division of Behavioral Health and Professional Licensure at the Iowa Department of Public Health identified offenders with dual-diagnosis (i.e. substance abuse need and mental health diagnosis) as a key issue faced by substance abuse programs (Hebron and LeBarge; Durskey, et al.; Bagby; Austin and Kelly). They were concerned about the substance abuse curriculums' abilities to help those with both a substance abuse and mental health need. This population is challenging because of the multiple issues they face. As such, it was expected that offenders with mental health diagnosis will be more likely to recidivate, and as offenders with dual-diagnoses increase as a percentage of population served by the substance abuse programs – the new conviction and total recidivism rates would also increase.

Department-wide, new conviction recidivism was 3.8% and total recidivism 7.4% higher among those successfully completing substance abuse treatment who have also been diagnosed with a mental health condition (other than substance abuse) compared to those who have not, see figure 12. When controlling the population for mental health diagnosis, new conviction recidivism among those receiving substance abuse treatment was 0.2% lower than offenders with substance abuse need and no treatment when neither population had offenders with mental health diagnosis.

Generally, offenders with both substance abuse need and a mental health diagnosis had higher recidivism rates over those who just had substance abuse needs at all institutions. Offenders receiving substance abuse treatment at ASP and NCF were exceptions – where offenders who had mental health diagnosis also had lower new conviction recidivism rates. Those offenders at NCF also had a lower total recidivism rate. See Appendix E for additional information.

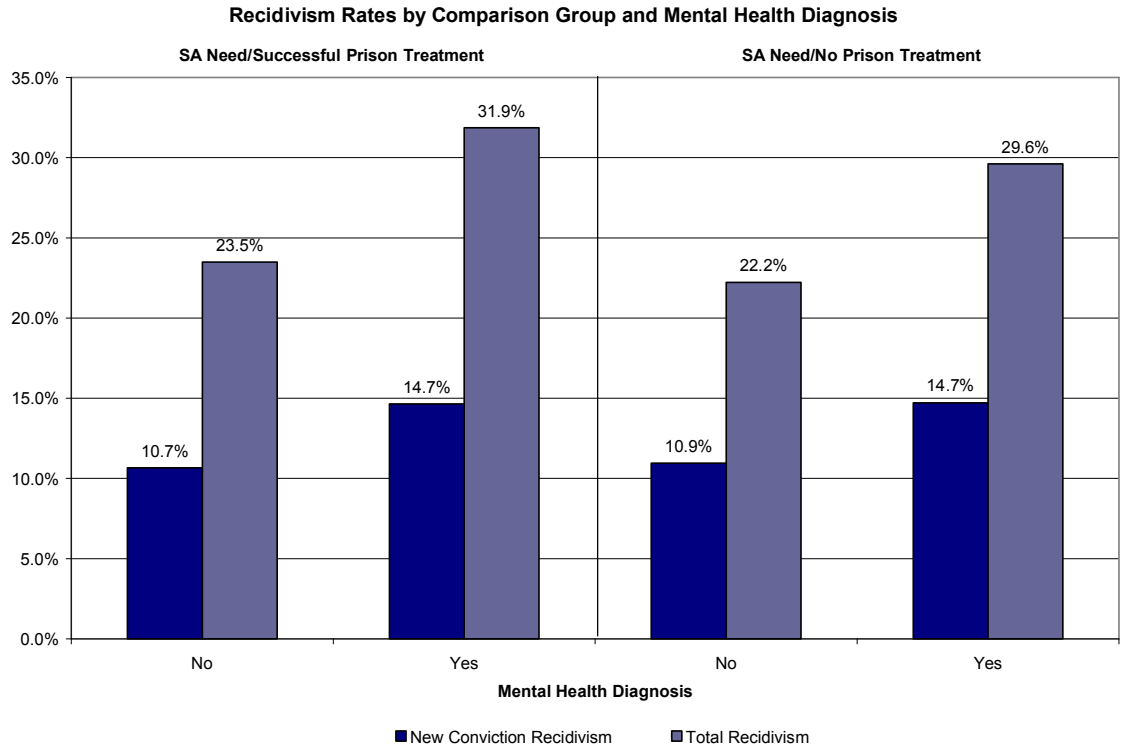

Figure 12: Department-wide recidivism rates by Comparison Group and Mental Health Diagnosis. Mental health diagnosis does not include those with only a substance abuse disorder. Data supporting figure provided in Appendix E.

The amount of time between the conclusion of treatment and release may influence recidivism, but data reliability made this difficult to evaluate.

DOC attempts to time treatment with an offender's target release date to help improve offender outcomes following release. The length of time between when an offender receives substance abuse treatment and when they are released from prison is believed to effect recidivism. The longer the length of time; the harder it becomes to retain the skills acquired during treatment. This lessens the offender's ability to apply the new skills in the community environment where they encounter high risk situations that could lead to substance abuse relapse and criminal behavior. However, the reliability of treatment end date was questionable impairing the audit's ability to examine its relationship to recidivism. Two issues indicated questionable treatment end date data:

⇒ A small percentage of offenders had treatment end dates that were more recent than their release date; and

⇒ The Violator Programs at both CRC and ICIW reflected more than 80% of their treatment population completing treatment more than a year prior to release.

The offenders in the violator programs are released once they have successfully completed treatment, therefore these programs should have a very small percentage – if any – in prison so long after treatment.

High risk offenders had higher recidivism rates.

Dynamic risk factors, including criminogenic needs, serve as predictor of adult offender recidivism[15]. As noted by Gendreu et al., LSI-R, the instrument used by DOC, produces correlations with recidivism 62 – 75% of time, and is better than other actuarial measures available (590). Lowenkamp and Betchel also noted that LSI-R use in Iowa was "significantly related to predicting future criminal activity" (30). Offenders with higher risks are more likely to recidivate than those at lower risk levels, and populations with higher percentage of offenders within the high risk category is believed to have higher recidivism rates. Figures 13 and 14, show the recidivism rates progressively increase as the risk level of the offender population increases. Department-wide new convictions recidivism rates ranged from 3.1% of those within the low risk category to 20.4% of those in the high risk

New conviction recidivism rates are 17.3% higher for offenders classified high risk compared to offenders in low risk category.

[15] Dynamic risk factors include: antisocial personality, attitudes and behavior, interpersonal conflict, personal distress, social achievement, and recent drug/alcohol abuse.

category among offenders successfully completing substance abuse treatment. Total recidivism ranged from 6.3% to 39.8%. With new convictions, substance abuse treatment had the greatest benefit to offenders in the low/moderate risk category. For total recidivism, successful substance abuse treatment only demonstrated lower recidivism rates in the low and low/moderate risk categories.

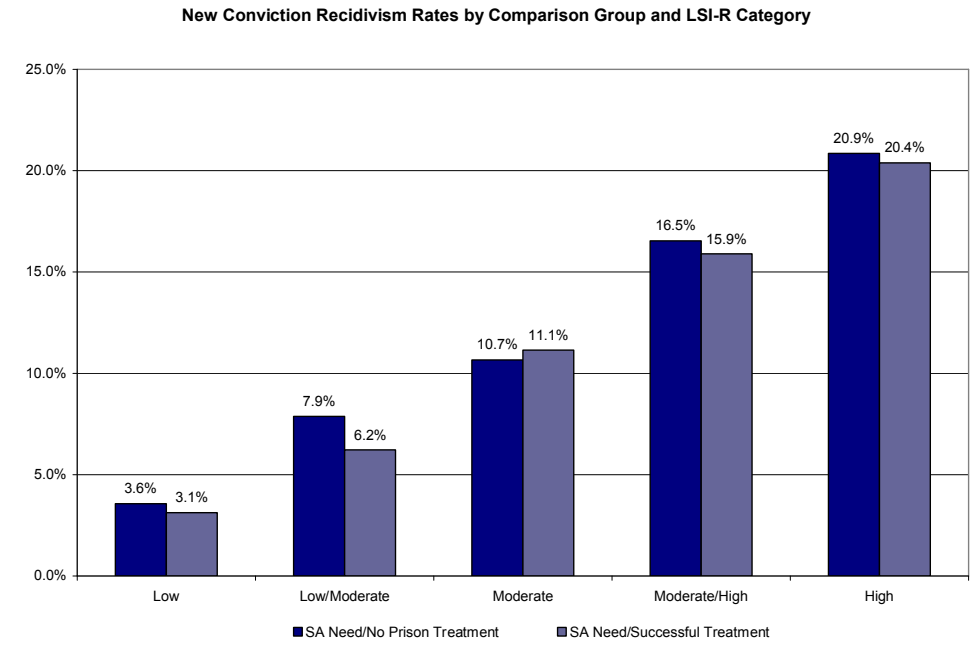

Figure 13: New conviction recidivism rates by comparison group and LSI-R category. LSI-R data was not available for all offenders, however the results presented in this figure were found to be statistically significant. Data supporting figure provided in Appendix F.

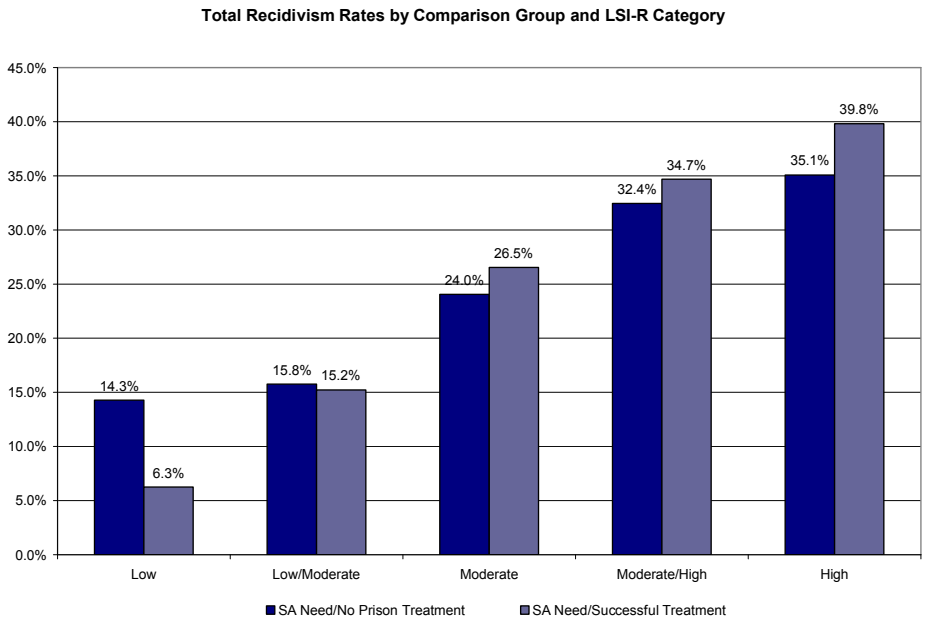

Figure 14: Total recidivism rates by comparison group and LSI-R Category. LSI-R data was not available for all offenders, however the results presented in this figure were found to be statistically significant. Data supporting figure provided in Appendix F.

Support within the community lowered new conviction recidivism; only 14.2% of offenders released to community supervision receive additional programming to continue their treatment.

Offenders face situations once released into the community that may result in relapse. These situations are often relevant at re-entry making them more difficult to address in prison-based treatment. The National Institute on Drug Abuse has framed continuity of care as a principle of drug abuse treatment, and suggests that treatment in prison can initiate the "process of therapeutic change" (4). Many stakeholders agree, noting that there is a need for additional and expanded aftercare in the community (Performance Audit – Stakeholders Survey). Studies have also demonstrated that individuals participating in both in-prison and post-release treatment in the community have better drug use and recidivism outcomes, than in-prison treatment alone (Klebe and O'Keefe 30; Inciardi et al., Martin and Butzin 102; Wexler et al. 163).

"Offenders receiving community supervision had new conviction recidivism rates 6.9 to 10% lower than offenders receiving no community supervision."

Transitional services following prison-based treatment are critical, and treatment effect can be greatly reduced or lost unless followed by continuous aftercare in the community (Simpson 110; Huebner

25). Pelissier et al. conclude that first two months after release are crucial, noting that "the first priority of probation officers and treatment providers may need to be on identifying how to avoid the high-risk situations for drug use and on finding alternative coping mechanisms to resist the temptation to use drugs…" (332). The Iowa Department of Public Health staff agreed that the transition to the community is full of challenges and changes – requiring comprehensive discharge planning (Austin and Kelly). However, community treatment providers do not always have comprehensive knowledge on treatment provided during incarceration (Performance Audit – Stakeholders Survey). Impaired communication between prison and the community could limit community aftercare's effectiveness when available.

New conviction recidivism rates among offenders receiving community supervision were 6.9 to 10% lower than offenders receiving no community supervision. The difference was larger among offenders who received substance abuse treatment, as shown in figure 15. Offenders who received substance abuse programming in the community also had lower new conviction recidivism rates than offenders who received prison treatment alone, except for inpatient/residential treatment, see figure 16. Total recidivism did not exhibit this pattern. Overall, only 14.2% of offenders released to community supervision were enrolled in programming to continue their treatment (i.e., case management, continuing care, and education).

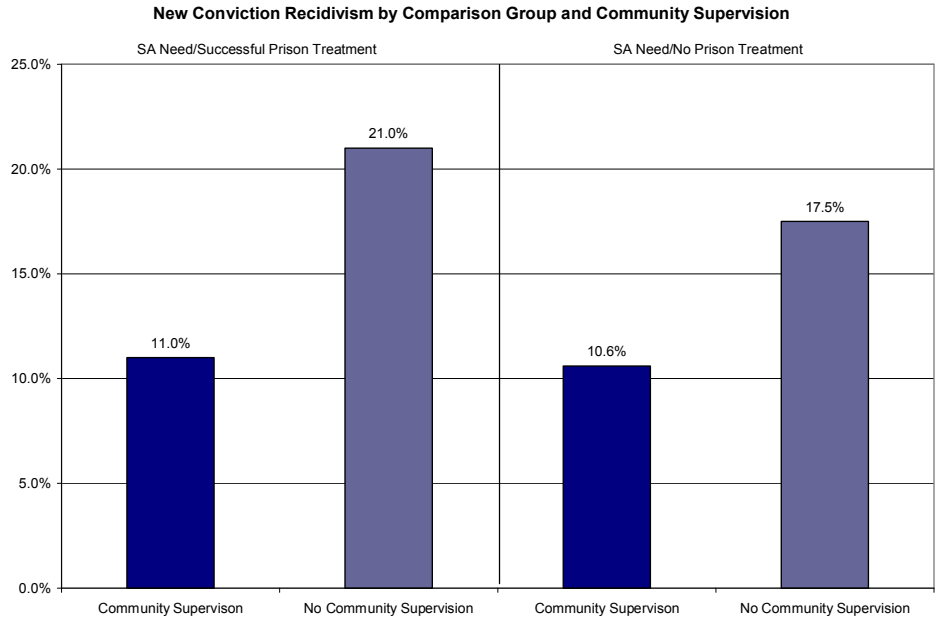

Figure 15: New conviction recidivism by comparison group and community supervision. Final discharge release codes were used to identify offenders without community supervision. Data supporting figure provided in Appendix G.

