What Works in Residential Reentry Centers

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December, 2010

This study was funded by a cooperative agreement #07EPI16GJT3 from the U.S. Department of Justice, Federal Bureau of Prisons, and the National Institute of Corrections.

Overview

What are the core strategies with respect to effective residential reentry center (RRC) services and treatment? RRCs are challenged to provide a range of services to address individuals' transition from prison to the community and this report examines the dimensions of those challenges. The study includes a sample of RRCs (N=9) that provide services to residents that address factors known to affect criminal behavior upon reentry into the community. For example, we attempted to learn whether RRC programs address the underlying causes of criminal behavior – an individual's antisocial behavior, personality, values and attitudes. We looked for details whether they change dynamic factors such as criminal associates, substance abuse, and dysfunctional family relationships. The study documented what roles these RRCs play in coordination with probation and parole that make RRCs part of our nation's public safety system. We were also interested in determining how these RRCs screened offenders to determine service needs and the extent to which they monitored service outcomes.

We surveyed directors and their staff to document knowledge and use of evidence-based practices, and to learn more about services. Site visits to these RRCs provided additional contextual information about service delivery and this report references these sources in tables. Director surveys, individual staff surveys, written materials provided as documentation by the RRCs and on-site observations provided information on how these RRCs were working with federal agencies to address the needs of their clients and monitor service outcomes.

Changing Criminal Behavior

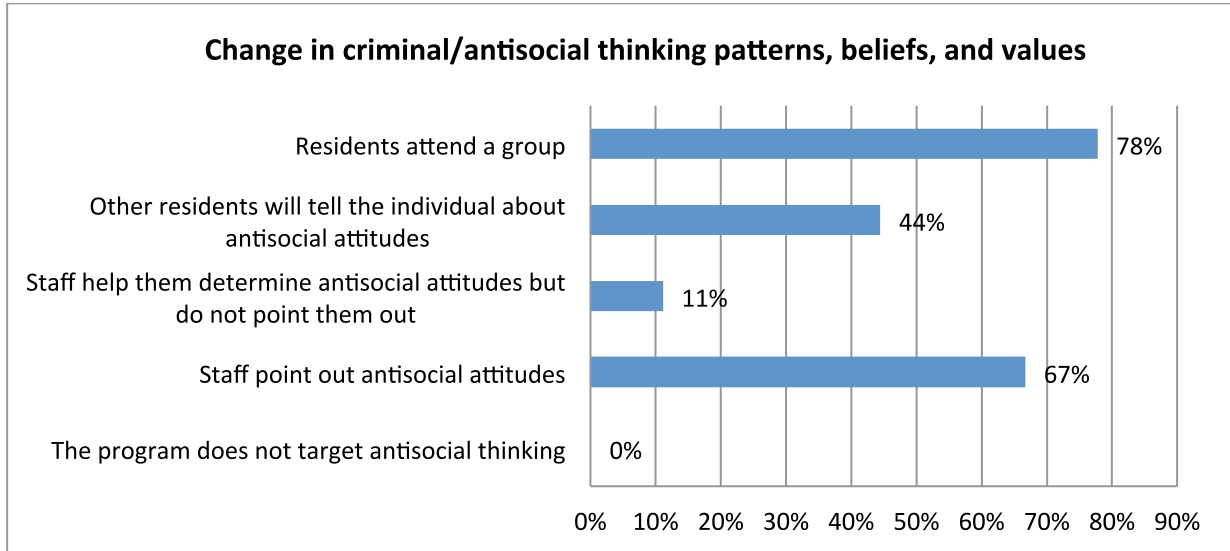
What are the behaviors that RRCs attempt to change?

All nine RRC program directors provided examples of program efforts to address the underlying causes of criminal behaviors, including individual's antisocial behavior, personality, values and attitudes, criminal peer associates, substance abuse and dysfunctional family relationships.

