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Enhancing prisoner reentry through access to prison-based and post-incarceration aftercare treatment: experiences from the Illinois Sheridan Correctional Center therapeutic community

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Abstract In an attempt to enhance dramatically the access of Illinois' prison inmates to substance abuse treatment services within prison and following their release, the Sheridan Correctional Center was opened in 2004 by the Illinois Department of Corrections as a fully-dedicated substance abuse treatment prison operating under a therapeutic community design. During the first 5 years of implementation and operation, the program has improved the rate of aftercare admission and completion through enhanced pre-release planning and coordination, the development of community-based partnerships, and a transformation of the parole model and, in doing so, has overcome many of the barriers to effective offender re-entry. The analyses illustrate how aftercare admission and completion has improved during the course of implementation, and what factors appear to predict aftercare entry and completion. The article discusses the implications of how this improved access to aftercare impacts upon post-release outcomes (i.e., recidivism).

Keywords Drug treatment completion · Prison-based drug treatment · Prisoner reentry

1 Introduction

Over the past 20 years, the prison population in the USA more than doubled, increasing from 627,000 in 1988 (Beck and Gilliard 1995) to nearly 1.6 million by

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the end of 2007 (West and Sabol 2008). As a result, there has also been an unprecedented number of inmates *released* from prison annually, with more than 725,000 released during 2007 alone (West and Sabol 2008). However, despite the high need for substance abuse treatment, and increased resources for treatment through the federal Residential Substance Abuse Treatment (RSAT) program, relatively few prison inmates receive drug treatment while incarcerated (Mumola and Karberg 2006), and the proportion of inmates receiving prison-based substance abuse treatment services decreased during the 1990s (Mumola 1999; Mears et al. 2003). Despite the evidence that prison-based treatment, followed by aftercare, can reduce recidivism and save money in the long run [i.e., the California Drug and Alcohol Treatment Assessment (CALDATA) study by Gerstein et al. 1994], the significant political, organizational, and resource barriers to implementing these types of programs have hindered their development and reduced their effectiveness (Mears et al. 2003). As a result of this limited rehabilitative programming, the high rate of recidivism has produced what many have described as the 'revolving door' of corrections: almost 40% of adults exiting parole were returned to prison (Glaze and Bonzcar 2006), and, within 3 years, two-thirds of prison releasees in the USA were rearrested and more than one-half of all releasees had been returned to prison (Langan and Levin 2002). These high numbers of exits from the nation's prisons, coupled with high rates of recidivism, have resulted in many calling for increased rehabilitative programming behind bars and improved re-entry services and support for inmates once they have been released (Travis 2005).

Our paper is intended to inform the field of the experiences and lessons learned from Illinois' efforts to reduce the recidivism of drug-abusing offenders through a comprehensive prison- and community-based substance abuse treatment and aftercare program operating out of the Sheridan Correctional Center. Specifically, the paper examines the extent to which the Sheridan program was able to accomplish the goal of having inmates who completed the prison phase of a therapeutic community program access and complete post-release aftercare services, and what factors appeared to influence and improve parolee participation in aftercare.

2 Literature review

The literature relevant to this examination includes that which has developed around the efficacy and effectiveness of prison-based substance abuse treatment, the influence of post-release aftercare services on the long-term recidivism reduction associated with prison-based treatment, and the literature regarding retention in substance abuse treatment programs. Further, the growing body of literature that has examined inmate re-entry, particularly those factors that improve or reduce chances of successful re-entry, is also examined.

Increasingly, prison-based drug treatment programs are operating under a therapeutic community (TC) design, often times considered 'modified' TCs due to some of the alterations needed, given the prison environment they operate within. Therapeutic communities are "residential [programs] that use a hierarchical model with treatment strategies that reflect increased levels of personal and social responsibility. Peer influence, mediated through a variety of group processes, is

used to help individuals learn and assimilate social norms and develop more effective social skills" (National Institute on Drug Abuse 2002). Because TCs are one of the most common and widely studied drug treatment modalities for prison inmates (Lurigio 2000), there is now a substantial body of empirical evidence that has shown how prison-based treatment programs operating under a TC design can generate substantial reductions in post-release recidivism patterns and drug use. The literature includes evaluations of specific prison-based TC programs, such as the Amity program operating in California (Wexler et al. 1999), those operating in Texas prisons (Knight et al. 1999, 2004) and the Key-crest program in Delaware (Inciardi et al. 1997), as well as a number of meta-analyses of prison-based drug treatment interventions (Lipton 1995; MacKenzie 1997; Pearson and Lipton 1999; Pearson et al. 2002; Mitchell et al. 2006). The Mitchell et al. (2006) review is one of the most comprehensive, rigorous, and recent meta-analyses published on the effectiveness of incarceration-based drug treatment.

In general, most of the research on prison-based TCs has documented reductions in recidivism, although the magnitude of the reduction varied, depending on the length of stay, the population served, and the inclusion of educational and vocational programming. For example, in the review by Mitchell et al. (2006: 31), it was noted that, among the TCs examined, most (15 of the 24 studies) were programs serving 'non-violent' offenders and that those programs serving 'mixed' types of offenders (i.e., violent and non-violent) tended to produce lower, albeit still significant, improvements in outcomes. Further, Mitchell et al. (2006: 30–31) also concluded that corrections-based TCs that served large proportions of non-white offenders (where 70% or more of the sample was non-white), programs serving exclusively male offenders, and those institution-based TCs that did not required post-release aftercare, all had smaller reductions in recidivism than did their counterparts. However, despite the apparent benefits of prison-based treatment and aftercare, a number of barriers to the effective implementation of these strategies has been identified (Mears et al. 2003), including restrictions on the criminal backgrounds of program participants (Farabee et al. 1999), staff retention (Inciardi et al. 1992), prison crowding and limited bed-space (Office of National Drug Control Policy 1999), and conflicting goals between the criminal justice and treatment personnel (Farabee et al. 1999; Morrissey et al. 1983; Inciardi et al. 1992).

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

post-release aftercare, and Lipton et al. (2000) specifically found that fewer than one-half of RSAT-funded programs placed participants in some type of aftercare. Further, it has generally been concluded that "inmates who complete treatment frequently are transitioned directly into society without any type of reentry planning or development of plans for maintaining continuity of care" (Mears et al. 2003: 6–8), which illustrates the challenges of implementing aftercare programs for prison releasees.