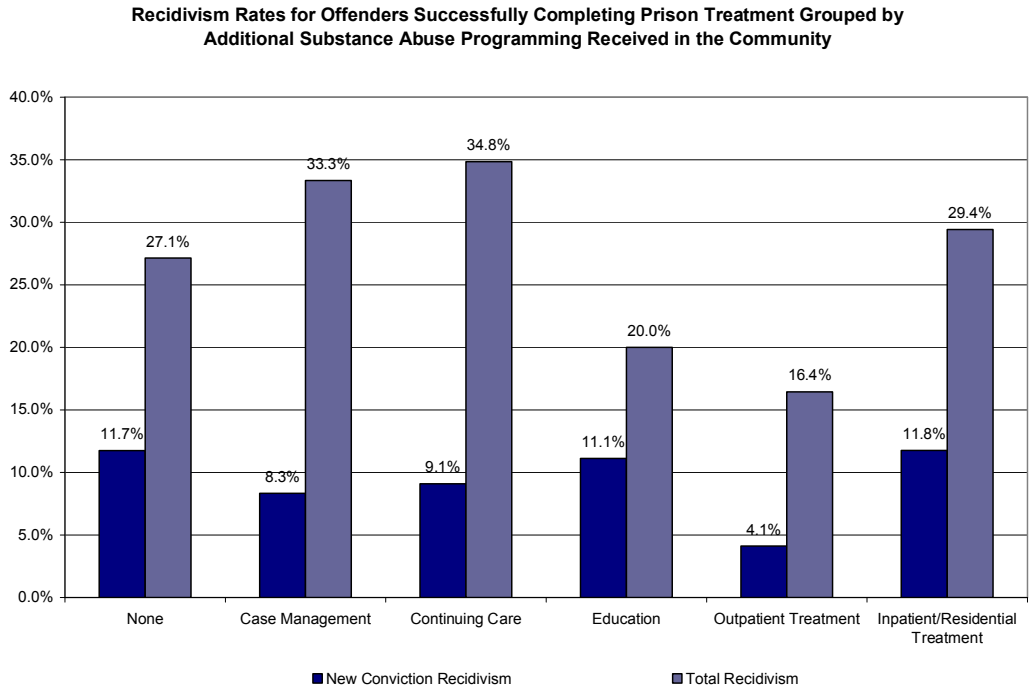

Figure 16: Recidivism rates for offenders successfully completing prison treatment grouped by additional substance abuse treatment received in the community. Data was only available for those offenders released to community supervision. Case management, continuing care and education are perceived to be the interventions most likely associated with "continuity of care." The results were not statistically significant to suggest a similar finding for entire release population. Data supporting figure provided in Appendix G.

Older offenders were less likely to be reconvicted for new offenses, and incur technical violations.

Uggen and Massogila found a tight linkage between an individual's involvement in crime and adult status, whether measured by behavioral markers (such as marriage, parenthood, full-time employment and school completion) or respondents' own sense of themselves as adults (32). This suggests that deviant behavior and crime are inconsistent with adult roles, and are held incompatible when one views themselves as an adult. As such, larger percentages of older offenders may perceive themselves as being "adults" making them less likely to recidivate. The data analyzed reflected a steady decline for both new conviction and total and new conviction recidivism rates for older offender populations. This pattern was consistent for treatment and substance abuse need/no treatment comparison groups, as reflected in figures 17 and 18. The high new conviction recidivism rate within the successful treatment group in the "Under 20" age group was likely attributable to a small number of offenders in this category.

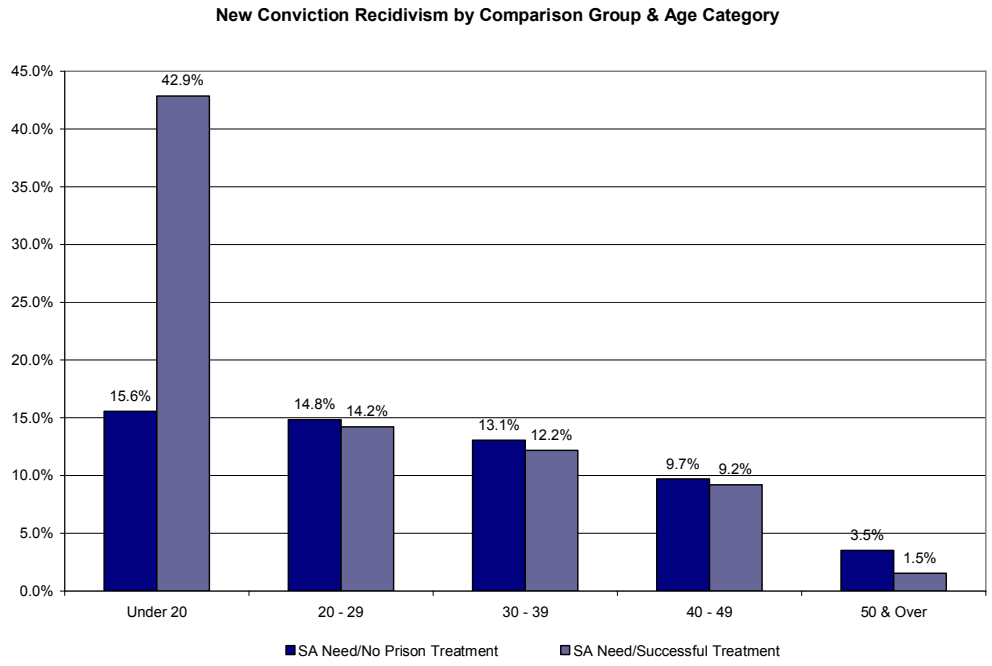

Figure 17: New conviction recidivism rates by comparison group and age category. The population within the "Under 20" age category for those successfully completing treatment was very small – only included seven offenders. Data supporting figure provided in Appendix H.

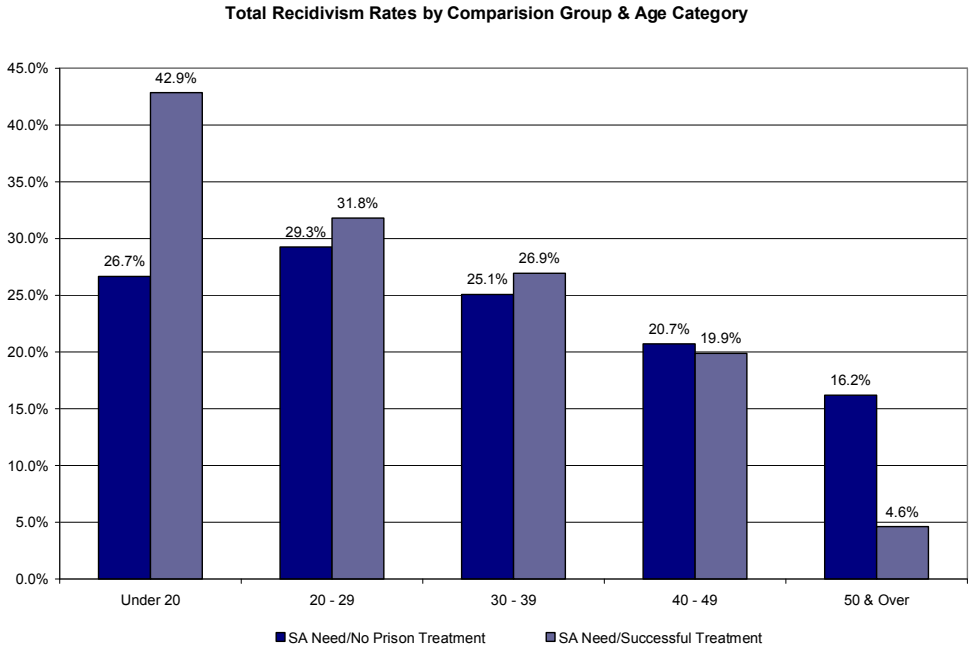

Figure 18: Total recidivism rates by comparison group and age category. The population within the "Under 20" age category for those successfully completing treatment was very small – only included seven offenders. Data supporting figure provided in Appendix H.

African Americans had higher new and total recidivism rates than Caucasians and other minority groups.

Recidivism studies have found certain minority groups (e.g., African Americans and Hispanics) to have higher rates of re-arrest. Findings from this audit are similar. African Americans had new conviction recidivism rates 4.7 to 4.8% than Caucasians, see figure 19. Total recidivism rates are 11.1 to 14.4% higher, as shown in figure 20. Reasons for higher recidivism rates among African-Americans represent a complex social phenomenon, and are likely similar to factors contributing to disparities in our state's prison population. According to the Governor's Task Force on Overrepresentation of African-Americans in Prison, the vast majority of African-American inmates in Iowa return to disadvantaged and segregated urban communities that are:

⇒ often plagued by crime;
⇒ have inadequate employment opportunities; and
⇒ have shrinking community resources and support to address poverty and unemployment, and provide safe housing, reliable transportation and adequate childcare.

These offenders also often struggle with weakened family structures, low academic achievement, and have limited access to substance abuse and mental health treatment (12, 13, and 18).

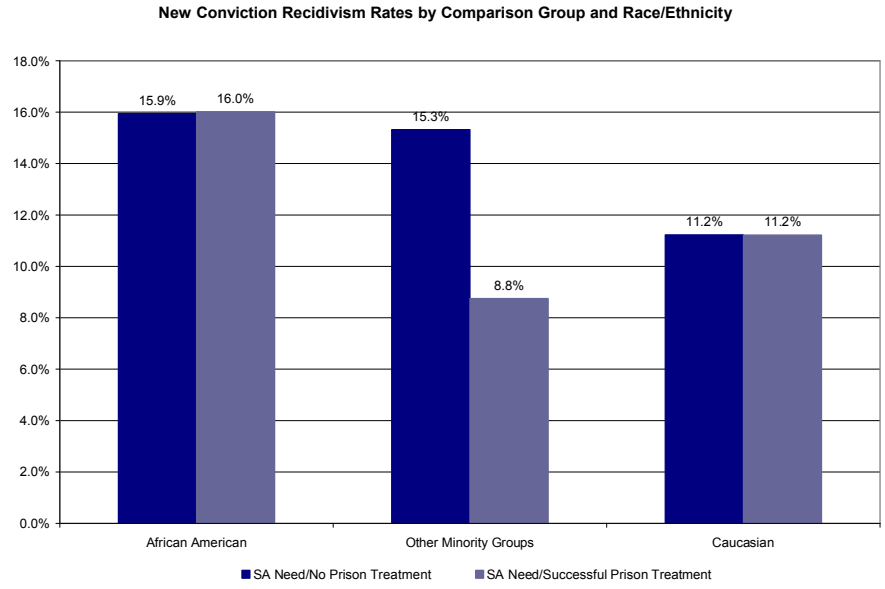

Figure 19: New conviction recidivism rates by comparison group and race/ethnicity. Other minority groups include American Indian/Alaska Native, Asian/Pacific Islander, Hispanic, and unknown. Individually, they represented such a small percentage of the total population reviewed. Data supporting figure provided in Appendix I.

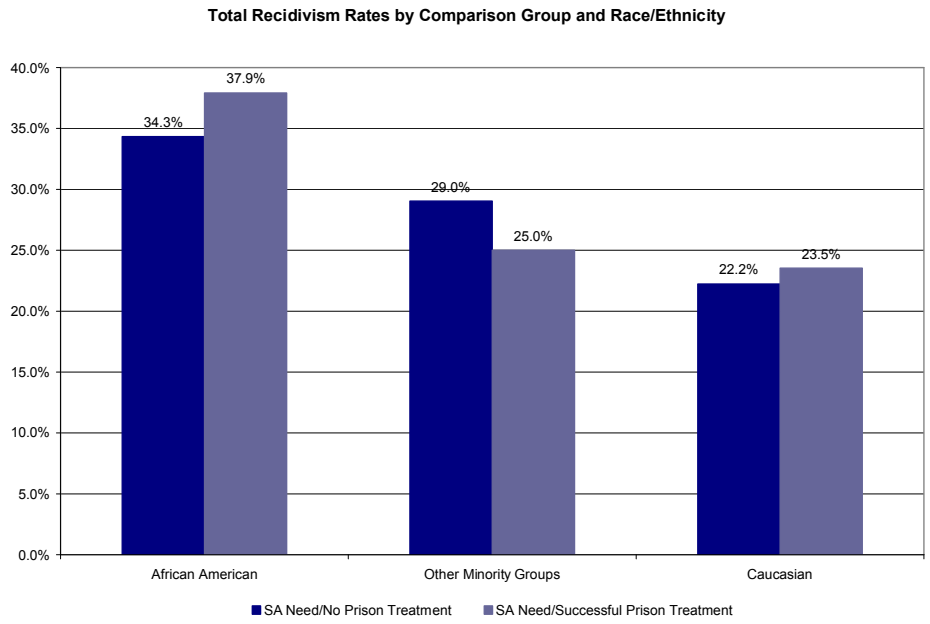

Figure 20: Total recidivism rates by comparison group and race/ethnicity. Other minority groups include American Indian/Alaska Native, Asian/Pacific Islander, Hispanic, and unknown. Individually, they represented such a small percentage of the total population reviewed. Data supporting figure provided in Appendix I.

While evidence-based practices may improve effectiveness, their use within substance abuse programs had not been fully evaluated.

Although, research has shown that substance abuse programs can be successful, it is important to recognize that success varies depending on the treatment approach utilized. NIDA recognizes that "not all drug abuse treatment is equally effective" ("Drug Abuse Treatment" 8). The general assumption that any "treatment works" should be avoided. This assumption over-simplifies a complex recovery process often requiring sustained and repeated treatment episodes (White 23). Results from Mitchell, Wilson and MacKenzie's meta-analysis also demonstrated varying degrees of treatment effectiveness depending on the type of treatment provided (17).

Palmer highlights more effective approaches at reducing recidivism, as those with the "strongest positive results (e.g., the largest effect sizes or recidivism reduction)." Approaches include: behavioral, cognitive behavioral or cognitive, life skills or skills oriented, multimodal, and family intervention (147 – 148). Interventions with the lowest percentage of successful outcomes include: diversion, group counseling or therapy, and individual counseling or therapy which often reflected mixed results toward recidivism reduction; and confrontation had the weakest (in

fact, the most negative) (Palmer, 135, 146).[16]

As mentioned previously, DOC intends to reduce adult offender recidivism through evidence-based programming ("Strategic Plan" 5; "Performance Plan" 1; "Self-Assessment" 15, 19, 38). Figure 21 outlines the principles embodied in DOC's efforts. They also intend to replicate and expand practices that prove to be the most effective through the redirection of resources (Bucklew, Prell "Substance Abuse" 19).

Evidence-Based Principles for Effective Interventions

1. Assess Actuarial Risk/Needs;
2. Enhance Intrinsic Motivation;
3. Target Intervention: Risk, Need, Responsivity, Dosage and Treatment;
4. Skill Train with Directed Practice;
5. Increase Positive Reinforcement;
6. Engage Ongoing Support in Natural Communities;
7. Measure Relevant Processes/Practices; and
8. Provide Measurement Feedback.