Antisocial thinking

All of the programs target criminal thinking patterns, and 78% of directors use group participation as a method to change residents' behavior. As shown in Figure 5.1 (below), 67% of the nine program directors indicated that staff will point out antisocial attitudes. Only 11% indicated that staff help them determine antisocial attitudes but do not point them out. Forty-four percent of directors indicated that other residents tell offenders about antisocial behavior.

Figure 5.1 – Change in Criminal/Antisocial Thinking Patterns, Beliefs, and Values
Source: DS #49: How does your program teach residents about antisocial associates/friends? (check all) N=9

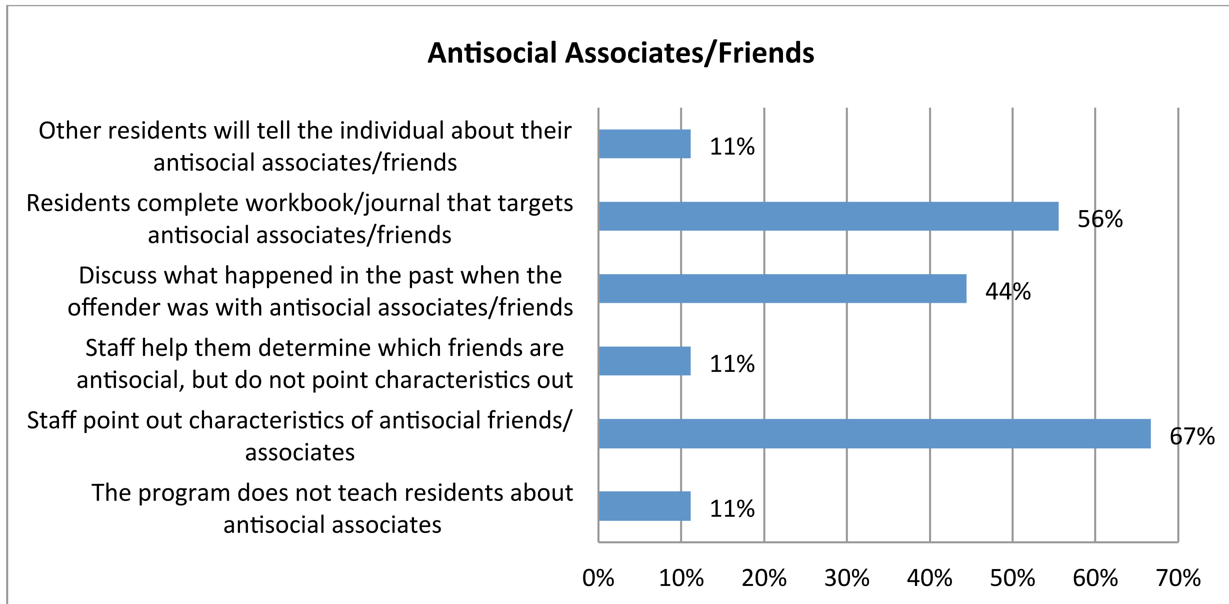


Criminal peers

Changing dynamic factors related to criminal peers was addressed by all nine sites but methods varied as depicted in Figure 5.2. Eleven percent noted that other residents will tell offenders about the problems associated with friends who are prone to crime. Fifty-six percent of directors (5 sites) indicated that residents complete a workbook or journal activities that target the subject of antisocial friends. Forty-four percent indicated that they discuss past problems. Eleven percent have staff help determine which friends are antisocial but do not point characteristics. However, 67% have staff point out these characteristics. Only one site indicated that the program did not teach about criminal peers.