However, making aftercare services available, or mandatory, does not necessarily ensure that released inmates will enter and complete those programs. The extensive body of literature that has examined treatment retention, and the factors associated with increased likelihoods of treatment completion, has consistently found that legal coercion can influence treatment compliance and completion (Anglin and Hser 1991; De Leon 1988; Hubbard et al. 1989). Still, in a review of the literature regarding drop-out rates in alternative-to-prison drug treatment programs, Brocato and Wagner (2008) concluded that approximately one-half of offenders admitted to these types of program drop out within 90 days, a conclusion supported by numerous other evaluations and literature reviews (Anglin et al. 1999; Hubbard et al. 1989; Knight et al. 2000; Messina et al. 2000; Nielsen and Scarpitti 2002; Simpson et al. 1997). The literature on treatment retention has also been fairly consistent regarding the conclusion that older participants are retained in treatment longer and have higher completion rates than younger participants (i.e., Hiller et al. 1998; Melnick et al. 1997), while less consistent findings have been evident in the literature with respect to participant race, education level, gender and child-care issues (Nielsen and Scarpitti 2002).

There is also an emerging body of literature that has sought to examine the experiences and challenges associated with inmate re-entry and the barriers to the provision of support services and referrals to the formerly incarcerated. Despite the general conclusion that prison-based treatment followed by aftercare can reduce recidivism, in many instances this does not occur, due either to limited availability of services in the community or lack of coordination among agencies involved in the prison-to-community transition. Mears et al (2003: 22) found that, oftentimes, inmates who had completed prison-based treatment were transitioned back into society with little re-entry programming or continuing care, and that many communities simply lack the services needed for former inmates to continue their treatment. Field (1998) and Mears et al. (2003: 16) determined that "a major obstacle to developing linkages with post-incarceration supervision and community services is the lack of coordination among correctional institutions, mental health providers, and other aftercare service providers in the community."

3 Illinois' Sheridan Correctional Center model for prison-based treatment and post-release aftercare

The analyses described here sought to understand better the challenges and process of implementing a large-scale offender re-entry model through the examination of the Illinois Department of Corrections' (IDOC) experience in implementing the Sheridan Correctional Center therapeutic community (TC) program. The Sheridan Correctional Center is a medium security prison housing inmates convicted of felony

offenses and sentenced to prison and is located approximately 70 miles southwest of Chicago, in Sheridan, Illinois. When opened in 2004, the Sheridan Correctional Center TC was rated to house 950 inmates and has since expanded to a capacity of 1,300. During the first 5 years of operation (January 2004 through December 2008), 5,353 inmates had been admitted to the Sheridan Correctional Center, and more than 3,200 have completed the prison-phase of the program and been released to the post-release aftercare and supervision phase. Unlike many prison-based treatment programs, which exclude offenders with current charges or past criminal histories involving crimes of violence (Mears et al. 2003; Farabee et al. 1999), the Sheridan Correctional Center's eligibility criteria are quite broad and inclusive. The only restrictions to participation are that the inmate must be in need of treatment based on a substance abuse assessment [Texas Christian University (TCU) Drug Screen II plus the addiction severity index (ASI)], be male, be appropriate for placement in a medium security prison, have 9–24 months of time left to serve on their sentence,[1] not suffer from severe mental illness, have no current or prior murder or sex offenses, and volunteer for the program. As will be described later, the characteristics of those inmates who completed the prison phase of the Sheridan program were consistent with those of a serious offender population in terms of their current conviction offense and prior criminal history.

While at Sheridan, all inmates actively participate in TC activities, including didactic groups, process groups, encounter groups, cognitive restructuring program groups, aggression management and domestic violence groups, behavior management, TC structures and responsibilities, and support groups (Illinois Department of Corrections 2006). In addition to these activities, all inmates are required to participate in educational and/or vocational programs, the nature of which varies, depending on the inmates' educational abilities. All inmates are also required to have an institutional work assignment, with the specific assignment dictated by their clinical, educational, vocational and behavioral progress (Illinois Department of Corrections 2006). Inmates who fail to abide by the program requirements, refuse to participate in treatment, or break other institutional rules, face disciplinary sanctions, which can include removal from the facility and transfer to another state prison. During the first 5 years of program operation, 863 of the 5,353 inmates admitted were removed from the program for disciplinary reasons, primarily refusal to participate in the treatment.

Prior to an inmate's release from Sheridan, an aftercare plan is developed by a multi-disciplinary team during two pre-release case staffings, one at 120 days and again at 30 days pre-release, where specific aftercare requirements are identified and discussed. Initially, inmates were not allowed to participate in the 120 day staffing, but this was later changed to increase participants' understanding and compliance with aftercare requirements. These post-release aftercare services are coordinated by clinical case managers from Treatment Alternatives for Safe Communities (TASC), a community-based agency that provides substance abuse assessments, referrals to treatment, and clinical case management services. The referrals to aftercare are made

[1] The initial criterion was a minimum of 6 months left to serve at the facility, but this was increased to a minimum of 9 months in the fall of 2006, based on findings that fewer than 9 months did not result in recidivism reductions.

to ensure that they are appropriate for the inmates' particular needs and are also geographically accessible, given the location where the releasee will be living. All inmates released from Sheridan are required to participate in some form of aftercare, ranging from outpatient treatment to continued residential treatment in the community. The intake assessments for these community-based aftercare referrals are ideally scheduled prior to an inmate's release and usually take place within the first week or two following the inmate's release from Sheridan.

Thus, upon completion of the institutional phase of the program, all Sheridan releasees are required to participate in aftercare services, with the specific type of aftercare determined by the re-entry management team, based on clinical and public safety considerations. Many releasees are referred to and placed in multiple aftercare programs (i.e., some type of residential setting plus outpatient treatment, or intensive outpatient treatment followed by traditional outpatient treatment). Given the fact that, at that time, inmates had to serve a minimum of 6 months at Sheridan, the first cohorts of inmates were not released from the facility until July 2004. Among the nearly 2,900 Sheridan participants released through June 2008,[2] intensive outpatient treatment accounted for the single largest category of aftercare referrals (60% of releasees), followed by traditional outpatient treatment (42%). In addition, one-quarter (25%) of Sheridan releasees were referred to recovery homes, which provided the parolee with a sober living environment and may have had self-help group meetings, but would also usually require a referral to outpatient counseling. A relatively small proportion of Sheridan releasees were referred to a half-way house (16%), which provided outpatient treatment within a setting where residents were able to leave for work or educational programming, or traditional residential treatment (15%), at some point following their release. Combined, 44% of the Sheridan releasees were referred to some type of residential aftercare program, including a recovery home, residential treatment program or a half-way house. Also, because participants could be referred to multiple aftercare services, the figures presented above total more than 100%. Finally, in addition to the aftercare requirements that are unique to Sheridan releasees, upon release from prison in Illinois all inmates were required to be under mandatory supervised release (MSR) by a parole agent for 1, 2 or 3 years. The length of this post-release supervision is specified under Illinois law and is determined exclusively by the felony class of the crime for which the offender is sentenced to prison. The most serious felony classes (classes M and X) require 3 years of MSR, followed by 2 years of MSR for classes 1 and 2 felonies and 1 year of MSR for classes 3 and 4 felonies (the least serious felony offenses in Illinois). Thus, the length of post-release supervision is based only on the nature of the conviction offense and not on therapeutic or clinical needs.