Figure 21: Evidence-Based Principles for Effective Interventions developed by the National Institute of Corrections and Crime & Justice Institute. The principles are intended to help building learning organizations that reduce recidivism through systemic integration of evidence-based principles in collaboration with community and justice partners.

DOC has partially evaluated the conformance to evidence-based principles (EBP) in the substance abuse programs. In 2002, five programs were assessed using the Correctional Program Assessment Inventory (CPAI). This assessment was developed by Paul Gendreau and Don Andrews in 1992. It is used to help ascertain how closely a program meets known principles of effective correctional treatment (DOC "CPAI"). However, because of time and resources to conduct such assessments, DOC has moved towards a self-assessment survey approach which is scored by a team of evaluators previously trained in the CPAI process. Once completed, DOC believes the scored survey will provide a "baseline for the status of EBP interventions across Iowa's correctional system" (Bucklew). The effort to conduct the survey is currently underway. DOC intends to compare the findings from the EBP survey to those from this audit.

The challenge comes in identifying the treatment approach that is most effective. Substance abuse programs often comprise multiple treatment approaches (modalities) making it challenging to understand which had the greatest impact on post-treatment drug use and recidivism. Harrison identifies the research needs to "examine the effectiveness of various treatment modalities, including the mix of elements found in TCs and other residential and outpatient treatment programs." She continues by highlighting the need to examine other intervening variables (such as individual involvement in treatment, ethnicity, age, social support, employment, and psychological status)

[16] The results were from an aggregate review of 9 meta-analysis and 23 literature reviews (between 1975 and 1996).

that play a role and may predict treatment efficacy (478-479).

The Iowa Practice Improvement Collaborative also note that although the term "evidence-based practice" is commonly used, there is "still no consensus on what exactly constitutes an evidence-based practice" (4).

DOC assesses offender risk and needs at institutions, but does not consistently measure addiction severity, and responsivity factors.

DOC utilizes LSI-R (Level of Service Inventory) as the main tool for assessing actuarial risk/needs of offenders. When properly administered, such assessments help identify the level of supervision and types of treatment required by offenders. However, Durrant states that the LSI-R assessments are completed at offenders' assigned institution – not reception, this limits potential treatment matches to those within the institution assigned (2).

"Offenders' cognitive and verbal skills may impair their ability to grasp complex ideas, and limit the effectiveness of some cognitive-based programs."

Institutions expressed the need for a consistent state-wide assessment tool that complements the LSI-R. LSI-R identifies a substance abuse need but does not indicate the level of addiction severity, or prevalence of mental health issues (Howard and Phillips, Nelson, and Bagby). Assessments to determine the required level of substance abuse treatment were previously conducted during reception, but due to budget reductions the service is no longer provided (Durrant 2).

The LSI-R is also limited in assessing offender responsivity (DOC, "CPAI"). Responsivity is critical because substance abuse treatment is mainly an inside job – that is it happens within the offender. Responsivity factors include offender characteristics such as: motivation, personality characteristics, cognitive and intellectual deficits, and demographic variables – which may or may not be criminogenic needs, but can impact treatment choices (Bonta "Offender Assessment" 17; Kennedy 20). Offenders' cognitive and verbal skills may impair their ability to grasp complex ideas, and limit the effectiveness of some cognitive-based programs. Additionally, responsivity factors are not always criminogenic need, but that does not diminish their importance:

> "Levels of anxiety are poor predictors of recidivism and decreases in anxiety are not associated with reductions in recidivism. Yet, the anxiety levels of offenders could impact on the choice of treatment. For example, an anger management program may work well in a group format consisting of relatively non anxious individuals. For clients who are extremely anxious in social situations however, the program would be more effective if delivered on an individual basis" (Bonta, 17).

Such factors could have significant implications regarding the

effectiveness of the program, regardless of a program's therapeutic integrity or competency of its staff. Kennedy concludes, "the need for a systematic and comprehensive assessment of responsivity and its related constructs (i.e., motivation and treatment readiness) is essential for the successful planning, implementation and delivery of appropriate and effective treatment programs" (21). A similar argument could be made for why systematic and comprehensive assessments of addiction severity and mental health conditions are essential.

Consistent approaches for offender responsivity assessments are not evident from reviewing DOC policy and procedure manuals. Some programs make use of psychological/social assessment questionnaires (DOC "ICIW - Treatment" 4; "ICIW – Violator Program" 3; "TOW" 1). Newton notes the use of Client Management Classification (CMC) and Jesness for their violator program ("NCF – Violator Program" 3). Most other programs, if noted at all discuss making use of various assessments when available; or rely on classification notes, pre-sentence investigations, and other less structured approaches (DOC "ASP" 17; "NCF - PSD" 3; "MPCF" 3).

Addiction severity assessments and instruments used reflected little consistency among substance abuse programs. FDCF noted utilizing Substance Abuse Subtle Screening Inventory (SASSI), and Adult Substance Use Survey (ASUS) (DOC "New Frontiers" 24). NCCF also notes the use of SASSI (DOC "NCCF" 4). Other institutions' policies make no reference to any instruments, refer to an evaluation conducted by MECCA, or just reference the data collected during the intake process at Iowa Medical and Classification Center (IMCC).

22.8% of offenders treated had low to low/moderate risks, while over 1,800 moderate to high risk offenders with substance abuse needs received no treatment.

According to the National Institute of Corrections and Crime and Justice Institute, the risk principle calls for programs to "prioritize supervision and treatment resources for higher risk offenders" (3). Their premise is that prioritizing the higher risk offenders places emphasis on "harm-reduction and public safety," since higher risk offenders have a greater need for pro-social skills and thinking development and are more likely to commit new offenses (4). Bonta concurs stating that research evidence "suggests that it is the higher risk client that can benefit from treatment more so than the lower risk offender" ("Offender Assessment" 16).

22.8% of the offenders (321 offenders) released with substance abuse treatment had low to low/moderate risk levels – with Newton Correctional Facility having 50% of the offenders treated in the two lower risk categories, and Anamosa State Penitentiary the least at 13.9% - see table 5. During the

same timeframe, 994 moderate risk offenders, 641 moderate/high risk offenders, and 211 high risk offenders in need of substance abuse treatment did not receive any prior to their release from prison. Of the higher risk offenders receiving no prison substance abuse treatment, 483 were released due to the end of their prison sentence – offering no additional opportunity for treatment.

Risk-based admissions/selection criteria were not prevalent in substance abuse treatment policy and procedure documents. ICIW has specific admission/selection criteria related to risk level for entrance into the program "LSI-R scores 25 and above for sentences 5 years and up" is a specific admission criterion for STAR and WINGS (DOC "ICIW - Treatment" 3). NCF does as well for the violator program, "will accept males who scored within the range of 24 to 40" (DOC "NCF – Violators Program" 1). FDCF, ASP and MPCF note referring to LSI-R or LSI scores, but do not indicate how an offenders' risk level will impact admission into the program (DOC "ASP" 11-12; DOC "MPCF" 3; DOC "New Frontiers" 15).

Percentage of Offenders Receiving Substance Abuse Treatment in Risk Categories by Institution

Institution		LSI-R Score Category					Total
		Low	Low/Mod	Moderate	Mod/High	High	Low
Anamosa State Penitentiary	Count	0	19	77	31	10	137
	%	.0%	13.9%	56.2%	22.6%	7.3%	100.0%
Clarinda Correctional Facility	Count	1	47	160	97	39	344
	%	.3%	13.7%	46.5%	28.2%	11.3%	100.0%
Fort Dodge Correctional Facility	Count	1	29	115	63	17	225
	%	.4%	12.9%	51.1%	28.0%	7.6%	100.0%
Iowa Correctional Institution for Women	Count	6	57	69	36	14	182
	%	3.3%	31.3%	37.9%	19.8%	7.7%	100.0%
Iowa State Penitentiary	Count	2	6	24	5	1	38
	%	5.3%	15.8%	63.2%	13.2%	2.6%	100.0%
Mount Pleasant Correctional Facility	Count	3	47	121	73	19	263
	%	1.1%	17.9%	46.0%	27.8%	7.2%	100.0%
Newton Correctional Facility	Count	19	77	61	34	1	192
	%	9.9%	40.1%	31.8%	17.7%	.5%	100.0%
North Central Correctional Facility	Count	0	7	10	7	2	26
	%	.0%	26.9%	38.5%	26.9%	7.7%	100.0%
Total	Count	32	289	637	346	103	1407
	%	2.3%	20.5%	45.3%	24.6%	7.3%	100.0%

Table 5: Table highlights the number and percentage of offenders receiving substance abuse treatment within each risk category by institution for those released between October 1, 2004 and December 31, 2005.

System-level measures are either inconsistent or do not exist across programs limiting performance management capabilities – new data systems may offer solutions.

Licensure standards for substance abuse treatment programs in correctional facilities provide the framework for establishing consistent system-level measures. 641 *Iowa Administrative Code* Paragraph 156.3(13) requires programs to document the quality of inmate care and use that information to detect trends and patterns of performance. Iowa Department of Public Health staff said this requirement was initiated three years ago, and progress has been made. However, it is left to the individual programs to define the criteria they will look at (Austin and Kelly). The effort is a step in the right direction, but when the criteria are developed independently it hinders the ability for DOC to use the information collected for program comparison purposes.

"The data is not compiled in such a way to see changes over time, nor is there a consistent approach used across programs minimizing the data's usefulness for program comparisons."

Many of the programs attempt to learn from offenders completing treatment about the quality of their programs through a survey or interview conducted when offenders exit the program. The survey or interview results serve as a gauge for offender satisfaction and a mechanism to learn what is working and what is not (Howard and Phillips; Dick and Comp; Nelson; Johnson; Dursky et al.; Bagby; Lawson et al.). The information collected in this way is reviewed periodically (monthly, quarterly or at the end of the treatment session). Programs tend to look for patterns in responses given for issues to address and improvements to make. The data is not compiled in such a way to see changes over time, nor is there a consistent approach used across programs minimizing the data's usefulness for program comparisons.

FDCF, ASP, and NCCF discussed the use of pre and post tests as ways to assess or measure learning that takes place as a result of the program (Dick and Comp; Hebron and LaBarge; Johnson). Tests used are usually associated with the program's curriculum, and results are often kept in offender files. No indication was provided that the information is aggregated to assess the programs' performance relative to offender learning over time. One institution did not believe the test they use to be the greatest, but did not have another alternative available. NCF conducts pre and post tests using the criminal sentiment scale, which measures changes in antisocial attitudes (Dursky et al.).[17] This was the only approach

[17] The Criminal Sentiment Scale instrument measures antisocial attitudes to determine offender tolerance for the law and identification with criminal activities, and reflects tendencies to have antisocial attitudes.

identified that attempts to quantitatively measure behavioral changes. However, the data produced by the criminal sentiment scale test was not mentioned when discussing performance data periodically reviewed for management purposes – suggesting it may be collected at the individual level, but not aggregated to assess program performance. ISP and ICIW noted that behavior change is not specifically measured but is captured through discussions between the offender and counselor. The information is likely kept in progress notes and not used for measuring program effectiveness (Lawson et al; Bagby).

"...promises to help with various research issues/questions, and will place all individual data in a database enabling the aggregation of data."

Institutions also discussed following-up on offenders once they exit treatment programs. However, what they check and when they check varies. FDCF said an 18 month recidivism check is conducted by counselors (Dick and Comp). MPCF conducts follow-ups at 30, 60, and 90 days, six months and one year following treatment completion to check on arrests, parole violations and convictions (Nelson). ASP said that recidivism data is collected every six months on the TC for grant reporting purposes, but was not collected for ALTA and LH SAT (Hebron and LeBarge). NCCF sends mailings to offenders one year after treatment, but does not have good response rates, and ISP reviews ICON for behavior issues recorded by parole officers and urinalysis results (Johnson; Lawson et al.).

DOC has begun to pilot test the Iowa Service Management and Reporting Tool (I-SMART) in two institutions which promises to help with various research issues/questions, and will place all individual record data in a database enabling the aggregation of data (Lawson et al). According to the Iowa Department of Public Health, a key goal for I-SMART is to "advance the standardization and quality of treatment data to provide the best available treatment information for managing and monitoring system outcomes" ("I-SMART"). It will allow providers using the system to capture data related to intake, treatment services, discharge, and follow-up tracking. However, another chief benefit is that it will enable the sharing of treatment information within the constraints of individual privacy regulations, which is critical according to stakeholders to enhance community aftercare. Additionally, DOC's ICON system promises to offer a standard approach for gathering recidivism data, as reflected in this performance audit, which will be beneficial for conducting future outcome evaluations.

More frequent recognition of quality work and ensuring adequate resources are available could enhance employee engagement.

Simpson describes the therapeutic relationship between offender and counselor as a major component to early engagement of offenders in treatment programs. The offender-counselor relationship is "commonly considered to be at the very core of effective treatment" (106). The relationship requires empathy, warmth and genuineness on behalf of the counselor. As part of the performance audit, employees were surveyed to identify and measure the elements of worker engagement, utilizing questions developed by the Gallop Organization, see figure 22. Results have shown a strong link between high survey scores and worker performance (Buckingham and Coffman 31-41). A counselor more highly engaged (i.e. loyal and productive) in their work arguably is more likely to develop the therapeutic relationship required for effective treatment – than those who are disengaged (i.e. unhappy and spreading their discontent). As such, the survey results may serve as a proxy indicator for the therapeutic relationship.

The 12 Elements of Great Managing

To identify the elements of worker engagement, Gallup conducted many thousands of interviews in all kinds of organizations, at all levels, in most industries, and in many countries. These 12 statements – the Gallup Q12 – emerged from Gallup's pioneering research as those that best predict employee and workgroup performance.

1. I know what is expected of me at work.
2. I have the materials and equipment I need to do my work right.
3. At work, I have the opportunity to do what I do best every day.
4. In the last seven days, I have received recognition or praise for doing good work.
5. My supervisor, or someone at work, seems to care about me as a person.
6. There is someone at work who encourages my development.
7. At work, my opinions seem to count.
8. The mission or purpose of my company makes me feel my job is important.
9. My associates or fellow employees are committed to doing quality work.
10. I have a best friend at work.
11. In the last six months, someone at work has talked to me about my progress.
12. This last year, I have had opportunities at work to learn and grow.

Figure 22: The 12 elements of great managing. Copyright © 1992-1999 The Gallup Organization, Princeton, NJ. All rights reserved.

Although the survey data can not be related to recidivism results, it does highlight issues DOC management can focus on to help improve future program performance. Over 25% of the employees working in the substance abuse program disagreed or were neutral with five statements:

⇒ I have the materials and equipment I need to do my work right (36.4%).
⇒ At work, I have the opportunity to do what I do best every day (27.2%).
⇒ In the last seven days, I have received recognition or praise for doing good work (45.5%).