Figure 5.2: Antisocial Associates/Friends

Source: DS #47: How does your program teach residents about antisocial associates/friends (Check all that apply)? N=9

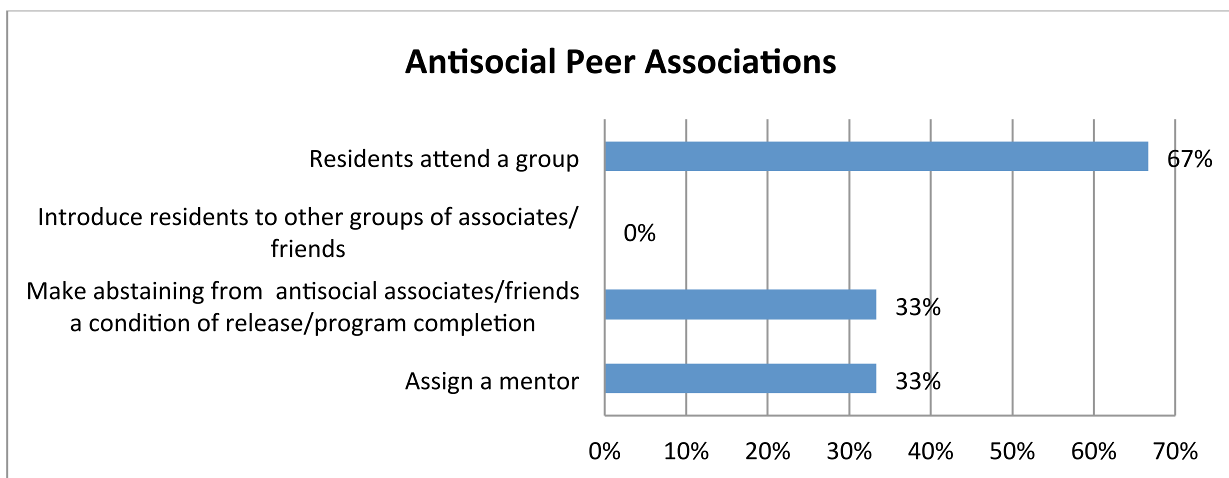


Peer-related teaching

Once the education process about criminal friends had commenced, sites were asked to check boxes describing ways that their programs attempted to change associations with antisocial peers of the residents. The most frequently used method was for residents to attend a group to help them with behavior change (67%). One-third (33%) indicated that they assign a mentor and another third introduce residents to other groups of peers or friends (See Figure 5.3).

Figure 5.3: Antisocial Peer Associations

Source: DS #48 How does your program attempt to change the antisocial peer associations of the residents? (Check all that apply) N=9