However, despite this goal of having all inmates released from Sheridan access and complete aftercare, which is also supported by the previously described literature, the capacity and desire among community-based service providers to serve this population was not immediately evident. As has been documented by others, in

[2] For the analyses, only those participants released through June 2008 were included, to allow them sufficient time to enroll in and complete aftercare services. Data regarding post-release aftercare referrals and completion were available through December 2008, thereby allowing each participant included in the sample at least 6 months to access and complete aftercare.

many instances potential providers have little incentive to work with a previously incarcerated population, due to limited resources and a group of clients they might see as too dangerous to serve (Mears et al. 2003: 6-3). Further, the volume of inmates released from the Sheridan Correctional Center more than doubled the number of prison releasees in Illinois being referred to community-based treatment providers. Thus, the existing network of community-based agencies treating substance abuse had relatively limited experience of working with the parolee population. Because of these potential obstacles, the availability of resources to serve this population was ensured by having the actual payment for services provided through contracts between the individual providers and the Illinois Department of Corrections, although the community-based agencies were all licensed by the Illinois Department of Human Services as treatment providers. Thus, the payment of aftercare services for the Sheridan releasees followed the program participants, thereby making them a higher priority for aftercare admission and ensuring coordination between the IDOC, TASC, and the community-based providers. In addition to ensuring adequate resources were available for aftercare, series of 3-day immersion training sessions during 2004 and 2005 were held at the Sheridan Correctional Center for directors and staff from community-based substance abuse treatment providers that were, or would potentially be, working with Sheridan parolees. Parole agents and staff working at the facility also participated in this immersion training, the goal of which was to familiarize these community-based agencies with the TC program at Sheridan, provide them with a better understanding of the Sheridan population's characteristics and needs, and also to increase their familiarity with the other agencies involved in the program (i.e., parole, TASC, and the treatment provider at the institution). This represented one of the first formal efforts within Illinois' prison system to 'connect' community-based treatment providers to the prison population they would potentially be working with during the re-entry and aftercare phases of the program.

Once participants are on MSR (i.e., parole) and have been referred to aftercare, their attendance, participation and performance are communicated by the community-based service provider to TASC and the participants' parole agents. Thereafter, TASC and parole staff meet monthly to discuss participants' progress and make any necessary modifications to the conditions of the participants' supervision. Again, during the initial stages of program implementation, these types of meetings represented a very different approach to how post-release supervision and monitoring had operated in the past. There were new challenges to defining post-release supervision for the population, including determining staff roles and responsibilities (i.e., the treatment vs. public safety responsibilities of TASC and parole personnel) and how to best work together to achieve the common goal of lower recidivism. For example, post-release monitoring also had to be re-defined for the Sheridan population. If a treatment participant misses aftercare appointments, fails to participate actively, or otherwise does not make satisfactory progress, the aftercare provider can 'unsatisfactorily' discharge the participant from treatment. If this occurs, the parole agent and TASC case manager meet to discuss the next appropriate step, which could include referral to a more intensive level of treatment or a different provider, or could result in revocation of parole and the return of the inmate to prison.

The Sheridan Correctional Center TC represented Illinois' most substantial effort in decades to deliver substance abuse treatment services, rehabilitative programming, and intensive aftercare and support upon release. The overall program design and philosophy represented a paradigm shift from the way inmates were typically released from prison and supervised in the community, and, as a result, it presented a number of implementation challenges to be explored. One of these challenges was the limited prior collaborative working relationships across prison-based treatment providers, parole agents, and community-based agencies and service providers. In addition to these new inter-agency working relationships, another challenge related to the limited experience in placing large numbers of parolees into aftercare across Illinois' diverse communities, which range from highly populated urban areas, like Chicago, to numerous small rural communities. Finally, during the course of initial program implementation, the large number of new staff that needed to be hired and trained by the service providers, with some initial high rates of turnover, resulted in some staff shortages during the first 2 years of program implementation.

For purposes of the analyses that will follow, the implementation and operation of the Sheridan Correctional Center's post-release efforts can be viewed as occurring over three different phases, tied closely to the state's fiscal years and the funding available to support the enhancements made as a result of the Sheridan program. During the first full state fiscal year (SFY) of operation [1 July 2004 to 30 June 2005 (SFY 2005)], the first cohort of inmates was released from Sheridan and the pre-operational expectations of the re-entry process were tested. During the second full state fiscal year of operation [1 July 2005 to 30 June 2006 (SFY 2006)] a number of substantive changes was made to the program, including the participation of the inmate in the 120-day pre-release case staffing, an increase in the number of TASC case managers working both within and outside the Sheridan facility, the development of a comprehensive standard operating procedures manual, clearly describing the roles, responsibilities, and performance measures of the various entities involved in the Sheridan Program, an increase in the number of parole agents, and an increase in the number of community support advisory councils (CSAC) operating in Chicago. These CSACs were financially supported by IDOC and were designed to develop and enhance the community's capacity to provide support for returning inmates, including the involvement of faith-based organizations, in the re-entry process. During the third and fourth full state fiscal years of operation (1 July 2006 to 30 June 2007, or SFY 2007, and 1 July 2007 to 30 June 30 2008, SFY 2008) additional TASC clinical case managers and parole agents were hired to facilitate re-entry efforts, and CSACs in other parts of Illinois began operating and working with releasees. Specifically, the number of pre-release clinical case managers employed by TASC and working at Sheridan increased from 4 to 7 between SFY 2005 and SFY 2007, and the number of post-release case managers working in the community with Sheridan releasees increased from 13 to 21 between SFY 2005 and SFY 2007, and to 26 by SFY 2008. Similarly, the number of parole agents hired by the Illinois Department of Corrections also increased by 56 during the same period, reducing caseloads by 13%. Thus, over the course of program implementation, a number of substantial changes and improvements were made to ensure that adequate resources were available and to increase the frequency and effectiveness of communication and coordination among the treatment agencies,

pre- and post-release clinical case managers, parole agents, institutional staff, and program participants.