⇒ At work, my opinions seem to count (30.9%).
⇒ I have a best friend at work (34.5%).

Over 25% disagreed with receiving recognition and praise in last seven days, and 18.2% disagreed with having the materials and equipment to do their job right. The percentages were higher among survey respondents.[18] Survey data is provided in Appendix J.

[18] 65% of DOC employees working in the substance abuse programs responded to the employee survey.

Conclusions and Recommendations

DOC has begun to look for ways to improve their substance abuse treatment programs, and is committed to reducing recidivism – specifically with efforts to:

⇒ evaluate the utilization of EBPs within interventions and programs;
⇒ develop program corrective action plans to drive the implementation of EBPs; and
⇒ redirect resources into promising or excellent strategies.

Even though connecting the implementation of evidence-based practices to improvements in recidivism is not possible currently, research supports their use. DOC should continually strive to evaluate, integrate and implement evidence-based practices into their treatment offerings.

Many of the licensed substance abuse programs have also established quality assurance programs to allow ongoing continual improvement, focused on making small programmatic changes, which over time – taken collectively – have the potential to greatly affect program results. While the quality assurance programs offer a good start, DOC's efforts could be greatly enhanced with instruments to monitor patient progress or aggregate patient records to provide measures of motivation, engagement, and functioning – and for these measures to be tracked over time. Such measures have the benefit of demonstrating program effectiveness, identifying problem areas and supporting focused improvement efforts. Approaching measurement consistently across the prison system will provide the added benefit of identifying unique programmatic problems from systemic problems prominent across the entire prison-system.

DOC also has the need to fully understand dynamic population characteristics across the system. The limited information presents challenges in knowing which type of treatment in terms of intensity, duration, and modalities used are of greater need Department-wide. Currently, the delivery of appropriate and effective treatment is hindered by restricting programming to what is available at the institution where the offender has been placed, which may not best fit the offender's needs. It also places the burden of challenging offender populations, such as those with co-occurring disorders (mental health and substance abuse need), on the institutions where programming may not adequately address the problem.

While many strategies can be implemented within the prison-system, some issues call for a broader approach. Recidivism rate changes associated with community supervision, enrollment in community based substance abuse programming, and environmental factors associated with higher recidivism rates among African Americans suggest the need for enhanced social support systems and networks within communities. More offenders need continuing support and care in the community to maintain and further enhance treatment received while in prison.

The following recommendations are offered for DOC's consideration:

⇒ Enhance community support networks and release planning to positively reinforce desired behaviors;
⇒ Develop a consistent assessment protocol and standard intake process;
⇒ Develop a system for monitoring program performance, setting targets and furthering the use of evidence-based practices;
⇒ Deliver substance abuse programming across the correctional system in an integrated fashion; and
⇒ Develop strategies to give substance abuse treatment staff positive recognition and praise on a frequent basis.

All of the recommendations discussed below will require DOC to manage change. Employees and stakeholders must understand the real costs, benefits and rationale. A communication plan accompanying strategies the Department intends to move forward with will be beneficial. The mantra regarding change management is to communicate early and often.

Enhance community support networks and release planning to positively reinforce desired behaviors.

Community aftercare is a critical element to NIDA. They have it listed as a principle of drug abuse treatment for criminal justice populations – "Continuity of care is essential for drug abusers re-entering the community" ("Treatment for Criminal Justice Populations" 5). Community aftercare is also listed as an evidence based principles for effective interventions, "Engage ongoing support in natural communities," see figure 21. Its importance is further supported by researchers in the substance abuse field, Simpson states that "nowhere is the importance of transitional services treatment more evident than for correctional populations, especially community re-entry programs that follow prison-based treatment" (110). Data presented in this audit suggests that community aftercare can reduce recidivism. The following information presents a number of short-term and long-term actions DOC can undertake to enhance community support networks and release planning that will positively reinforce desired behaviors and reduce recidivism.

Short-term actions:

1. *Review recidivism data geographically* – by region or county where offenders are located following release – to identify where additional support may be required. Release location variable was not part of the data set reviewed as part of this performance audit.
2. *Review the discharge planning process* to ensure substance abuse aftercare requirements are incorporated and detailed in offenders' discharge plans.

3. *Reinforce treatment received in prison* by encouraging offenders' participation in self-help and peer support groups and religious activities after release that will improve offenders' bonds to pro-social community members (National Institute of Corrections 6).
4. Enhance or expand interventions that *increase offenders' family contact* and educate family members how they can better support offenders' recovery.
5. *Evaluate the effectiveness of I-SMART pilot* in conveying prison treatment information to providers in the community, and mainstream the system to other programs if success is demonstrated.

Long-term actions:

1. Develop *partnerships with community-based organizations* and substance abuse providers to ensure services are available to offenders after their release from prison.
2. Develop and pilot test *a coordinated, supportive approach to community supervision* that emphasizes offenders' pro-social goals in their conditions to release and encourages positive responses to attainment of these goals (Re-Entry Policy Council 5). See Step'n Out behavioral management approach outlined on www.cjdats.org. The goal of the approach is to enable community supervision officials to become more of a change agent, and to rely less on negative sanctions – which lead to recidivism due to technical violations.
3. Enable *local care providers to meet with offenders prior to their release* and to be involved in discharge planning. The Re-Entry Policy Council suggests community-based providers are "likely to be more familiar with the community to which an individual will return after his or her incarceration than are corrections staff" (12).

In order to *leverage departmental resources*, DOC may want to explore ways to focus such initiatives, the following are some examples:

⇒ Build partnerships in communities where African Americans reside to help combat prevalent socioeconomic issues.
⇒ Build partnerships in communities where higher recidivism rates are evident.
⇒ Enhance discharge planning for higher risk offenders, or with those mental health diagnoses.

Develop a consistent assessment protocol and standard intake process.

The assessment process is arguably one of the most critical functions DOC conducts, because with growing prison populations and declining resources where and how services are provided become more and more critical with each admission. The following four offender classification factors help with security decisions and guiding treatment:

⇒ Risk,
⇒ Need (criminogenic needs),
⇒ Responsivity, and
⇒ Professional discretion, which uses professional judgment to assess variables, deemed important (Kennedy 19, Bonta "Offender Assessment" 16-17).

However, as Bonta notes, interview questions can vary from offender to offender, and the range of error associated with measurement instruments available can make assessing offenders challenging. He suggests a "multi-method measurement of theoretically relevant factors" as a way to reduce error and increase the accuracy of the assessment. This approach combines the use of a measurement instrument (test) and a structured interview ("Offender Assessment" 15-16). DOC utilizes the validated LSI-R to assess risk and need (Lowenkamp and Bechtel). Classification notes and pre-sentence investigation are also utilized by a number of substance abuse programs as part of their intake phase, but were not reviewed as part of this audit. However, the consistent use of instruments related to mental health, addiction severity and responsivity is not apparent.

Short-term actions:

1. *Review addiction severity instruments.* According to a study of prisoner intake systems, SASSI, the Texas Christian University Drug Dependency Screen (TCUDDS) and the Addiction Severity Index (ASI) are common instruments used nationally (Hardyman et al. 12).
2. *Review mental health instruments.* Millon Clinical Multiaxial Inventory (MCMI) and Minnesota Multiphasic Personality Inventory (MMPI) were more common instruments used to assess psychopathology and address compulsive behaviors (Hardyman et al. 12).
3. *Review responsivity instruments.* Kennedy discusses CMC and the Jesness Personality Inventory, as commonly used instruments for responsivity, but highlights LSI – Ontario Revision (OR) as the first risk assessment instrument to incorporate "a section on 'special responsivity considerations'." The section measures "motivation as a barrier, denial/minimization, interpersonal anxiety, cultural issues, low intelligence and communication barriers" (21). Bonta highlights other valid and reliable measures for intelligence, anxiety, and interpersonal maturity ("Offender Assessment" 18).
4. Review existing interview methodologies used, and identify ways to *establish structured interviews* that will help ensure consistency in administration.
5. Develop a *standard comprehensive assessment protocol and intake process*. In the DOC executive meeting on December 18, 2006, it was noted that 1) there is not a state-wide assessment, and 2) there is a need to make the reception/intake process at IMCC more efficient. DOC may want to consider utilizing a lean tool called Design for Lean Sigma, which is a methodology to

create a new service, product or process; is applicable to any high-value project that needs a significant amount of new design; and places strong emphasis on capturing and understanding the customer and organization needs.

6. *Train assessment staff* on how the assessment and intake process will work and how to use the instruments.
7. Develop training material so substance abuse counselors and other treatment staff understand how the comprehensive assessment works and *know how to use the information from the assessment* in developing individual treatment plans.

Long-term actions:

1. Train substance abuse counselors and other treatment staff.
2. *Validate* any new measurement instruments used.
3. Conduct an assessment to *identify gaps in treatment services* offered within the correctional system.
4. Establish *treatment acceptance criteria* for treatment offerings based on information provided by the comprehensive assessment. The criteria should be unique, so that it is appropriate for the specific intervention, yet standard among similar interventions.
5. *Redirect staffing resources*, especially those with strong substance abuse expertise to support the assessment function.

Develop a system for monitoring program performance, setting targets and furthering the use of evidence-based practices.

System-level measures allow program comparisons, help programs tell their story, track progress over time, and identify improvement opportunities. Measuring relevant processes/practices and providing measurement feedback are also two principles of for effective interventions (National Institute of Corrections and Crime & Justice Institute 7). The litmus test for any measurement system is how it is used. Managers need to define the specific purpose for the measurement system and specific measures, and how it will be used as well as what it will be answering. Measures should help agencies manage themselves better – drive improvement, measure progress towards achieving one's mission (or at least to know whether or not they are doing a better job), and help answer key questions that stakeholders have about the program.

Short-term actions:

1. *Continue efforts to assess the use of evidence-based practices* to better inventory what practices are used and where they are implemented. The Iowa Consortium for Substance Abuse Research and Evaluation highlight that numerous studies show positive outcomes in a variety of fields including substance abuse treatment – when programs "accurately" implement evidence-based protocols (24). The integrity of program implementation is just as important as understanding program results – whether it is relapse or recidivism.
2. *Identify key aspects of the program that are the most important.* The TCU Treatment Model highlights six broad areas, which may establish common aspects programs can look at: patient attributes, program attributes, early engagement, early recovery, stabilized recovery, and post-treatment outcomes (Simpson 103). DOC work on evidence-based practices provides a start on what to look at.
3. Identify *who will have questions* about aspects of the substance abuse program, and what questions they will have, and how the answers to those questions would be used.
    a. Internally, DOC has interest in knowing how well programs are implementing evidence-based practices and how do offenders change as a result of treatment, whereas policy makers are interested in broader outcome related questions – such as does the program keep offenders from returning to prison? In these cases, the answers will generally be used for driving improvements and allocating resources.
    b. DOC may want to consider asking stakeholders what questions they have about the substance abuse programs.
4. *Prioritize questions to answer.* Generally, resources are not available to answer every possible question. Additionally, attempting to answer too many questions through measurement can hinder DOC's ability to explain what the data is telling you, which is just as important as the data itself.
    a. When prioritizing, DOC should look for commonalities among questions asked.
    b. Most performance management efforts place focus on outcomes, Iowa's Accountable Government Act is no different. DOC should consider focusing on more immediate outcomes for the substance abuse programs. Although reduced recidivism is key result, a lot of variables influence it. Incremental offender change is a more immediate outcome that can be directly attributable to the substance abuse program – it is also more immediate giving management an opportunity to react, and make necessary changes.

c. DOC must also have information that will help explain unusual or unexpected outcomes. For instance, dosage is a key principle for effective treatment – so are offenders in therapeutic tasks 40% or more of their time? Does a drop in offenders meeting the dosage standard coincide with a reduction in the amount of change exhibited by offenders?

5. *Identify data needed* to help answer your questions; and how and when it will be collected.

   a. Queries have been built to answer recidivism questions related to this audit, which can be used.

   b. I-SMART database piloted in two institutions may offer other opportunities.

   c. Samples may be sufficient – treatment managers are already sampling case files for quality assurance purposes, what other questions can they answer during this exercise? If sampling is used, questions asked, and how they are answered should be consistent across the substance abuse programs.

   d. DOC could continue to use the Q12 survey questions to measure employee engagement, as a proxy for therapeutic relationships.

   e. Some questions may need new data – such as monitoring the change in an offender's dynamic risk factors as a result of treatment, or offender engagement during treatment.

   f. Consider how DOC will need the data disaggregated – considering geographical or other demographic characteristics. In order to avoid a central office orientation, it is important to include measures that are relevant at the institution and program level as well.

   g. Avoid unnecessary precision or confidence requirements that are of little benefit and only make measurement more costly.

   h. Collect and document data to support monitoring performance over time and observing changes.

   i. Ensure what is measured and how frequently it is measured is consistent over time and across programs.

6. *Baseline and set targets and standards for action for every measure intended to monitor performance.* This helps establish what level of performance is expected and provides a means to signal problems. It also allows substance abuse programs to explore creative/innovative approaches for achieving targets. Having targets and standards can help evaluate a program or processes fidelity – how close is the process or program implemented in the way it was intended.

7. Assign *individuals responsible* for each performance measure identified.
8. Make the data visual – utilizing graphical analysis of the data. This report provides some examples, other techniques are run and control charts, which are especially useful for time series data.
9. *Use the data.* Substance abuse programs have quality assurance teams or committees, and most also have periodic employee/team meetings where monitoring system data can be reviewed and corrective action plans devised. With measures that are consistently measured over time and across programs, the monitoring systems will support the "inside – out approach" for implementing the "Principles of Evidence-Based Practices" allowing for comparisons across programs – in search of "best" or at least better practices to replicate in other areas of the department (National Institute of Corrections and Crime & Justice Institute 12).
10. *Share the data.* The data, in some cases, was collected to answer stakeholder questions – let them see it. Some of the substance abuse programs have advisory groups, which may serve as a good place to start.

Long-term actions:

1. Develop a *system for external benchmarking* of other incarceration-based substance abuse programs/models supported by research. Although it is good to look internally for utilization of evidence-based practices, external review can provide new insights, and identify other practices or strategies that would benefit DOC's substance abuse programs. It can also serve as a major catalyst for change, and would allow DOC to build upon the work of others. External benchmarking should only be considered after DOC's internal monitoring and benchmarking methods are well developed.

Deliver substance abuse programming across the correctional system in an integrated fashion.

As noted previously, most of the substance abuse programming offered by DOC was developed at the institution level. Independent program development creates treatment programs that are specific to the institution – rather than supportive of a comprehensive departmental system – and may not adequately address service gaps when looking at needs across the department. Also, the small percentage of offenders receiving continuing substance abuse programming in the community, suggests that many of DOC's treatment programs are stand alone where therapeutic change is hopefully completed while the offender is incarcerated, rather than as part of a treatment continuum spanning incarceration, work release and parole. Approaching substance abuse programming in an integrated fashion promotes consistent delivery of services, as well as, provides for the standardization of key processes – such as offender assessment and discharge planning. It would also allow DOC to focus on advantages that incarceration-based treatment offers – such

as time. As Inciardi et al. notes, "there is the time and opportunity for focused and comprehensive treatment, perhaps for the first time in a drug offender's career" (91).