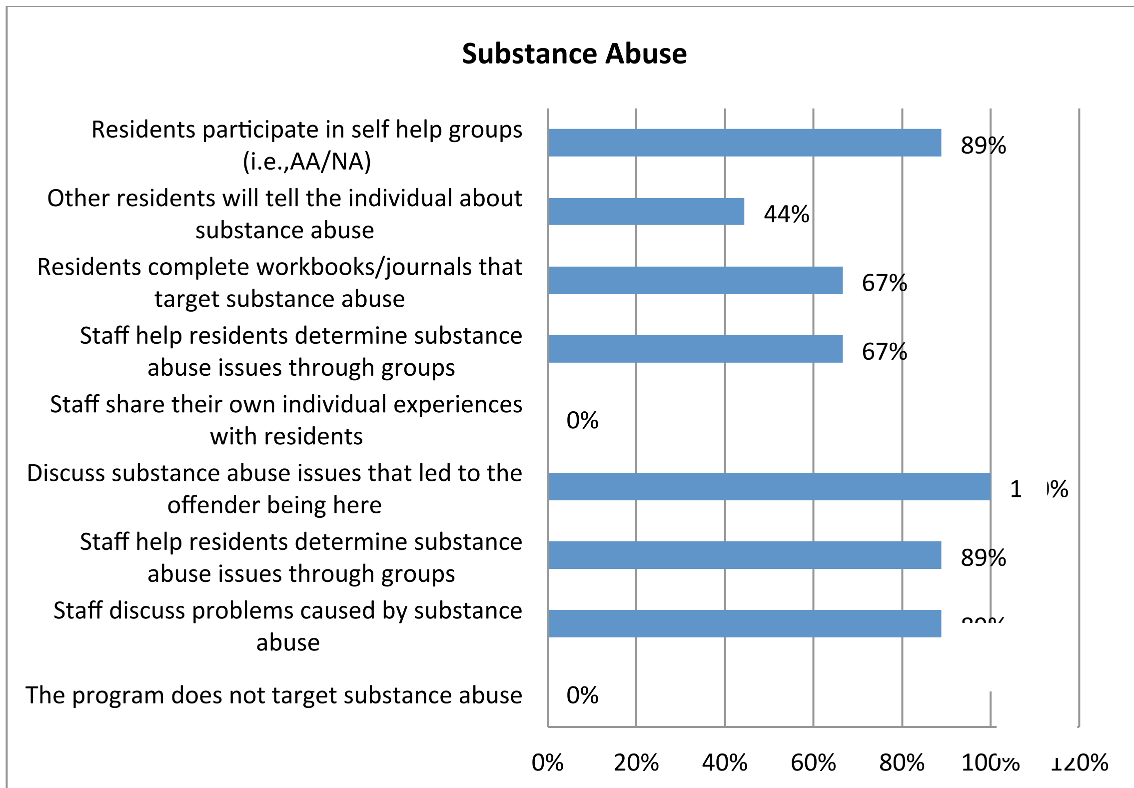


Substance Abuse

A key factor predicting recidivism is substance abuse, and these issues were addressed by all sites with variations between the sites. However, there is no consensus among RRC sites about the best method for addressing substance abuse and very little evaluation of these various methods in the context of RRCs. Figure 5.4 breaks down how RRCs attempt to change substance abusing behavior. The graph below indicates that all of the directors said their program discusses substance abuse issues in attempting to change behavior. Eighty-nine percent of directors indicated that staff help residents determine substance abuse issues through groups and the same percentage said they discuss problems caused by substance abuse. Eighty-nine percent also indicated that residents participate in self help groups. Another 44% of directors indicated that residents will tell individuals about substance abuse. Sixty-seven percent of RRC directors said they have offenders complete journals or workbooks and 67% report that staff help residents determine substance abuse issues through individual counseling.

Figure 5.4: Substance Abuse

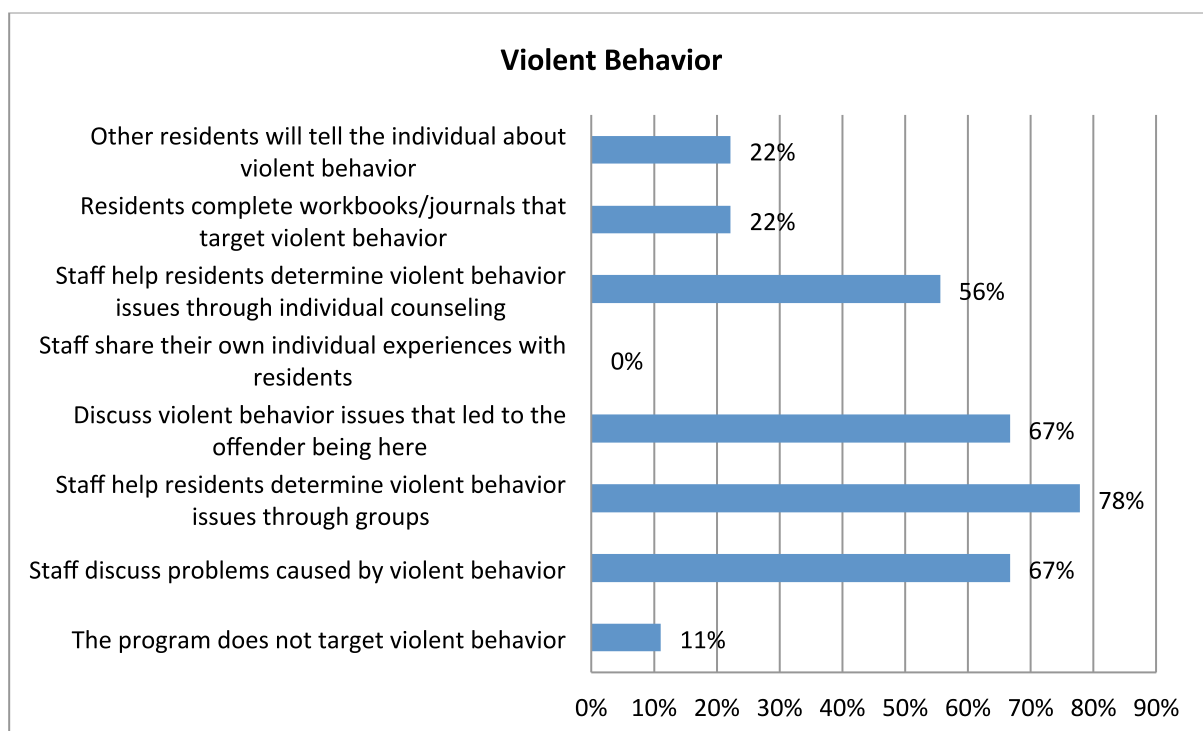
Source: DS #50: How does the program attempt to change the residents' substance abuse? N=9