After the release of more than 2,800 inmates over four state fiscal years, current research seeks to determine the extent to which the Sheridan Correctional Center program was able to achieve the goals of aftercare admission and completion for all releasees from the institutional phase of the program, the extent to which this goal was achieved across different participant characteristics, over time and across Illinois' diverse geography, and, ultimately, the extent to which compliance with aftercare had an impact on participant recidivism.

4 Methodology

The analysis described here is part of a larger, long-term, process and impact evaluation of the Sheridan Correctional Center that is being carried out by researchers from Loyola University Chicago, the Illinois Department of Corrections, the Illinois Criminal Justice Information Authority, and the service providers associated with the program. The participant-level data used to answer the research questions included the demographic, socio-economic, and criminal history characteristics of the nearly 3,000 inmates who completed the prison phase of the program between SFY 2005 and SFY 2008. These data were obtained from a combination of administrative data maintained by the Illinois Department of Corrections and data regarding post-release aftercare referrals and compliance provided by TASC for all program participants. The aftercare referral and compliance data for these releasees included their post-release aftercare status as of 31 December 2008. Since all aftercare intakes were scheduled to occur no later than 2 weeks following release, all individuals in the sample had at least 6 months to comply with the aftercare requirements.

Summarized in Table 1, in the column 'Total Sample,' are the characteristics of the 2,841 program participants included in these analyses.[3] It can be noted that, in addition to all participants being in need of treatment based on a substance abuse assessment, the average age of the Sheridan participants was just under 33 years and that the majority of those released from the program were non-white (73%), single (84%), lacking a high-school diploma or General Equivalency Diploma (GED) (56%), with one or more children (66%), and from the Cook County/Chicago areas (57%). Fewer than one-half (42%) of the releasees were identified as active gang members. In addition to a high prevalence of socioeconomic characteristics associated with increased risk of recidivism (age, race, marital status, education level, and gang involvement), those released from Sheridan also had extensive criminal histories, with an average of nearly 20 prior arrests, including an average of three prior arrests for violent crimes. Further, over 60% of the releasees had been sentenced to prison previously, and 20% were at Sheridan serving a sentence for a violent crime. Thus, the results presented in the following analyses need to be tempered in light of the fact that the Sheridan program is serving a population that is

[3] At the time of this writing, information regarding prior arrests for program participants was only available for those participants released between SFY 2005 and SFY 2007.

Table 1 Comparison of demographic, socio-economic and criminal history characteristics among Sheridan releasees that entered and did not complete aftercare (*HS* high school, *DUI* driving under the influence, *df* degrees of freedom)

Characteristic	Completed Aftercare, 1,597 (56.5%)	Did not Complete Aftercare, 1,229 (43.5%)	Total, 2,826 (100%)	Percent of Total Sample
Age (mean, years), F=77.2, $P<0.001$	34.2	31.0	32.8	32.8
Race	$X^2=5.3$, 1df, $P<0.05$, phi=0.04, $P<0.05$			
White	52.9%	47.1%	100%	26.3%
Non-White	57.8%	42.2%	100%	73.7%
Marital status	$X^2=1.0$, 1df, $P=0.31$, phi=0.02, $P=0.31$			
Married/common law	58.6%	41.4%	100%	16.0%
Divorced/single	56.1%	43.9%	100%	84.0%
Education level	$X^2=6.2$, 1df, $P<0.05$, phi=0.05, $P<0.05$			
HS diploma, GED or beyond	59.1%	40.9%	100%	43.1%
No HS diploma or GED	54.5%	45.5%	100%	56.9%
Total	100.0%	100.0%	100.0%	
Children	$X^2=2.9$ 1df, $P=0.08$, phi=0.03, $P=0.08$			
None	54.3%	45.7%	100%	33.2%
1 or More	57.6%	42.4%	100%	66.8%
Gang member	$X^2=1.1$, 1df, $P=0.30$, phi=0.02, $P=0.30$			
No	57.3%	42.7%	100%	57.1%
Yes	55.4%	44.6%	100%	42.9%
Total prior arrests[a] (mean), F=0.0; $P=0.94$	19.6	19.6	19.6	19.6
Total prior arrests for violent crimes[a] (mean), F=3.4, $P=0.06$	2.9	3.1	3.0	3.0
Total prior arrests for property crimes[a] (mean), F=0.1, $P=0.76$	6.3	6.2	6.2	6.2
Total prior arrests for drug law violations[a] (mean), F=6.2, $P<0.05$	5.1	4.6	4.9	4.9
Prior prison sentences	$X^2=3.5$, 2df, $P=0.17$, Cramer's V=0.04, $P=0.17$			
None	56.5%	43.5%	100%	37.5%
One	53.9%	46.1%	100%	25.2%
Two or more	58.3%	51.7%	100%	37.2%
Current offense type	$X^2=12.7$, 3df, $P<0.01$, Cramer's V=0.07, $P<0.01$			
Violent	53.5%	46.5%	100%	20.1%
Property	53.4%	46.6%	100%	32.1%
Drug law violation (including DUI)	60.0%	40.0%	100%	47.3%
Other	46.7%	53.3%	100%	0.5%
Current offense felony class	$X^2=8.5$, 1df, $P<0.01$, phi=0.05, $P<0.01$			
Class X 2	58.6%	41.4%	100%	62.9%
Class 3–4	53.0%	47.0%	100%	37.1%
Length of stay in prison (mean, years), F=29.8, $P<0.001$	1.16 years	1.03 years	1.10 years	1.10 years

Table 1 (continued)

Characteristic	Completed Aftercare, 1,597 (56.5%)	Did not Complete Aftercare, 1,229 (43.5%)	Total, 2,826 (100%)	Percent of Total Sample
Release cohort	X^2=75.9, 3df, P<0.001, Cramer's V=0.16, P<0.001			
2005	47.2%	52.8%	100%	47.2%
2006	52.7%	47.3%	100%	52.7%
2007	58.8%	41.2%	100%	58.8%
2008	70.0%	40.0%	100%	70.0%
Region of Illinois released to	X^2=50.7, 1df, P<0.001, phi=0.13, P<0.001			
Cook County/Chicago	62.7%	37.7%	100%	62.7%
Rest of Illinois	50.7%	49.3%	100%	50.7%
Referral for residential treatment or halfway house, recovery home or transitional living	X^2=131.5, 1df, P<0.001, phi=0.22, P<0.001			
No	47.0%	53.0%	100%	56.0%
Yes	68.6%	31.4%	100%	44.0%

[a] Data on the number of prior arrests were only available at the time of this writing for those Sheridan participants released during SFY 2005 through SFY 2007

F refers to the F statistics

clearly high risk and is not the typical population served by many prison-based programs, which, as described earlier, often exclude individuals with serious or violent criminal histories or current charges.