Short-term actions:

1. Work with Community Based Correction Districts to develop a *multistage treatment continuum model*. Durrant notes that "CBC facilities are an integral and critical part of the correctional system" (16). Exploring how the prison-based and community-based substance abuse programs work together is a natural extension to DOC's efforts to evaluate the use of evidence-based practices – and may offer opportunities to deliver services more cost effectively. The multistage model used within the Delaware correctional system since the mid-1990 has been the subject of many studies – where primary treatment is provided in the prison system, transitional treatment is provided in a work release setting and aftercare is provided when the offender enters parole or is placed under some other form of community supervision (Inciardi et al. 91-92). This approach may also support utilizing prison treatment resources for offenders with more severe addictions requiring more intensive treatment. While others with less severe addictions could be treated in the community rather than in prison.

2. Evaluate opportunities to create *prison-wide centers* that address specific issues or needs. Focusing on a specific issue or problem typically allows for a greater degree of specialization that is not possible or practical in all situations. The co-occurrence of mental health and substance abuse needs may be appropriate for such a center.

Develop strategies to give substance abuse treatment staff positive recognition and praise on a frequent basis.

Evidence-based practices suggest that effective correctional programs are ones who utilize rewards at a much higher rate than punishments as a way to change offender behavior (DOC "CPAI"). The same principle can be applied to employees in the form of frequent recognition and praise that:

⇒ Focus on positive interactions;
⇒ Promote positive emotions that can profoundly influence employee productivity; and
⇒ Enhance therapeutic relationships that are critical in substance abuse treatment.

This is especially critical in the field of substance abuse treatment, where relapse is prevalent and often considered inevitable.

Short-term actions:

1. Develop strategies to *increase positive interactions* occurring within work teams. How Full is Your Bucket? by Tom Rath and Donald O. Clifton and www.bucketbook.com offer some simple and practical suggestions on how an organization can increase positive interactions.

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Department of Corrections' Response

Iowa Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF CORRECTIONS
JOHN R. BALDWIN, DIRECTOR

June 5, 2007

Scott Vander Hart, Performance Auditor
Iowa Department of Management
State Capitol
Des Moines, Iowa 503009

RE: Department of Correction Response to Prison-Based Substance Abuse Performance Audit

Dear Mr. Vander Hart:

The Department has reviewed the substance abuse program performance audit conducted by Scott Vander Hart, Iowa Department of Management. The results and recommendations have been reviewed by the Department of Corrections executive team, and they will be very useful to the Department in improving the outcomes of offenders receiving treatment in our prison-based programs.

The Department is positioned to immediately address the following issues identified by the audit:

- An FY08 appropriation funds Level of Service assessments upon admission to prison at the Iowa Medical & Classification Center to support the "right offender" receiving the "right treatment."
- Reentry coordinators are being hired in the three largest releasing institutions—North Central Correctional Facility, Iowa Correctional Institution for Women, and Newton Correctional Facility—to improve reentry transition planning in collaboration with reentry coordinators in all eight judicial districts.
- The Department has conducted Evidence-Based Program Assessments for community correction and institution intervention programs and corrective action plans will be developed and implemented during the summer and fall of 2007.
- A Substance Abuse Focus Group is being assembled to develop and implement long term improvements in response to Durrant Study recommendations.
- A Department central classification position that is being filled following a retirement will be redirected to provide statewide substance abuse program direction and oversight.
- The Department of Public Health's I-SMART treatment data base is being piloted at two institutions to determine it's workability in the correctional environment.
- The Department is preparing to conduct Motivational Interviewing training in institutions to assist staff in improving their skills for engaging offenders in behavior change.

We appreciate this opportunity to evaluate our substance abuse treatment programs. Scott Vander Hart was very collaborative and competent in his work with the Department, resulting in a highly professional and valuable work product that will assist the Department greatly to improve program outcomes.

Sincerely,

John R. Baldwin

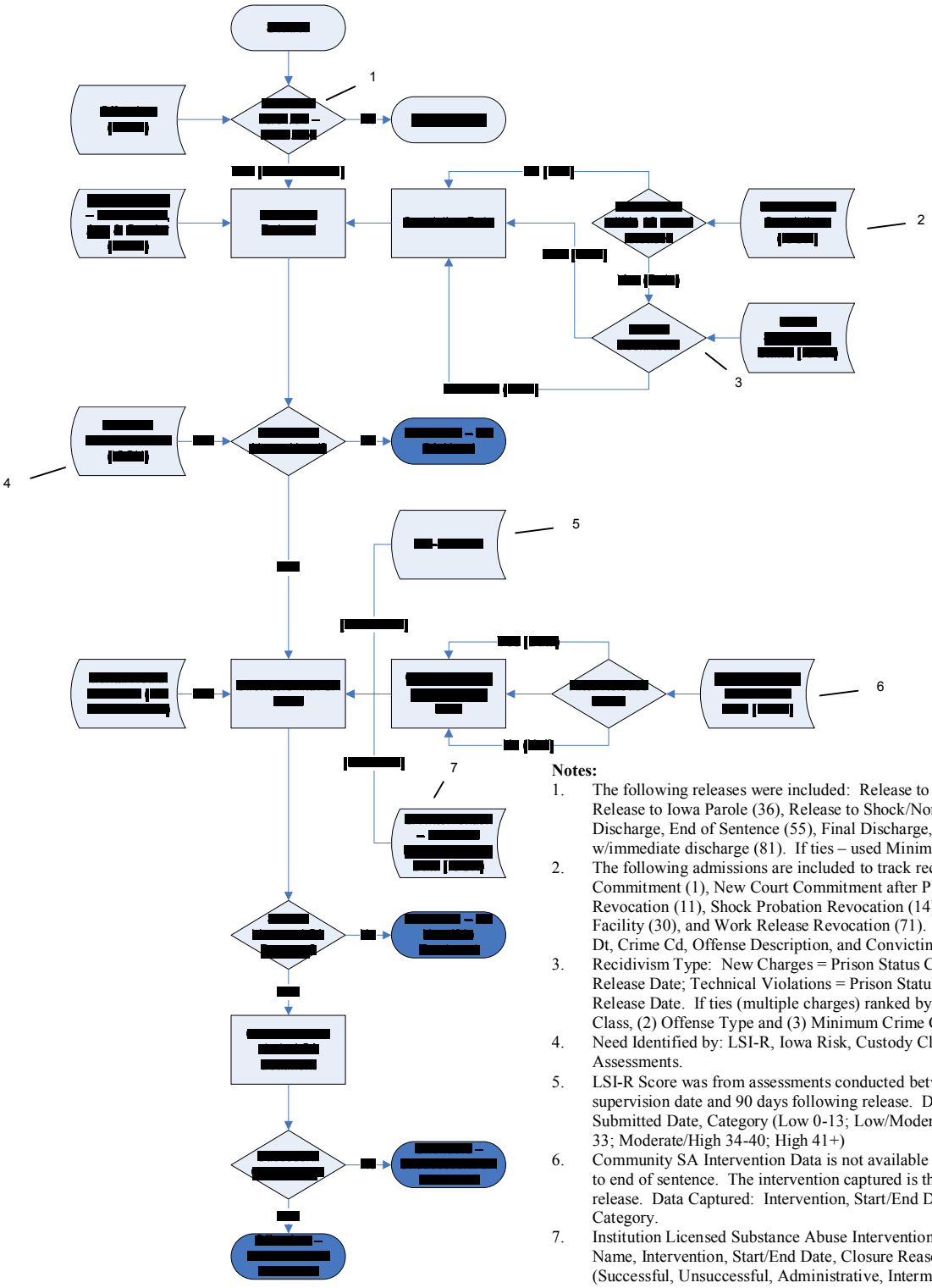
John R. Baldwin, Director

The mission of the Iowa Department of Corrections is to:
Protect the Public, the Employees, and the Offenders.

(Office) 515-725-5701 - 510 East 12th Street, Des Moines, Iowa 50319 - (FAX) 515-725-5799

www.doc.state.ia.us

Appendix A: Data Collection Methodology



Notes:

1. The following releases were included: Release to work release (32), Release to Iowa Parole (36), Release to Shock/Non-shock PB (38/39), Final Discharge, End of Sentence (55), Final Discharge, Other (56), and Parole w/immediate discharge (81). If ties – used Minimum Release Date.
2. The following admissions are included to track recidivism: New Court Commitment (1), New Court Commitment after PB Rev (2), Parole Revocation (11), Shock Probation Revocation (14), Admission from OWI Facility (30), and Work Release Revocation (71). Data Captured: Offense Dt, Crime Cd, Offense Description, and Convicting Crime Type/Sub Type.
3. Recidivism Type: New Charges = Prison Status Charge Offense Date > Release Date; Technical Violations = Prison Status Charge Offense Date < Release Date. If ties (multiple charges) ranked by Most Serious (1) Offense Class, (2) Offense Type and (3) Minimum Crime Cd Id.
4. Need Identified by: LSI-R, Iowa Risk, Custody Classification, and Jesness Assessments.
5. LSI-R Score was from assessments conducted between the offender's first supervision date and 90 days following release. Data Captured: Score, Submitted Date, Category (Low 0-13; Low/Moderate 14-23; Moderate 24-33; Moderate/High 34-40; High 41+)
6. Community SA Intervention Data is not available for offenders released due to end of sentence. The intervention captured is the first intervention after release. Data Captured: Intervention, Start/End Date, and Intervention Category.
7. Institution Licensed Substance Abuse Interventions Data Captured: Region Name, Intervention, Start/End Date, Closure Reason, and Closure Category (Successful, Unsuccessful, Administrative, Intermediate Sanction).

Appendix B: Non-Recidivism and Recidivism Rates by Comparison Group and Institution.

	Comparison Group		Did Not Recidivate	Recidivism Rates: New Convictions	Recidivism Rates: Technical Violations	Recidivism Rates: Total
Anamosa State Penitentiary	No SA Need	Count	47	6	5	58
		%	81.0%	10.3%	8.6%	100.0%
	SA Need/No Prison Treatment	Count	114	23	22	159
		%	71.7%	14.5%	13.8%	100.0%
	SA Need/Successful Prison Treatment	Count	93	24	31	148
		%	62.8%	16.2%	20.9%	100.0%
	SA Need/Unsuccessful Prison Treatment	Count	6	2	2	10
		%	60.0%	20.0%	20.0%	100.0%
	SA Need/Prison Treatment - Other	Count	8	2	1	11
		%	72.7%	18.2%	9.1%	100.0%
	Total	Count	268	57	61	386
		%	69.4%	14.8%	15.8%	100.0%
Clarinda Correctional Facility	No SA Need	Count	52	8	8	68
		%	76.5%	11.8%	11.8%	100.0%
	SA Need/No Prison Treatment	Count	156	29	23	208
		%	75.0%	13.9%	11.1%	100.0%
	SA Need/Successful Prison Treatment	Count	257	49	58	364
		%	70.6%	13.5%	15.9%	100.0%
	SA Need/Unsuccessful Prison Treatment	Count	38	12	14	64
		%	59.4%	18.8%	21.9%	100.0%
	SA Need/Prison Treatment - Other	Count	17	1	2	20
		%	85.0%	5.0%	10.0%	100.0%
	Total	Count	520	99	105	724
		%	71.8%	13.7%	14.5%	100.0%
Fort Dodge Correctional Facility	No SA Need	Count	58	16	15	89
		%	65.2%	18.0%	16.9%	100.0%
	SA Need/No Prison Treatment	Count	262	62	43	367
		%	71.4%	16.9%	11.7%	100.0%
	SA Need/Successful Prison Treatment	Count	146	36	56	238
		%	61.3%	15.1%	23.5%	100.0%
	SA Need/Unsuccessful Prison Treatment	Count	12	3	2	17
		%	70.6%	17.6%	11.8%	100.0%
	SA Need/Prison Treatment - Other	Count	3	1	2	6
		%	50.0%	16.7%	33.3%	100.0%
	Total	Count	481	118	118	717
		%	67.1%	16.5%	16.5%	100.0%

	Comparison Group		Did Not Recidivate	Recidivism Rates: New Convictions	Recidivism Rates: Technical Violations	Recidivism Rates: Total
Iowa Correctional Institution for Women	No SA Need	Count	98	10	9	117
		%	83.8%	8.5%	7.7%	100.0%
	SA Need/No Prison Treatment	Count	219	28	33	280
		%	78.2%	10.0%	11.8%	100.0%
	SA Need/Successful Prison Treatment	Count	151	21	16	188
		%	80.3%	11.2%	8.5%	100.0%
	SA Need/Unsuccessful Prison Treatment	Count	22	2	3	27
		%	81.5%	7.4%	11.1%	100.0%
	SA Need/Prison Treatment - Other	Count	10	1	2	13
		%	76.9%	7.7%	15.4%	100.0%
	Total	Count	500	62	63	625
		%	80.0%	9.9%	10.1%	100.0%
Iowa Medical & Classification Center	No SA Need	Count	34	8	2	44
		%	77.3%	18.2%	4.5%	100.0%
	SA Need/No Prison Treatment	Count	70	6	2	78
		%	89.7%	7.7%	2.6%	100.0%
	Total	Count	104	14	4	122
		%	85.2%	11.5%	3.3%	100.0%
Iowa State Penitentiary	No SA Need	Count	86	13	15	114
		%	75.4%	11.4%	13.2%	100.0%
	SA Need/No Prison Treatment	Count	231	32	31	294
		%	78.6%	10.9%	10.5%	100.0%
	SA Need/Successful Prison Treatment	Count	33	2	4	39
		%	84.6%	5.1%	10.3%	100.0%
	SA Need/Unsuccessful Prison Treatment	Count	2	0	0	2
		%	100.0%	.0%	.0%	100.0%
	SA Need/Prison Treatment - Other	Count	7	1	1	9
		%	77.8%	11.1%	11.1%	100.0%
	Total	Count	359	48	51	458
		%	78.4%	10.5%	11.1%	100.0%

	Comparison Group		Did Not Recidivate	Recidivism Rates: New Convictions	Recidivism Rates: Technical Violations	Recidivism Rates: Total
Mount Pleasant Correctional Facility	No SA Need	Count	120	10	13	143
		%	83.9%	7.0%	9.1%	100.0%
	SA Need/No Prison Treatment	Count	199	18	39	256
		%	77.7%	7.0%	15.2%	100.0%
	SA Need/Successful Prison Treatment	Count	225	33	27	285
		%	78.9%	11.6%	9.5%	100.0%
	SA Need/Unsuccessful Prison Treatment	Count	10	3	1	14
		%	71.4%	21.4%	7.1%	100.0%
	SA Need/Prison Treatment - Other	Count	12	2	3	17
		%	70.6%	11.8%	17.6%	100.0%
	Total	Count	566	66	83	715
		%	79.2%	9.2%	11.6%	100.0%
Newton Correctional Facility	No SA Need	Count	96	17	11	124
		%	77.4%	13.7%	8.9%	100.0%
	SA Need/No Prison Treatment	Count	359	70	78	507
		%	70.8%	13.8%	15.4%	100.0%
	SA Need/Successful Prison Treatment	Count	169	12	22	203
		%	83.3%	5.9%	10.8%	100.0%
	SA Need/Unsuccessful Prison Treatment	Count	5	0	2	7
		%	71.4%	.0%	28.6%	100.0%
	SA Need/Prison Treatment - Other	Count	6	1	0	7
		%	85.7%	14.3%	.0%	100.0%
	Total	Count	635	100	113	848
		%	74.9%	11.8%	13.3%	100.0%
North Central Correctional Facility	No SA Need	Count	68	6	12	86
		%	79.1%	7.0%	14.0%	100.0%
	SA Need/No Prison Treatment	Count	283	46	50	379
		%	74.7%	12.1%	13.2%	100.0%
	SA Need/Successful Prison Treatment	Count	21	3	2	26
		%	80.8%	11.5%	7.7%	100.0%
	Total	Count	372	55	64	491
		%	75.8%	11.2%	13.0%	100.0%

Appendix C: Non-Recidivism and Recidivism Rates by Comparison Group and Location.