Violence

With respect to factors related to violent behavior, all nine of the directors listed various ways they try to change the resident's violent behavior. As indicated in Figure 5.5, 78% indicated that staff help residents determine violence issues through groups. Staff also discuss problems caused by violence and violence that led to clients being there (67%). Fifty-six percent indicated that staff assist residents to determine violent behavior issues through individual counseling. Twenty-two percent of directors indicated that other residents tell about violent behavior and (22%) indicated that they used journals or workbooks for offenders to address violence issues. Eleven percent said the program does not target violence.

Figure 5.5: Violent Behavior
Source: DS #51: How does the program attempt to change the residents' violent behavior? Check all that apply. N=9



Assessment

What did RRC directors indicate about assessment practices?

Assessment provides information about level of risk, need for intense or specialized programs, and matching treatment services as appropriate to each individual. However, directors' surveys that indicated sites provided their own assessments and reassessments were rare. There was little evidence gathered about matching treatment to the individual based on assessments. Tables 5.1, 5.2 and 5.3 depict how RRCs assess for various criminal risks and needs.

Criminal Risk/Needs and Antisocial attitudes and cognition

Six site directors used a version of the Level of Service Inventory (LSI) to learn about criminal needs and risk for individuals (Table 5.1). One site used the Hare Psychopathy and another six indicated they used other standardized risk/needs instruments. Three sites do not use a

standardized instrument to assess for problems in thinking related to criminal behavior and one site did not respond to the question. One site (12.5%) used the Criminal Sentiments Scale. Three sites use the How I Think Questionnaire. One site used client self-rating, and another site used some other standardized instrument. Again there are no set standards and measurements of what can be accomplished with various RRC assessments, but if there were, it would provide a baseline for RRC directors to select assessment tools that would be beneficial in shaping the individual treatment plan and hopefully improve client outcomes.

Table 5.1 – Assessment Tools

Source: DS #35: Please indicate what standardized assessment tools are used in your facility/location and about how many residents are assessed with that tool? Check all that apply.

										Overall (N=9)			
	Site 1	**Site 2**	**Site 3**	**Site 4**	**Site 5**	**Site 6**	**Site 7**	**Site 8**	**Site 9**	**yes**	**no**	**missing**	**% yes**
Standardized Criminality Risk/Need Instruments													
Level of Service Inventory (LSI-R, LSI-R:SV. LS/CMI)	0	1	1	1	0	0	1	1	1	6	3	0	66.7
Wisconsin Risk Assessment (or variation)	0	0	0	0	0	0	0	0	_	0	8	1	0.0
Hare Psychopathy Checklist	0	0	1	0	0	0	0	0	_	1	7	1	12.5
Other Standardized Risk/Need Instrument	1	1	1	0	1	1	0	1	_	6	2	1	75.0
Antisocial Attitudes/Cognitive Distortions													
Criminal Sentiments Scale	0	0	0	0	0	0	1	0	_	1	7	1	12.5
How I Think Questionnaire	0	0	1	0	0	0	1	1	_	3	5	1	37.5
Beliefs Inventory	0	0	0	0	0	0	_	0	_	0	7	2	0.0
Pride in Delinquency	0	0	0	0	0	0	_	0	_	0	7	2	0.0
Client Self-Rating	0	0	0	0	0	0	1	0	_	1	7	1	12.5
Other Standardized Antisocial Attitudes/Cognitive Distortions Instrument	0	1	0	0	1	0	_	_	_	2	4	3	33.3