These quantitative data were examined using descriptive statistics, bivariate analyses and logistic regression to determine the overall rates of compliance with the aftercare requirements, how these changed over the course of program implementation, and to identify what participant and programmatic characteristics were statistically associated with aftercare compliance. The choice of independent variables was influenced by a combination of what had been suggested in the literature to influence treatment retention (i.e., age, race, marital status and childcare responsibilities, and current and past criminal involvement) as well as issues unique to the Sheridan program, including the time period to measure the maturation effect of the program on aftercare compliance, the community to which the inmate was to be released, and the nature of the aftercare referral. In addition, for the better understanding of the patterns evident in the quantitative analyses, these data were supplemented with additional qualitative data obtained through interviews and observations. Specifically, the evaluation design included ongoing formal and informal interviews with program participants, staff and administrators, including clinical staff and supervisors delivering the treatment within the facility, clinical case management staff and supervisors responsible for community-based aftercare referrals and placements, parole officers and parole supervisors, as well as the warden, assistant wardens, and upper administration of the Illinois Department of Corrections and the contractual service providers. These interviews were designed to

identify factors that either facilitated or hindered program implementation and operation. The research team also observed the delivery of the treatment programming and the pre-release planning meetings. Finally, because the evaluation was designed to be action oriented, members of the evaluation team also participated in a series of ongoing meetings and conference calls with program administrators to discuss overall program operations, including weekly conference calls during the first year and a half of program implementation, and monthly and quarterly face-to-face meetings with all the agencies and organizations involved in the program, including the evaluation team. The combination of quantitative with the qualitative information gleaned from these observations and interviews provided the basis of information upon which the analyses were made and interpreted. Also, consistent with the intent of action-oriented evaluation designs, and suggested as being critical to the development of prison-based treatment and aftercare programs (Mears et al. 2003), it is evident that there has been extensive support, involvement, and feedback from the evaluation team since the beginning of the program.

5 Results and discussion: examining completion of aftercare by Sheridan graduates

The first set of analyses examines the overall rate of aftercare completion of the Sheridan graduates and how this varied across participant characteristics. As seen in Table 1, over the entire 4-year period examined, 56.5% of the Sheridan releasees included in the sample successfully completed at least one aftercare program (the dependent variable in the analyses), despite this being required of all releasees. As described earlier, the aftercare programs included various types of residential placements as well as outpatient (intensive and regular) treatment. Further, relatively few of those unsatisfactorily removed from treatment were removed due to a new arrest or reincarceration (4% during the entire period). Thus, most unsuccessful aftercare terminations were due to the participant's failing to comply (i.e., missing excessive treatment sessions, not participating in the programming, etc.). The independent variables included in the analyses were those that had been identified as predictive in the treatment retention literature, such as age, race, marital status and education level, as well as measures predictive of recidivism, such as prior criminal history. In addition to these fairly established predictor variables, a number of others were included that related to some of the re-entry literature and also to the characteristics of the program and environment where Sheridan was implemented. Specifically, where the Sheridan participant was from (and released to) was included for two reasons. First, recidivism research in Illinois had found that prisoners and probationers discharged to Cook County/Chicago tended to have higher rates of recidivism than offenders in other parts of the state when other characteristics were statistically controlled (Olson et al. 2004; Huebner and Cobbina 2007; Olson et al. 2003).[4] In addition, the felony class of the current conviction offense was also

[4] It is likely that part of the explanation for these regional differences in the likelihood of rearrest after other factors have been controlled for is due to substantial differences in law enforcement presence. In 2006, there were approximately 403 police officers per 100,000 residents in Cook County, compared to 183 officers per 100,000 residents in the rest of Illinois (Illinois State Police 2006).

included as an independent variable, since that would dictate the length of time participants would be supervised on parole in Illinois, and thus would influence the length of time there was legal coercion to complete aftercare. We also included the length of time the Sheridan participant had spent in prison (i.e., at Sheridan), since the literature had consistently found length of time in treatment to be a predictor of completion and compliance. Length of time served at Sheridan was primarily influenced by the prison sentence length, or the length of time left to serve when the participant was transferred to Sheridan, but, as described previously, this had to be between 6 and 24 months. Thus, we hypothesized that a longer period of time spent in the institutional phase of the program would increase the likelihood of compliance and completion of the post-release aftercare. We also included a variable to indicate whether or not the releasee had been referred to any type of residential setting for his or her aftercare placement, since Roman and Travis (2004) had found that housing was a major issue for recently released inmates. Finally, we included a variable to indicate which cohort (i.e., SFYs 2005, 2006, 2007 or 2008) the releasee was part of, given the changes that had occurred during the course of program implementation. This last variable was included to assess the extent to which treatment completion rates had improved as the program matured.

Table 1 summarizes the bivariate analyses, which compared aftercare completion status (the dependent variable) with the participants' characteristics and programmatic/structural variables. As seen in Table 1, statistically higher rates of aftercare completion were evident among older participants, as well as non-whites, those with higher levels of education, those with more prior arrests for drug-law violations, those serving a prison sentence for a drug-law violation, those convicted of more serious felony-class offenses, and those who were in prison (at Sheridan) for a longer period of time. Also, participants released during the later periods of program implementation (i.e., SFYs 2007 and 2008), those released back to Cook County/Chicago and those who had been given an aftercare referral to a residential-type placement (i.e., a half-way house, recovery home, or residential treatment) were all more likely to complete aftercare. Importantly, the number of prior arrests, and, specifically, the number of prior violent arrests, was not correlated with aftercare completion.