Comparison Groups					Did Not Recidivate	Recidivism Rates: New Convictions	Recidivism Rates: Technical Violations	Recidivism Rates: Total
Anamosa State Penitentiary	ASP	Location-wide	No SA Need	Count	45	6	5	56
				%	80.4%	10.7%	8.9%	100.0%
			SA Need/No Prison Treatment	Count	93	18	20	131
				%	71.0%	13.7%	15.3%	100.0%
		ALTA	SA Need/Successful Prison Treatment	Count	51	15	14	80
				%	63.8%	18.8%	17.5%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	1	0	0	1
				%	100.0%	.0%	.0%	100.0%
			SA Need/Prison Treatment – Other	Count	2	0	0	2
				%	100.0%	.0%	.0%	100.0%
		TC	SA Need/Successful Prison Treatment	Count	35	8	17	60
				%	58.3%	13.3%	28.3%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	5	2	2	9
				%	55.6%	22.2%	22.2%	100.0%
			SA Need/Prison Treatment – Other	Count	3	2	1	6
				%	50.0%	33.3%	16.7%	100.0%
	LUH	Location-wide	No SA Need	Count	2	0	0	2
				%	100.0%	.0%	.0%	100.0%
			SA Need/No Prison Treatment	Count	21	5	2	28
				%	75.0%	17.9%	7.1%	100.0%
		Luster Heights SAP	SA Need/Successful Prison Treatment	Count	7	1		8
				%	87.5%	12.5%		100.0%
			SA Need/Prison Treatment – Other	Count	3	0		3
				%	100.0%	.0%		100.0%

[19] For those successfully completing treatment, the location was based on the location of the treatment, except for TOW at CCF. Location for TOW was determined by release location within CCF. Location for comparison groups were based on location of release.

Comparison Groups					Did Not Recidivate	Recidivism Rates		
						New Convictions	Technical Violations	Total
Clarinda Correctional Facility	CCF	Location-wide	No SA Need	Count	39	5	7	51
				%	76.5%	9.8%	13.7%	100.0%
			SA Need/No Prison Treatment	Count	118	24	16	158
				%	74.7%	15.2%	10.1%	100.0%
		TOW	SA Need/Successful Prison Treatment	Count	186	40	47	273
				%	68.1%	14.7%	17.2%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	29	12	10	51
				%	56.9%	23.5%	19.6%	100.0%
			SA Need/Prison Treatment – Other	Count	15	1	2	18
				%	83.3%	5.6%	11.1%	100.0%
	CCFL	Location-wide	No SA Need	Count	13	3	1	17
				%	76.5%	17.6%	5.9%	100.0%
			SA Need/No Prison Treatment	Count	38	5	7	50
				%	76.0%	10.0%	14.0%	100.0%
		TOW	SA Need/Successful Prison Treatment	Count	71	9	11	91
				%	78.0%	9.9%	12.1%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	9	0	4	13
				%	69.2%	.0%	30.8%	100.0%
			SA Need/Prison Treatment – Other	Count	2	0	0	2
				%	100.0%	.0%	.0%	100.0%
Fort Dodge Correctional Facility	FDCF	Location-wide	No SA Need	Count	58	16	15	89
				%	65.2%	18.0%	16.9%	100.0%
			SA Need/No Prison Treatment	Count	262	62	43	367
				%	71.4%	16.9%	11.7%	100.0%
		New Frontiers	SA Need/Successful Prison Treatment	Count	146	36	56	238
				%	61.3%	15.1%	23.5%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	12	3	2	17
				%	70.6%	17.6%	11.8%	100.0%
			SA Need/Prison Treatment – Other	Count	3	1	2	6
				%	50.0%	16.7%	33.3%	100.0%

Comparison Groups					Did Not Recidivate	Recidivism Rates		
						New Convictions	Technical Violations	Total
Iowa Correctional Institution for Women	ICIW	Location-wide	No SA Need	Count	98	10	9	117
				%	83.8%	8.5%	7.7%	100.0%
			SA Need/No Prison Treatment	Count	219	28	33	280
				%	78.2%	10.0%	11.8%	100.0%
		STAR	SA Need/Successful Prison Treatment	Count	52	3	1	56
				%	92.9%	5.4%	1.8%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	5	1	0	6
				%	83.3%	16.7%	.0%	100.0%
			SA Need/Prison Treatment - Other	Count	3	1	1	5
				%	60.0%	20.0%	20.0%	100.0%
		Violator's Program-Regular @ ICIW	SA Need/Successful Prison Treatment	Count	12	4	3	19
				%	63.2%	21.1%	15.8%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	6	0	0	6
				%	100.0%	.0%	.0%	100.0%
			SA Need/Prison Treatment - Other	Count	0	0	1	1
				%	.0%	.0%	100.0%	100.0%
		WINGS	SA Need/Successful Prison Treatment	Count	87	14	12	113
				%	77.0%	12.4%	10.6%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	11	1	3	15
				%	73.3%	6.7%	20.0%	100.0%
			SA Need/Prison Treatment - Other	Count	7	0	0	7
				%	100.0%	.0%	.0%	100.0%

Comparison Groups					Did Not Recidivate	Recidivism Rates		
						New Convictions	Technical Violations	Total
Iowa State Penitentiary	FM1	Location-wide	No SA Need	Count	24	3	5	32
				%	75.0%	9.4%	15.6%	100.0%
			SA Need/No Prison Treatment	Count	55	6	6	67
				%	82.1%	9.0%	9.0%	100.0%
		Project TEA - Class	SA Need/Successful Prison Treatment	Count	1			1
				%	100.0%			100.0%
			SA Need/Prison Treatment - Other	Count	1			1
				%	100.0%			100.0%
	FM3	Location-wide	No SA Need	Count	11	0	1	12
				%	91.7%	.0%	8.3%	100.0%
			SA Need/No Prison Treatment	Count	62	4	8	74
				%	83.8%	5.4%	10.8%	100.0%
		Project TEA	SA Need/Successful Prison Treatment	Count	13	1		14
				%	92.9%	7.1%		100.0%
			SA Need/Prison Treatment - Other	Count	3	1		4
				%	75.0%	25.0%		100.0%
	JBU	Location-wide	No SA Need	Count	27	0	7	34
				%	79.4%	.0%	20.6%	100.0%
			SA Need/No Prison Treatment	Count	64	14	10	88
				%	72.7%	15.9%	11.4%	100.0%
		Project TEA	SA Need/Successful Prison Treatment	Count	19	1	4	24
				%	79.2%	4.2%	16.7%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	2	0	0	2
				%	100.0%	.0%	.0%	100.0%
			SA Need/Prison Treatment - Other	Count	3	0	1	4
				%	75.0%	.0%	25.0%	100.0%
Mount Pleasant Correctional Facility	MPCF	Location-wide	No SA Need	Count	108	8	12	128
				%	84.4%	6.3%	9.4%	100.0%
			SA Need/No Prison Treatment	Count	158	18	34	210
				%	75.2%	8.6%	16.2%	100.0%
		SAP @ MPCF	SA Need/Successful Prison Treatment	Count	225	33	27	285
				%	78.9%	11.6%	9.5%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	10	3	1	14
				%	71.4%	21.4%	7.1%	100.0%
			SA Need/Prison Treatment - Other	Count	12	2	3	17
				%	70.6%	11.8%	17.6%	100.0%

Comparison Groups					Did Not Recidivate	Recidivism Rates: New Convictions	Recidivism Rates: Technical Violations	Recidivism Rates: Total
Newton Correctional Facility	CRC	Location-wide	No SA Need	Count	34	8	3	45
				%	75.6%	17.8%	6.7%	100.0%
			SA Need/No Prison Treatment	Count	160	17	26	203
				%	78.8%	8.4%	12.8%	100.0%
		SAT/Criminality	SA Need/Successful Prison Treatment	Count	72	6	5	83
				%	86.7%	7.2%	6.0%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	1	0	1	2
				%	50.0%	.0%	50.0%	100.0%
			SA Need/Prison Treatment - Other	Count	2	1	0	3
				%	66.7%	33.3%	.0%	100.0%
		Violator's Program - Regular @ CRC	SA Need/Successful Prison Treatment	Count	11	1	3	15
				%	73.3%	6.7%	20.0%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	2	0	1	3
				%	66.7%	.0%	33.3%	100.0%
			SA Need/Prison Treatment - Other	Count	2	0	0	2
				%	100.0%	.0%	.0%	100.0%
	NCF	Location-wide	No SA Need	Count	62	9	8	79
				%	78.5%	11.4%	10.1%	100.0%
			SA Need/No Prison Treatment	Count	199	53	52	304
				%	65.5%	17.4%	17.1%	100.0%
		IFI	SA Need/Successful Prison Treatment	Count	63	4	9	76
				%	82.9%	5.3%	11.8%	100.0%
			SA Need/Prison Treatment- Other	Count	1	0	0	1
				%	100.0%	.0%	.0%	100.0%
		PCD	SA Need/Successful Prison Treatment	Count	23	1	5	29
				%	79.3%	3.4%	17.2%	100.0%
			SA Need/Unsuccessful Prison Treatment	Count	2	0	0	2
				%	100.0%	.0%	.0%	100.0%
			SA Need/Prison Treatment - Other	Count	1	0	0	1
				%	100.0%	.0%	.0%	100.0%
North Central Correctional Facility	NCCF	Location-wide	No SA Need	Count	68	6	12	86
				%	79.1%	7.0%	14.0%	100.0%
			SA Need/No Prison Treatment	Count	283	46	50	379
				%	74.7%	12.1%	13.2%	100.0%
		Journey	SA Need/Successful Prison Treatment	Count	21	3	2	26
				%	80.8%	11.5%	7.7%	100.0%

Appendix D: Summary Comparisons by Program – Substance Abuse Treatment Program Compared to SA Need/No Prison Treatment Group from Same Location.

Program	Total Recidivism Difference	New Conviction Recidivism Difference	Difference in % Pop with Mental Health Diagnosis	Difference in % Pop within High LSI-R Risk Category	Difference in % Pop within Low LSI-R Risk Category	Difference in % Pop with African American Race/Ethnicity	Difference in % Pop Over 40 Years Old
ALTA	7.2%	5.0%	-11.4%	0.0%	0.0%	2.1%	-8.7%
IFI	-17.4%	-12.2%	-19.7%	-5.8%	16.2%	-18.4%	1.4%
Journey	-6.1%	-0.6%	-6.1%	-1.4%	-1.1%	5.2%	-8.0%
Luster Heights SAP	-12.5%	-5.4%	-17.9%	-4.3%	0.0%	-3.6%	16.1%
New Frontiers	10.0%	-1.8%	1.3%	-4.7%	0.4%	-2.0%	-0.7%
PCD	-13.8%	-14.0%	-19.3%	-5.8%	4.7%	9.5%	-4.8%
Project TEA @ FM3	-9.1%	1.7%	15.9%	-3.0%	-1.5%	-5.1%	-11.2%
Project TEA @ JBU	-6.4%	-11.7%	-3.5%	-7.5%	8.3%	-4.2%	6.5%
SAP @ MPCF	-3.7%	3.0%	2.5%	2.7%	-1.7%	4.3%	-4.9%
SAT/Criminality	-7.9%	-1.1%	-4.5%	-4.8%	-1.2%	-1.0%	-6.8%
STAR	-14.6%	-4.6%	-20.7%	-13.5%	6.7%	-7.9%	11.4%
TC	12.7%	-0.4%	-5.6%	1.9%	0.0%	-2.9%	-0.8%
TOW @ CCF	6.6%	-0.5%	-12.3%	-7.3%	-0.3%	-7.5%	-1.2%
TOW @ CCFL	-2.0%	-0.1%	0.5%	-4.6%	0.0%	-14.4%	10.7%
Violator's Program - Regular @ CRC	5.5%	-1.7%	2.3%	2.9%	-5.3%	8.2%	-42.9%
Violator's Program- Regular @ ICIW	15.1%	11.1%	11.9%	3.2%	-0.4%	-8.1%	-17.4%
WINGS	1.2%	2.4%	7.2%	-3.3%	1.5%	2.6%	0.4%

Difference = SA Need/Successful Prison Treatment - SA Need/No Prison Treatment

Appendix E: Mental Health Data.