In order to isolate statistically the effect of these independent variables on the outcome of aftercare completion, a logistic regression model was developed. Included in Table 2 is the coding of the variables, and each of the coefficients presented in Table 2 can be interpreted as whether they increased or decreased the odds of aftercare completion. For each of the categorical variables, the first value was the reference group for interpretation of the coefficients. As seen in Table 2, a number of the participants' characteristics and structural variables found to be associated with aftercare completion in the bivariate analyses were also found to be independently related to whether or not a Sheridan releasee completed aftercare in the multivariate model, including: age, current conviction offense, time served at Sheridan, region of release, and referral to a residential-type setting. The role of the structural variables, including jurisdiction (Chicago/Cook County compared to the rest of Illinois), type of referral (residential setting compared to others) and the participant's time period/cohort, was isolated by our entering these three variables as a second block in the logistic regression model, with the first block including the

Table 2 Logistic regression examining compliance with post-release treatment among Sheridan releasees

	B	Wald Statistic	Exp(*B*) (Odds Ratio)
Age (in years)	0.035	43.423	1.04 ***
Race (0=White, 1=non-White)	−0.026	0.058	0.97
Education (0=high school/GED; 1=no high school/GED	−0.146	2.948	0.86[a]
Marital status (0=married; 1=single)	0.037	0.104	1.04
Children (0=no; 1=yes)	−0.010	0.013	0.99
Gang member (0=no, 1=yes)	−0.165	2.854	0.85[a]
County released to (0=rest of Illinois, 1=Cook/Chicago)	0.491	27.277	1.63 ***
Current conviction offense (relative to violent)			
Property offense	−0.047	0.157	0.95
Drug-law violation	0.251	5.151	1.29 *
Other crimes	0.306	0.307	1.36
Current felony class (0=class X 2, 1=class 3–4)	−0.174	3.482	0.84[a]
Actual time served in prison (months)	0.289	10.648	1.34 ***
Prior prison sentences (relative to none)		15.102	
One Prior Prison Sentence	−0.237	4.746	0.79 *
Two or more prior prison sentences	−0.493	15.066	0.61 ***
Referral for residential treatment or halfway house, recovery home or transitional living (0=no, 1=yes)	0.834	95.863	2.30 ***
Period released from Sheridan (relative to 1st cohort, state fiscal year 2005)			
SFY 2006 relative to SFY 2005	0.068	0.380	1.07
SFY 2007 relative to SFY 2005	0.355	9.292	1.43 **
SFY 2008 relative to SFY 2005	0.705	29.424	2.02 ***
Constant	4.620	0.000	101.46

[a] ≤0.10, *P≤0.05, **P≤0.001. Nagelkerke R^2 =0.15

B refers to the regression coefficient and (B) refers to the estimated odds ratio

other participant characteristics. The three structural variables entered as the second block was associated with 60% (Nagelkerke R^2=0.09) of the explained variation in the model, whereas the offender characteristics was associated with 40% (Nagelkerke R^2=0.06) of the explained variation, for a combined Nagelkerke R^2 of 0.15.

Two variables, education level and current offense felony class, were significant at the P<0.05 level in the bivariate analyses but were only marginally significant (P<0.10) in the logistic regression model. On the other hand, prior prison sentences were not statistically significant in the bivariate analyses, but they were statistically significant predictors of aftercare completion in the multivariate analyses. Lastly, race was found to be statistically associated with aftercare

completion in the bivariate analyses, but it was not statistically significant in the multivariate model.[5]

Among the patterns evident in Table 2, there are four that warrant further explanation and discussion, given their importance in the understanding and evaluating of inmate re-entry programs and the gauging of aftercare completion, including: (1) the improvement in treatment completion rates that occurred over time; (2) the differences in treatment completion rates between inmates released to different parts of the state; (3) the higher completion rates among inmates admitted to some type of residential placement; and (4) the potential influence of post-release supervision length on aftercare completion.

5.1 Improvement in aftercare completion over time

The multivariate analyses confirmed what was evident in the bivariate comparisons—the pattern that each successive cohort of releasees had higher rates of aftercare completion. Based on the multiple sources of information used in the evaluation, it appears that these improvements in treatment completion reflect the maturation of the program over time, including increased communication to program participants regarding the requirements and expectations of aftercare compliance as a result of their participation in pre-release case staffings, improved communication between parole officers, TASC and community-based service providers, and more effective and efficient referral processes and monitoring due to increases in staff numbers, and increased staff experience in making the necessary referrals to appropriate providers. As illustrated in Table 2, inmates released during SFY 2007 were 43% more likely to complete aftercare than those released in SFY 2005 (odds ratio 1.43), and those released in SFY 2008 were twice as likely to complete aftercare (odds ratio 2.02) as the 2005 releasees, after statistic control for the other variables in the model.[6] Contributing to this improved rate of aftercare completion over time, and caused by the program improvements described above, were reductions in the rate of releasees failing to show up for aftercare referrals, a reduction in community-based providers rejecting participants, and a reduction in the time between release and admission into aftercare. Specifically, during SFY 2005, more than one-third (37%) of Sheridan releasees failed to show up for at least one of their aftercare intake assessments, and,

[5] Because data for prior arrests were not available for the SFY 2008 releasee cohort, these variables were not included in the multivariate model presented in Table 2. However, when the model was run for the SFY 2005 through SFY 2007 cohorts, and these prior criminal history variables were included, no statistically significant relationship was found between treatment completion and total prior arrests or prior drug arrests. A statistically significant relationship was found, however, between prior violent arrests and treatment completion, although the magnitude of this effect was relatively small and suggested that inclusion of offenders with prior histories of violent arrests did not substantially reduce treatment completion rates. For example, when the number of prior arrests was included in the model in its original form (a ratio-level measure), the odds ratio was 0.97, $P<0.05$. When the measure of prior violent arrests was recoded into a dichotomous variable (four or fewer prior arrests versus five or more), the effect on treatment completion was not statistically significant at the $P<0.10$ level.

[6] When the logistic regression model summarized in Table 2 was re-run using the repeated contrast for the categorical variable of release cohort, a statistically significant increased likelihood of aftercare admission was evident between SFY 2006 and SFY 2007, and between SFY 2007 and SFY 2008 as well.

during SFY 2006, this no-show rate was 30%. During this period, participants were not involved in the 120-day pre-release case staffing. However, this 'no-show' rate fell to approximately 16% during SFYs 2007 and 2008.[7] Similarly, between SFYs 2005 and 2008 the proportion of Sheridan releasee referrals being rejected by community-based aftercare providers also fell, from 9% to 3%, which indicated an increased understanding of the population being referred for services, as well as increased understanding among TASC and parole staff regarding appropriate aftercare placement sites. Also illustrative of the improvement to the aftercare referral process was the reduced time between the inmate's release from Sheridan and the admission into aftercare (among those who entered), which fell from an average of 19 days (median 10 days) for the SFY 2005 cohort to an average of 7 days (median 3 days) for the SFY 2008 cohort.