Recidivism Rates by Comparison Group and Mental Health Diagnosis

Mental Health Diagnosis	Comparison Group		Did Not Recidivate	Recidivism Rates		
				New Convictions	Technical Violations	Total
No	SA Need/No Prison Treatment	Count	1165	164	169	333
		%	77.8%	10.9%	11.3%	22.2%
	SA Need/Successful Prison Treatment	Count	710	99	119	218
		%	76.5%	10.7%	12.8%	23.5%
Yes	SA Need/No Prison Treatment	Count	694	145	147	292
		%	70.4%	14.7%	14.9%	29.6%
	SA Need/Successful Prison Treatment	Count	372	80	94	174
		%	68.1%	14.7%	17.2%	31.9%

Institution Recidivism Rates by Comparison Group and Mental Health Diagnosis

Institution	Mental Health Diagnosis	Comparison Group		Did Not Recidivate	Recidivism Rates		
					New Convictions	Technical Violations	Total
Anamosa State Penitentiary	No	SA Need/No Prison Treatment	Count	77	13	11	24
			%	76.2%	12.9%	10.9%	23.8%
		SA Need/Successful Prison Treatment	Count	67	17	20	37
			%	64.4%	16.3%	19.2%	35.5%
	Yes	SA Need/No Prison Treatment	Count	35	10	11	21
			%	62.5%	17.9%	19.6%	37.5%
		SA Need/Successful Prison Treatment	Count	25	6	11	17
			%	59.5%	14.3%	26.2%	40.5%
Clarinda Correctional Facility	No	SA Need/No Prison Treatment	Count	87	12	9	21
			%	80.6%	11.1%	8.3%	19.4%
		SA Need/Successful Prison Treatment	Count	164	26	30	56
			%	74.5%	11.8%	13.6%	25.4%
	Yes	SA Need/No Prison Treatment	Count	67	17	14	31
			%	68.4%	17.3%	14.3%	31.6%
		SA Need/Successful Prison Treatment	Count	87	23	28	51
			%	63.0%	16.7%	20.3%	37.0%

Institution	Mental Health Diagnosis	Comparison Group		Did Not Recidivate	Recidivism Rates: New Convictions	Technical Violations	Total
Fort Dodge Correctional Facility	No	SA Need/No Prison Treatment	Count	178	33	27	60
			%	74.8%	13.9%	11.3%	25.2%
		SA Need/Successful Prison Treatment	Count	104	22	29	51
			%	67.1%	14.2%	18.7%	32.9%
	Yes	SA Need/No Prison Treatment	Count	77	27	16	43
			%	64.2%	22.5%	13.3%	35.8%
		SA Need/Successful Prison Treatment	Count	41	14	26	40
			%	50.6%	17.3%	32.1%	49.4%
Iowa Correctional Institution for Women	No	SA Need/No Prison Treatment	Count	85	8	10	18
			%	82.5%	7.8%	9.7%	17.5%
		SA Need/Successful Prison Treatment	Count	62	3	6	9
			%	87.3%	4.2%	8.5%	12.7%
	Yes	SA Need/No Prison Treatment	Count	131	20	22	42
			%	75.7%	11.6%	12.7%	24.3%
		SA Need/Successful Prison Treatment	Count	87	18	10	28
			%	75.7%	15.7%	8.7%	24.4%
Iowa State Penitentiary	No	SA Need/No Prison Treatment	Count	143	19	15	34
			%	80.8%	10.7%	8.5%	19.2%
		SA Need/Successful Prison Treatment	Count	21	1	1	2
			%	91.3%	4.3%	4.3%	8.6%
	Yes	SA Need/No Prison Treatment	Count	83	13	16	29
			%	74.1%	11.6%	14.3%	25.9%
		SA Need/Successful Prison Treatment	Count	11	1	3	4
			%	73.3%	6.7%	20.0%	26.7%
Mount Pleasant Correctional Facility	No	SA Need/No Prison Treatment	Count	116	9	20	29
			%	80.0%	6.2%	13.8%	20.0%
		SA Need/Successful Prison Treatment	Count	150	18	17	35
			%	81.1%	9.7%	9.2%	18.9%
	Yes	SA Need/No Prison Treatment	Count	83	9	19	28
			%	74.8%	8.1%	17.1%	25.2%
		SA Need/Successful Prison Treatment	Count	73	15	10	25
			%	74.5%	15.3%	10.2%	25.5%

Institution	Mental Health Diagnosis	Comparison Group		Did Not Recidivate	Recidivism Rates		
					New Convictions	Technical Violations	Total
Newton Correctional Facility	No	SA Need/No Prison Treatment	Count	220	38	44	82
			%	72.8%	12.6%	14.6%	27.2%
		SA Need/Successful Prison Treatment	Count	123	10	16	26
			%	82.6%	6.7%	10.7%	17.4%
	Yes	SA Need/No Prison Treatment	Count	133	31	31	62
			%	68.2%	15.9%	15.9%	31.8%
		SA Need/Successful Prison Treatment	Count	46	2	4	6
			%	88.5%	3.8%	7.7%	11.5%
North Central Correctional Facility	No	SA Need/No Prison Treatment	Count	214	29	31	60
			%	78.1%	10.6%	11.3%	21.9%
		SA Need/Successful Prison Treatment	Count	19	2	0	2
			%	90.5%	9.5%	.0%	9.5%
	Yes	SA Need/No Prison Treatment	Count	63	15	18	33
			%	65.6%	15.6%	18.8%	34.4%
		SA Need/Successful Prison Treatment	Count	2	1	2	3
			%	40.0%	20.0%	40.0%	60.0%

% of Offender Population with Mental Health Diagnosis by Program and Institution

Institution	Location	Comparison Group		Mental Health Diagnosis: No	Mental Health Diagnosis: Yes	Mental Health Diagnosis: Substance Abuse Disorder Only	Total
Anamosa State Penitentiary	ASP	SA Need/No Treatment	Count	78	51	2	131
			%	59.5%	38.9%	1.5%	100.0%
		ALTA	Count	56	22	2	80
			%	70.0%	27.5%	2.5%	100.0%
		TC	Count	40	20		60
			%	66.7%	33.3%		100.0%
	LUH	SA Need/No Treatment	Count	23	5		28
			%	82.1%	17.9%		100.0%
		Luster Heights SAP	Count	8			8
			%	100.0%			100.0%
Clarinda Correctional Facility	CCF	SA Need/No Treatment	Count	78	79	1	158
			%	49.4%	50.0%	.6%	100.0%
		TOW	Count	165	103	5	273
			%	60.4%	37.7%	1.8%	100.0%
	CCFL	SA Need/No Treatment	Count	30	19	1	50
			%	60.0%	38.0%	2.0%	100.0%
		TOW	Count	55	35	1	91
			%	60.4%	38.5%	1.1%	100.0%
Fort Dodge Correctional Facility	FDCF	SA Need/No Treatment	Count	238	120	9	367
			%	64.9%	32.7%	2.5%	100.0%
		New Frontiers	Count	155	81	2	238
			%	65.1%	34.0%	.8%	100.0%
Iowa Correctional Institution for Women	ICIW	SA Need/No Treatment	Count	103	173	4	280
			%	36.8%	61.8%	1.4%	100.0%
		STAR	Count	32	23	1	56
			%	57.1%	41.1%	1.8%	100.0%
		Violator's Program-Regular @ ICIW	Count	5	14		19
			%	26.3%	73.7%		100.0%
		WINGS	Count	34	78	1	113
			%	30.1%	69.0%	.9%	100.0%

Institution	Location	Comparison Group		Mental Health Diagnosis: No	Mental Health Diagnosis: Yes	Mental Health Diagnosis: Substance Abuse Disorder Only	Total
Iowa State Penitentiary	FM1	SA Need/No Treatment	Count	51	16		67
			%	76.1%	23.9%		100.0%
		Project TEA - Class	Count	1			1
			%	100.0%			100.0%
	FM3	SA Need/No Treatment	Count	51	20	3	74
			%	68.9%	27.0%	4.1%	100.0%
		Project TEA	Count	8	6		14
			%	57.1%	42.9%		100.0%
	JBU	SA Need/No Treatment	Count	51	36	1	88
			%	58.0%	40.9%	1.1%	100.0%
		Project TEA	Count	14	9	1	24
			%	58.3%	37.5%	4.2%	100.0%
Mount Pleasant Correctional Facility	MPCF	SA Need/No Treatment	Count	143	67		210
			%	68.1%	31.9%		100.0%
		SAP @ MPCF	Count	185	98	2	285
			%	64.9%	34.4%	.7%	100.0%
Newton Correctional Facility	CRC	SA Need/No Treatment	Count	134	63	6	203
			%	66.0%	31.0%	3.0%	100.0%
		SAT/Criminality	Count	61	22		83
			%	73.5%	26.5%		100.0%
		Violator's Program - Regular @ CRC	Count	10	5		15
			%	66.7%	33.3%		100.0%
	NCF	SA Need/No Treatment	Count	168	132	4	304
			%	55.3%	43.4%	1.3%	100.0%
		IFI	Count	58	18		76
			%	76.3%	23.7%		100.0%
		PCD	Count	20	7	2	29
			%	69.0%	24.1%	6.9%	100.0%
North Central Correctional Facility	NCCF	SA Need/No Treatment	Count	274	96	9	379
			%	72.3%	25.3%	2.4%	100.0%
		Journey	Count	21	5		26
			%	80.8%	19.2%		100.0%

Appendix F: LSI-R Category Data

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
LSI-R Score Category * Offender Recidivism * Group	3649	90.8%	370	9.2%	4019	100.0%

Recidivism Rates by Comparison Group and LSI-R Category

Group	LSI-R Category		Did Not Recidivate	Recidivism Rates: New Conviction	Technical Violation	Total
SA Need/No Prison Treatment	Low	Count	24	1	3	4
		%	85.7%	3.6%	10.7%	14.3%
	Low/Moderate	Count	310	29	29	58
		%	84.2%	7.9%	7.9%	15.8%
	Moderate	Count	755	106	133	239
		%	76.0%	10.7%	13.4%	24.0%
	Moderate/High	Count	433	106	102	208
		%	67.6%	16.5%	15.9%	32.4%
	High	Count	137	44	30	74
		%	64.9%	20.9%	14.2%	35.1%
SA Need/Successful Prison Treatment	Low	Count	30	1	1	2
		%	93.8%	3.1%	3.1%	6.2%
	Low/Moderate	Count	245	18	26	44
		%	84.8%	6.2%	9.0%	15.2%
	Moderate	Count	468	71	98	169
		%	73.5%	11.1%	15.4%	26.5%
	Moderate/High	Count	226	55	65	120
		%	65.3%	15.9%	18.8%	34.7%
	High	Count	62	21	20	41
		%	60.2%	20.4%	19.4%	39.8%

Chi-Square Tests

Group		Value	df	Asymp. Sig. (2-sided)
SA Need/No Prison Treatment	Pearson Chi-Square	54.080(a)	8	.000
	Likelihood Ratio	54.866	8	.000
	Linear-by-Linear Association	30.760	1	.000
	N of Valid Cases	2242		
SA Need/Successful Prison Treatment	Pearson Chi-Square	48.410(b)	8	.000
	Likelihood Ratio	51.273	8	.000
	Linear-by-Linear Association	35.300	1	.000
	N of Valid Cases	1407		

a 2 cells (13.3%) have expected count less than 5. The minimum expected count is 3.57.
b 2 cells (13.3%) have expected count less than 5. The minimum expected count is 3.78.

% of Offender Population with Substance Abuse Need within Each Risk Category by Program and Institution[20]

Institution	Location	Comparison Group		LSI-R Score Category					Total
				Low	Low/ Moderate	Moderate	Moderate /High	High	
Anamosa State Penitentiary	ASP	SA Need/No Treatment	Count		11	47	36	7	101
			%		10.9%	46.5%	35.6%	6.9%	100.0%
		ALTA	Count		6	41	20	5	72
			%		8.3%	56.9%	27.8%	6.9%	100.0%
		TC	Count		13	29	10	5	57
			%		22.8%	50.9%	17.5%	8.8%	100.0%
	LUH	SA Need/No Treatment	Count		4	10	8	1	23
			%		17.4%	43.5%	34.8%	4.3%	100.0%
		Luster Heights SAP	Count			7	1		8
			%			87.5%	12.5%		100.0%

[20] The approximation to the chi-square distribution breaks down if expected frequencies are too low. It will normally be acceptable so long as no more than 10% of the events have expected frequencies below 5. Unfortunately, that is not the case here. Because of the missing values, the distributions presented in the table can not be related to the entire population.

Institution	Location	Comparison Group		LSI-R Score Category					Total
				Low	Low/ Moderate	Moderate	Moderate /High	High	
Clarinda Correctional Facility	CCF	SA Need/No Treatment	Count	1	20	43	50	27	141
			%	.7%	14.2%	30.5%	35.5%	19.1%	100.0%
		TOW	Count	1	33	115	75	30	254
			%	.4%	13.0%	45.3%	29.5%	11.8%	100.0%
	CCFL	SA Need/No Treatment	Count		7	25	9	7	48
			%		14.6%	52.1%	18.8%	14.6%	100.0%
		TOW	Count		14	45	22	9	90
			%		15.6%	50.0%	24.4%	10.0%	100.0%
Fort Dodge Correctional Facility	FDCF	SA Need/No Treatment	Count		36	144	106	40	326
			%		11.0%	44.2%	32.5%	12.3%	100.0%
		New Frontiers	Count	1	29	115	63	17	225
			%	.4%	12.9%	51.1%	28.0%	7.6%	100.0%
Iowa Correctional Institution for Women	ICIW	SA Need/No Treatment	Count	1	40	115	62	34	252
			%	.4%	15.9%	45.6%	24.6%	13.5%	100.0%
		STAR	Count	4	32	17	3		56
			%	7.1%	57.1%	30.4%	5.4%		100.0%
		Violator's Program-Regular @ ICIW	Count		4	4	7	3	18
			%		22.2%	22.2%	38.9%	16.7%	100.0%
		WINGS	Count	2	21	48	26	11	108
			%	1.9%	19.4%	44.4%	24.1%	10.2%	100.0%
Iowa State Penitentiary	FM1	SA Need/No Treatment	Count		7	31	24	3	65
			%		10.8%	47.7%	36.9%	4.6%	100.0%
		Project TEA - Class	Count			1			1
			%			100.0%			100.0%
	FM3	SA Need/No Treatment	Count	1	11	40	13	2	67
			%	1.5%	16.4%	59.7%	19.4%	3.0%	100.0%
		Project TEA	Count		3	9	1		13
			%		23.1%	69.2%	7.7%		100.0%
	JBU	SA Need/No Treatment	Count		10	41	17	9	77
			%		13.0%	53.2%	22.1%	11.7%	100.0%
		Project TEA	Count	2	3	14	4	1	24
			%	8.3%	12.5%	58.3%	16.7%	4.2%	100.0%

Institution	Location	Comparison Group		LSI-R Score Category					Total
				Low	Low/ Moderate	Moderate	Moderate /High	High	
Mount Pleasant Correctional Facility	MPCF	SA Need/No Treatment	Count	5	39	85	42	8	179
			%	2.8%	21.8%	47.5%	23.5%	4.5%	100.0%
		SAP @ MPCF	Count	3	47	121	73	19	263
			%	1.1%	17.9%	46.0%	27.8%	7.2%	100.0%
Newton Correctional Facility	CRC	SA Need/No Treatment	Count	10	62	75	32	9	188
			%	5.3%	33.0%	39.9%	17.0%	4.8%	100.0%
		SAT/Criminality	Count	3	30	26	15		74
			%	4.1%	40.5%	35.1%	20.3%		100.0%
		Violator's Program - Regular @ CRC	Count			6	6	1	13
			%			46.2%	46.2%	7.7%	100.0%
	NCF	SA Need/No Treatment	Count	6	48	114	91	16	275
			%	2.2%	17.5%	41.5%	33.1%	5.8%	100.0%
		IFI	Count	14	43	15	4		76
			%	18.4%	56.6%	19.7%	5.3%		100.0%
		PCD	Count	2	4	14	9		29
			%	6.9%	13.8%	48.3%	31.0%		100.0%
North Central Correctional Facility	NCCF	SA Need/No Treatment	Count	4	56	159	100	32	351
			%	1.1%	16.0%	45.3%	28.5%	9.1%	100.0%
		Journey	Count		7	10	7	2	26
			%		26.9%	38.5%	26.9%	7.7%	100.0%

Appendix G: Community Supervision Data.