5.2 Regional differences in aftercare completion

Another factor found to have had a substantial impact on aftercare completion was the region of Illinois to which the Sheridan participant had been released, with those released to Cook County (Chicago) being 63% more likely to complete post-release treatment than those released to other regions of Illinois (odds ratio 1.63). The significantly higher likelihood of post-release treatment admission and completion among those released back to Chicago/Cook County is likely explained by a number of factors. First is the fact that the concentration and diversity of community-based treatment providers in Chicago is much greater than anywhere else in Illinois. It is also clear that the relationships between TASC staff, the community-based clinical case managers, and the aftercare providers in Chicago are much stronger and have been in place much longer than in other parts of Illinois. TASC has a long history and presence in Chicago and has worked to facilitate treatment access for pre-trial diversion populations and probationers and parolees, as well as jail releasees. Although TASC has served populations in other parts of Illinois, the duration and extent of these working relationships is substantially less outside the Chicago metropolitan area. Accessibility may also be a factor and, again, relates to the concentration of service providers, coupled with the relative ease, due to public transportation, of physically getting to these services in an urban area like Chicago. These findings suggest the need to consider relative community capacity to provide aftercare and support services and the ability of inmates released to less urbanized areas to access these services. Thus, while the Urban Institute's research on re-entry across a number of states, including Illinois, found that the communities many inmates are released to have high levels of social and economic disadvantage (LaVigne et al. 2004), this may be potentially mitigated by the relatively higher levels of aftercare availability and accessibility than that to prisoners released to less urbanized areas. Finally, the first community support advisory council (CSAC)

[7] The 'no-show' rate was based on whether a Sheridan releasee failed to show up for any of his or her post-release aftercare referrals. Thus, an inmate who failed to show up for an intake assessment at one provider, but did show up at a subsequent referral, would have been considered as a 'no show.' The inverse of the no-show rate would have been the proportion of releasees that never failed to show up to an aftercare referral intake.

was in place in Chicago beginning in 2005, whereas the CSACs in other parts of the state did not begin operating until 2007. It is also interesting to note the paradox between these findings regarding higher rates of aftercare completion in Cook County/Chicago and the findings described previously regarding research that has consistently found recidivism to be higher among offenders in Cook County/Chicago than among those in other parts of the state. Thus, while offenders released from prison to heavily urbanized areas may be more likely to be rearrested than those released to less urban communities, our current analyses would suggest that they are more likely to access and complete aftercare.

5.3 Aftercare completion and referrals to residential-based aftercare

By far the strongest predictor (based on the Wald statistic) of aftercare entry and completion was whether the Sheridan releasees were referred to any type of residential aftercare placement, which included referrals to residential treatment, halfway houses, and/or recovery homes. Part of this high rate of aftercare admission and completion can be explained by the fact that most of those referred to these types of settings went directly from Sheridan to the placement and were usually provided with transportation by the aftercare provider. This was possible, in part, because Sheridan is relatively close (70 miles) to Chicago, which is where a large number of the releasees were discharged to, and it also reflects the advantage of this type of a prison program being relatively close to major urban centers of a state. The improvement in aftercare completion for those referred to residential-type placements also points to the importance and benefits of newly released inmates living in an environment that promotes drug-free living, more so than some of the other living arrangements the parolee might need to rely on following release. Indeed, housing options for returning inmates is often quite limited and not always conducive to successful re-entry (Roman and Travis 2004).

5.4 Aftercare completion and length of post-release supervision

Finally, the relationship between the current felony class, which dictates the length of post-release supervision, suggests ($P<0.10$) that a longer period of post-release supervision may improve aftercare completion rates. Specifically, the results revealed that Sheridan releasees who were convicted of a class 3 or 4 felony (which require 1 year of post-release supervision) were 16% less likely to complete aftercare successfully (odds ratio 0.84) than those releasees subject to at least 2 years of post-release supervision (i.e., the reference category, or those convicted of class X, 1 or 2 felonies) (Table 2). As described previously, in Illinois the length of post-prison supervision is set at 1, 2 or 3 years by law and is based exclusively on the felony class of the crime for which the offender was convicted, not on any clinical assessment. Although this pattern could be the result of having a shorter length of time that the Sheridan releasee can be referred to and complete aftercare (i.e., 1 year as opposed to 2 or 3 years), this is not likely the case, since almost all aftercare admissions take place within the first month of release and placements generally do not last more than 6 months. It may be more plausible to believe that those releasees with 2 or 3 years of supervised release face much more severe consequences for

non-compliance than do those with shorter lengths of supervision (i.e., 1 year), since violators can be returned to prison to serve the remaining time of their supervised release behind bars. This might suggest that longer periods of post-release supervision impose a greater degree of coercion for treatment compliance among the releasees, and it may also support the view that discharge from supervision be based more on individual clinical determinations than standardized lengths of time based solely on the felony class of the conviction offense. In previous recidivism research in Illinois, the felony class (i.e., length of post-release supervision) has not been found to be independently associated with either rates of rearrest or return to prison (Olson et al. 2004). Thus, as states like Illinois begin moving toward parole models that focus on clinical case management and completion of needed aftercare services, factors other than just the conviction offense will need to be considered in determinations of how long an offender should be on mandatory supervised release.

6 Conclusions

From the analyses presented, a number of important findings emerge that can be used to better understand, plan for, and evaluate large-scale re-entry reforms involving the provision of prison-based and post-release aftercare. One of the most important findings is that, despite substantial resources and an organizational and political commitment to the implementation of substantive reform within Illinois' prison system, the time needed actually to put in place all the necessary pieces for an efficient and seamless continuum of care from prison to the community can be substantial (i.e., 2–3 years). The lack of patience and limited time commitment to allowing new programs to be implemented and evolve has been identified as one of the major obstacles to implementing these types of comprehensive re-entry strategies (Mears et al. 2003). The need to allow new programs, particularly those that dramatically change the traditional procedures and practices of agencies, to evolve, before conclusions about their overall efficacy and effectiveness are made is critical but oftentimes difficult, given the highly volatile (politically and financially) nature of some new programs. Sheridan clearly benefited from leadership and an environment that allowed it to be implemented consistent with the model.