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
CBCIntCategory * Offender Recidivism	1335	89.5%	156	10.5%	1491	100.0%

Recidivism Rates for Offenders Successfully Completing Substance Abuse Treatment By Intervention in the Community

CBC Intervention Type		Did Not Recidivate	Recidivism Rates		
			New Conviction	Technical Violation	Total
None	Count	757	122	160	282
	%	72.9%	11.7%	15.4%	27.1%
Case Management	Count	8	1	3	4
	%	66.7%	8.3%	25.0%	33.3%
Continuing Care	Count	86	12	34	46
	%	65.2%	9.1%	25.8%	34.9%
Education	Count	36	5	4	9
	%	80.0%	11.1%	8.9%	20.0%
Inpatient/Residential Treatment	Count	24	4	6	10
	%	70.6%	11.8%	17.6%	29.4%
Outpatient Treatment	Count	61	3	9	12
	%	83.6%	4.1%	12.3%	16.4%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.472(a)	10	.065
Likelihood Ratio	17.602	10	.062
Linear-by-Linear Association	.275	1	.600
N of Valid Cases	1335		

a 4 cells (22.2%) have expected count less than 5. The minimum expected count is 1.32.

Recidivism Rates by Comparison Group and Supervision after Release

Supervision After Release	Group		Did Not Recidivate	Recidivism Rates		
				New Conviction	Technical Violation	Total
No	SA Need/No Prison Treatment	Count	543	116	3	119
		%	82.0%	17.5%	.5%	18.0%
	SA Need/Successful Prison Treatment	Count	124	33	0	33
		%	79.0%	21.0%	.0%	21.0%
Yes	SA Need/No Prison Treatment	Count	1350	198	318	516
		%	72.3%	10.6%	17.0%	27.6%
	SA Need/Successful Prison Treatment	Count	971	147	216	363
		%	72.8%	11.0%	16.2%	27.2%

Appendix H: Age Category Data.

Recidivism Rates by Age Category and Comparison Group

Comparison Group	Age Category		Did Not Recidivate	Recidivism Rates		
				New Conviction	Technical Violation	Total
SA Need/Successful Prison Treatment	Under 20	Count	4	3	0	3
		%	57.1%	42.9%	.0%	49.2%
	20 – 29	Count	446	93	115	208
		%	68.2%	14.2%	17.6%	31.8%
	30 – 39	Count	312	52	63	115
		%	73.1%	12.2%	14.8%	26.9%
	40 – 49	Count	270	31	36	67
		%	80.1%	9.2%	10.7%	19.9%
	50 & Over	Count	62	1	2	3
		%	95.4%	1.5%	3.1%	4.6%
SA Need/No Prison Treatment	Under 20	Count	33	7	5	12
		%	73.3%	15.6%	11.1%	26.7%
	20 – 29	Count	677	142	138	280
		%	70.7%	14.8%	14.4%	29.3%
	30 – 39	Count	574	100	92	192
		%	74.9%	13.1%	12.0%	25.1%
	40 – 49	Count	490	60	68	128
		%	79.3%	9.7%	11.0%	20.7%
	50 & Over	Count	119	5	18	23
		%	83.8%	3.5%	12.7%	16.2%

Age Groups by Location and Comparison Group

Institution	Location	Comparison Group		Age at Release		Total
				Under 40	40 and Older	
Anamosa State Penitentiary	ASP	SA Need/No Treatment	Count	95	36	131
			%	72.5%	27.5%	100.0%
		ALTA	Count	65	15	80
			%	81.3%	18.8%	100.0%
		TC	Count	44	16	60
			%	73.3%	26.7%	100.0%
	LUH	SA Need/No Treatment	Count	22	6	28
			%	78.6%	21.4%	100.0%
		Luster Heights SAP	Count	5	3	8
			%	62.5%	37.5%	100.0%

Institution	Location	Comparison Group		Age at Release: Under 40	Age at Release: 40 and Older	Total
Clarinda Correctional Facility	CCF	SA Need/No Treatment	Count	104	54	158
			%	65.8%	34.2%	100.0%
		TOW	Count	183	90	273
			%	67.0%	33.0%	100.0%
	CCFL	SA Need/No Treatment	Count	35	15	50
			%	70.0%	30.0%	100.0%
		TOW	Count	54	37	91
			%	59.3%	40.7%	100.0%
Fort Dodge Correctional Facility	FDCF	SA Need/No Treatment	Count	352	15	367
			%	95.9%	4.1%	100.0%
		New Frontiers	Count	229	8	237
			%	96.6%	3.4%	100.0%
Iowa Correctional Institution for Women	ICIW	SA Need/No Treatment	Count	187	93	280
			%	66.8%	33.2%	100.0%
		STAR	Count	31	25	56
			%	55.4%	44.6%	100.0%
		Violator's Program-Regular @ ICIW	Count	16	3	19
			%	84.2%	15.8%	100.0%
		WINGS	Count	75	38	113
			%	66.4%	33.6%	100.0%
Iowa State Penitentiary	FM1	SA Need/No Treatment	Count	34	33	67
			%	50.7%	49.3%	100.0%
		Project TEA - Class	Count		1	1
			%		100.0%	100.0%
	FM3	SA Need/No Treatment	Count	34	40	74
			%	45.9%	54.1%	100.0%
		Project TEA	Count	8	6	14
			%	57.1%	42.9%	100.0%
	JBU	SA Need/No Treatment	Count	46	42	88
			%	52.3%	47.7%	100.0%
		Project TEA	Count	11	13	24
			%	45.8%	54.2%	100.0%
Mount Pleasant Correctional Facility	MPCF	SA Need/No Treatment	Count	140	70	210
			%	66.7%	33.3%	100.0%
		SAP @ MPCF	Count	204	81	285
			%	71.6%	28.4%	100.0%

Institution	Location	Comparison Group		Age at Release: Under 40	Age at Release: 40 and Older	Total
Newton Correctional Facility	CRC	SA Need/No Treatment	Count	116	87	203
			%	57.1%	42.9%	100.0%
		SAT/Criminality	Count	53	30	83
			%	63.9%	36.1%	100.0%
		Violator's Program - Regular @ CRC	Count	15		15
			%	100.0%		100.0%
	NCF	SA Need/No Treatment	Count	216	88	304
			%	71.1%	28.9%	100.0%
		IFI	Count	53	23	76
			%	69.7%	30.3%	100.0%
		PCD	Count	22	7	29
			%	75.9%	24.1%	100.0%
North Central Correctional Facility	NCCF	SA Need/No Treatment	Count	261	118	379
			%	68.9%	31.1%	100.0%
		Journey	Count	20	6	26
			%	76.9%	23.1%	100.0%

Appendix I: Race/Ethnicity Data.

Recidivism Rates by Race/Ethnicity and Comparison Group

Group	Race/Ethnicity		Did Not Recidivate	Recidivism Rates		
				New Conviction	Technical Violation	Total
SA Need/No Prison Treatment	African American	Count	350	85	98	533
		%	65.7%	15.9%	18.4%	100.0%
	Other Minority	Count	88	19	17	124
		%	71.0%	15.3%	13.7%	100.0%
	Caucasian	Count	1455	210	206	1871
		%	77.8%	11.2%	11.0%	100.0%
SA Need/Successful Prison Treatment	African American	Count	190	49	67	306
		%	62.1%	16.0%	21.9%	100.0%
	Other Minority	Count	60	7	13	80
		%	75.0%	8.8%	16.3%	100.0%
	Caucasian	Count	845	124	136	1105
		%	76.5%	11.2%	12.3%	100.0%

Race/Ethnicity by Institution and Comparison Group

Institution	Location	Comparison Group		African American	Other Minority	Caucasian
Anamosa State Penitentiary	ASP	SA Need/No Prison Treatment	Count	30	5	96
			%	22.9%	3.8%	73.3%
		ALTA	Count	20	2	58
			%	25.0%	2.5%	72.5%
		TC	Count	12	1	47
			%	20.0%	1.7%	78.3%
	LUH	SA Need/No Prison Treatment	Count	1	1	26
			%	3.6%	3.6%	92.9%
		Luster Heights SAP	Count			8
			%			100.0%

Institution	Location	Comparison Group		African American	Other Minority	Caucasian
Clarinda Correctional Facility	CCF	SA Need/No Prison Treatment	Count	39	7	112
			%	24.7%	4.4%	70.9%
		TOW	Count	47	24	202
			%	17.2%	8.8%	74.0%
	CCFL	SA Need/No Prison Treatment	Count	16	2	32
			%	32.0%	4.0%	64.0%
		TOW	Count	16	5	70
			%	17.6%	5.5%	76.9%
Fort Dodge Correctional Facility	FDCF	SA Need/No Prison Treatment	Count	103	21	243
			%	28.1%	5.7%	66.2%
		New Frontiers	Count	62	16	160
			%	26.1%	6.7%	67.2%
Iowa Correctional Institution for Women	ICIW	SA Need/No Prison Treatment	Count	52	20	208
			%	18.6%	7.1%	74.3%
		STAR	Count	6	2	48
			%	10.7%	3.6%	85.7%
		Violator's Program-Regular @ ICIW	Count	2		17
			%	10.5%		89.5%
		WINGS	Count	24	6	83
			%	21.2%	5.3%	73.5%
Iowa State Penitentiary	FM1	SA Need/No Prison Treatment	Count	13	2	52
			%	19.4%	3.0%	77.6%
		Project TEA - Class	Count			1
			%			100.0%
	FM3	SA Need/No Prison Treatment	Count	9		65
			%	12.2%		87.8%
		Project TEA	Count	1		13
			%	7.1%		92.9%
	JBU	SA Need/No Prison Treatment	Count	33	4	51
			%	37.5%	4.5%	58.0%
		Project TEA	Count	8	3	13
			%	33.3%	12.5%	54.2%
Mount Pleasant Correctional Facility	MPCF	SA Need/No Prison Treatment	Count	47	15	148
			%	22.4%	7.1%	70.5%
		SAP @ MPCF	Count	76	16	193
			%	26.7%	5.6%	67.7%

Institution	Location	Comparison Group		African American	Other Minority	Caucasian
Newton Correctional Facility	CRC	SA Need/No Prison Treatment	Count	24	8	171
			%	11.8%	3.9%	84.2%
		SAT/Criminality	Count	9	1	73
			%	10.8%	1.2%	88.0%
		Violator's Program - Regular @ CRC	Count	3	1	11
			%	20.0%	6.7%	73.3%
	NCF	SA Need/No Prison Treatment	Count	76	12	216
			%	25.0%	3.9%	71.1%
		IFI	Count	5	2	69
			%	6.6%	2.6%	90.8%
		PCD	Count	10	1	18
			%	34.5%	3.4%	62.1%
North Central Correctional Facility	NCCF	SA Need/No Prison Treatment	Count	53	19	307
			%	14.0%	5.0%	81.0%
		Journey	Count	5		21
			%	19.2%		80.8%

Appendix J: Q12 Results.

I know what is expected of me at work.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	3	5.5	8.3	8.3
	Neutral	2	3.6	5.6	13.9
	Agree	20	36.4	55.6	69.4
	Strongly Agree	11	20.0	30.6	100.0
	Total	36	65.5	100.0	
Missing	System	19	34.5		
Total		55	100.0		

I have the materials and equipment I need to do my work right.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	10	18.2	27.8	27.8
	Neutral	10	18.2	27.8	55.6
	Agree	11	20.0	30.6	86.1
	Strongly Agree	5	9.1	13.9	100.0
	Total	36	65.5	100.0	
Missing	System	19	34.5		
Total		55	100.0		

At work, I have the opportunity to do what I do best every day.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	8	14.5	22.2	22.2
	Neutral	7	12.7	19.4	41.7
	Agree	14	25.5	38.9	80.6
	Strongly Agree	7	12.7	19.4	100.0
	Total	36	65.5	100.0	
Missing	System	19	34.5		
Total		55	100.0		

In the last seven days, I have received recognition or praise for doing good work.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	3	5.5	8.3	8.3
	Disagree	11	20.0	30.6	38.9
	Neutral	11	20.0	30.6	69.4
	Agree	7	12.7	19.4	88.9
	Strongly Agree	4	7.3	11.1	100.0
	Total	36	65.5	100.0	
Missing	System	19	34.5		
Total		55	100.0		

My supervisor, or someone at work, seems to care about me as a person.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	2	3.6	5.6	5.6
	Neutral	6	10.9	16.7	22.2
	Agree	19	34.5	52.8	75.0
	Strongly Agree	9	16.4	25.0	100.0
	Total	36	65.5	100.0	
Missing	System	19	34.5		
Total		55	100.0		

There is someone at work who encourages my development.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	1.8	2.8	2.8
	Disagree	3	5.5	8.3	11.1
	Neutral	8	14.5	22.2	33.3
	Agree	18	32.7	50.0	83.3
	Strongly Agree	6	10.9	16.7	100.0
	Total	36	65.5	100.0	
Missing	System	19	34.5		
Total		55	100.0		

The mission or purpose of my company makes me feel my job is important.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	3	5.5	8.3	8.3
	Neutral	7	12.7	19.4	27.8
	Agree	17	30.9	47.2	75.0
	Strongly Agree	9	16.4	25.0	100.0
	Total	36	65.5	100.0	
Missing	System	19	34.5		
Total		55	100.0		

My associates or fellow employees are committed to doing quality work.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	2	3.6	5.6	5.6
	Disagree	1	1.8	2.8	8.3
	Neutral	7	12.7	19.4	27.8
	Agree	18	32.7	50.0	77.8
	Strongly Agree	8	14.5	22.2	100.0
	Total	36	65.5	100.0	
Missing	System	19	34.5		
Total		55	100.0		

At work, my opinions seem to count.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	7	12.7	19.4	19.4
	Neutral	10	18.2	27.8	47.2
	Agree	13	23.6	36.1	83.3
	Strongly Agree	6	10.9	16.7	100.0
	Total	36	65.5	100.0	
Missing	System	19	34.5		
Total		55	100.0		

I have a best friend at work.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	2	3.6	5.6	5.6
	Disagree	5	9.1	13.9	19.4
	Neutral	12	21.8	33.3	52.8
	Agree	12	21.8	33.3	86.1
	Strongly Agree	5	9.1	13.9	100.0
	Total	36	65.5	100.0	
Missing	System	19	34.5		
Total		55	100.0		

In the last six months, someone at work has talked to me about my progress.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	4	7.3	11.1	11.1
	Neutral	11	20.0	30.6	41.7
	Agree	15	27.3	41.7	83.3
	Strongly Agree	6	10.9	16.7	100.0
	Total	36	65.5	100.0	
Missing	System	19	34.5		
Total		55	100.0		

This last year, I have had opportunities at work to learn and grow.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	2	3.6	5.6	5.6
	Neutral	8	14.5	22.2	27.8
	Agree	16	29.1	44.4	72.2
	Strongly Agree	10	18.2	27.8	100.0
	Total	36	65.5	100.0	
Missing	System	19	34.5		
Total		55	100.0		

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