Similarly, the time needed for comprehensive programs to reach a high degree of fidelity to the program model also has implications for those conducting impact evaluations and points to the benefit of having an action-oriented process evaluation conducted simultaneously. As illustrated in the preceding analyses, evaluations that examine the first cohorts participating in new programs may underestimate their true impacts. The experience from the Sheridan Correctional Center also illustrates the importance of having the evaluation team provide feedback to program administrators quickly and frequently. For example, the Sheridan evaluation team identified the low aftercare admission rate experienced during the first year, which, in part, prompted some of the changes described above. The evaluation also provided empirical validation to what some of the practitioners felt was occurring, particularly with respect to the difficulty of getting parolees released to the more

rural parts of Illinois into and through aftercare. The objective data confirming this pattern were then able to be used to justify additional resources and training to enhance the ability of clinical case managers to get these releasees successfully through their aftercare.

Finally, although the analyses were designed specifically to inform the field of Illinois' experiences in developing and implementing the mandatory aftercare associated with a prison-based TC, it is worth noting that the larger evaluation effort has examined the extent to which the Sheridan program has reduced recidivism, the findings from which are briefly described here. In a quasi-experimental design, the post-prison recidivism (measured as return to prison) of the 2,238 Sheridan participants released as of 30 June 30 2007, and a comparison group of 4,365 inmates released from prison during the same period, was compared, using survival analyses/Cox regression, to isolate statistically the variable of interest (Sheridan vs. comparison group) and control for the influence of other inmate characteristics.[8] It is important to note that two critical characteristics could not be statistically controlled for between the Sheridan and comparison group inmates at this time: treatment need and motivation/desire for treatment. While it would be expected that there would be similarities between the two groups in terms of treatment *need*, given how closely matched they were across almost every characteristic, what cannot currently be determined is the desire for treatment among the comparison group. These data were currently being collected and were therefore not yet available for inclusion in the analyses. The determination of recidivism was based on whether or not the inmates had been returned to prison for either a new crime or a technical violation of parole as of 31 December 2008; thus, the minimum time at risk for the Sheridan and comparison groups was 18 months, and the maximum time at risk was 4.5 years. The preliminary results from these multivariate analyses are consistent with those in the literature regarding the efficacy of prison-based TCs and the further improvement in recidivism reduction when aftercare has been completed. Specifically, after statistically controlling for all the variables described above, Cox regression (survival analyses) revealed that, overall, those released from Sheridan

[8] The comparison group was selected by a stratified, random, selection process. The pool of inmates eligible for selection in the comparison group included those adult male inmates released from prison during the same period as the Sheridan releasees, who were released from a medium or minimum security prison and incarcerated for an offense other than murder or a sex offense. From this group, a random sample stratified on time served and prior prison sentences was selected, with two comparison group inmates ensured for every Sheridan release. Bivariate analyses were then performed to determine if the comparison and Sheridan inmates differed across the following characteristics: age, race, marital status, education level, having children, gang membership, prior arrests (total and specifically for violent and drug offenses), prior prison sentences, current offense, current offense felony class, length of time served in prison, and the jurisdiction to which the inmate was released. Analyses revealed that there were no statistically significant differences across many of these characteristics and only slight statistical differences among others. Where statistical differences between the Sheridan and comparison group were noted, the strengths of these differences were small, with all measures of correlation (Pearson's r, phi or Cramer's V) being less than 0.10. To control statistically for the influence of these characteristics in the recidivism analyses, the Cox regression models included all the variables listed above as covariates.

had a 20% lower likelihood of being returned to prison than the comparison group.[9] Moreover, when Sheridan graduates were further distinguished between those that had completed aftercare and those that had not, those that had completed aftercare had a 52% lower likelihood of being returned to prison than the comparison group, but those who had not completed aftercare actually had a *higher* likelihood of being returned to prison than the comparison group.[10] This latter pattern was likely due to the fact that failure to comply with aftercare among the Sheridan releasees was a technical violation of parole and, therefore, might have increased the likelihood of return to prison relative to the comparison group, which generally did not have any mandatory treatment requirements. Thus, although these findings are preliminary and limited by the inability to account statistically for differences in treatment motivation among the comparison group, they are consistent with the growing body of literature regarding the improvement in recidivism outcomes when prison-based TC participation is following by community-based aftercare. As described throughout this paper, it is possible to achieve relatively high rates of aftercare completion with a population of former inmates with extensive criminal histories; however, doing so requires substantial time and organizational and political commitment, to allow this to evolve, and effective communication and coordination across agencies and organizations that do not have extensive histories of working together on offender re-entry.

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[9] The omnibus test of model coefficients examining post-release return to prison had an overall chi-square of 650, with 18 degrees of freedom, and was statistically significant at the $P<0.001$ level. Of the variables included in the model, the following were statistically significant predictors of recidivism, in addition to the dummy variable identifying the comparison group vs. Sheridan: age, marital status, education level, gang membership, total prior arrests, prior prison sentences, current offense, and length of time served in prison. Not statistically significant in the recidivism model were offender race, having children, prior arrests specifically for violent and drug offenses, current offense felony class, and the jurisdiction to which the inmate was released. The value of the predicted change in the hazard between the comparison and Sheridan groups was 0.80, $P<0.001$, indicating a 20% reduction in the likelihood of recidivism among Sheridan releasees relative to the comparison group.

[10] A model similar to that used to examine the overall effect of Sheridan was employed, but the variable distinguishing the comparison and Sheridan groups was recoded into a multicotomous measure, with 0= comparison, 1=Sheridan without aftercare, and 2=Sheridan with aftercare. The omnibus test of model coefficients examining post-release return to prison in this model had an overall chi square of 797, with 19 degrees of freedom, and was statistically significant at the $P<0.001$ level. All the same patterns of statistical significance among the covariates found in the first recidivism model were similar to those in this model. The value of the predicted change in the hazard between the comparison group and the Sheridan *with* aftercare completion group was 0.48, $P<0.001$, indicating a 52% reduction in the likelihood of recidivism among Sheridan releasees who had completed aftercare, relative to the comparison group. On the other hand, the predicted change in the hazard between the comparison group and Sheridan releasees who *had not* complete aftercare was 1.20, $P<0.001$, indicating a 20% increase in the likelihood of recidivism among Sheridan releasees who had not completed aftercare, relative to the comparison group.

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