Mental health and sex offender assessment

Six sites answered questions about mental health assessment; of those, one site uses the Beck's Depression Inventory, and three noted they use other standardized mental health instruments. Of the five sites who gave information on sex offenders, only one uses a sex offender assessment tool (Static-99). The most types of mental health and sex offender screening was in site 3 as depicted in Table 5.2.

Table 5.2 – Assessment Tools Cont'd

Source: DS #35: Please indicate what standardized assessment tools are used in your facility/location and about how many residents are assessed with that tool? Check all that apply.

	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8	Site 9	Overall (N=9) yes	no	missing	% yes
Mental Health													
Becks Depression Inventory (BDI)	-	-	1	0	0	0	0	0	-	1	5	3	16.7
Symptoms Checklist-90 Revised (SCL-90R)	-	-	0	0	0	0	0	0	-	0	6	3	0.0
Other Standardized Mental Health Instrument	-	1	1	0	1	0	0	-	-	3	3	3	50.0
Sex Offender													
STATIC-99	0	-	1	0	n/a	0	n/a	0	-	1	4	2	20.0
Other Standardized Sex Offender Instrument	0	-	0	0	n/a	0	n/a	0	-	0	5	2	0.0

Substance abuse and other assessments

Table 5.3 shows that the CAGE tool was used by one site and the Addiction Severity Index was used by two sites. Other standardized substance abuse assessments were noted by three RRCs. One other standardized instrument was used for assessment other than substance abuse and those described in Tables 5.1 and 5.2. Given the number of offenders with history of substance abuse, it is surprising that assessment is not more widely administered.

Table 5.3 – Assessment Tools Cont'd

Source: DS #35: Please indicate what standardized assessment tools are used in your facility/location and about how many residents are assessed with that tool? Check all that apply.

	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8	Site 9	Overall (N=9) yes	no	missing	% yes
Substance Abuse													
Substance Abuse Assessment Tool Developed By Your Agency	0	0	0	0	0	0	0	-	-	0	7	2	0.0
Addiction Severity Index (ASI)	1	0	0	0	0	0	0	0	1	2	7	0	22.2
CAGE	-	0	1	0	0	0	0	0	-	1	6	2	14.3
Drug Abuse Screening Tool (DAST)	-	0	0	0	0	0	0	0	-	0	7	2	0.0
Other Standardized Substance Abuse Instrument	-	-	1	0	1	0	1	-	-	3	2	4	60.0

Other Uses for Standardized Instruments												
Other Standardized Instrument	-	1	-	0	0	0	-	-	-	1	3	25.0

Treatment and Services to prevent further criminal behavior

What did directors reveal about their RRCs' offender services?

Behavioral services are depicted in Tables 5.4, 5.5, 5.6, and 5.7 below. In Table 5.4, anger management and cognitive skills development were used in all nine sites. Criminal thinking and parenting were noted in seven sites. Domestic violence and relationship counseling were available in six sites. Five sites had family services/counseling and three sites had criminal friends programs. Sex offender counseling was noted in only two sites.

Table 5.4 – Treatment Services Offered

Source: DS #41: Do any of the groups offered at your facility use any of the programs listed below? Check all

Behavioral Topics	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8	Site 9	Total (N=9)
Anger or Stress Management	1	1*	1	1	1	1	1	1	1*	9
Cognitive Skills Development	1	1	1	1	1	1	1	1	1*	9
Criminal Friends	0	0	0	1	0	1	-	0	1*	3
Criminal Thinking	1	0	1	0	1	1	1	1	1*	7
Domestic Violence	1	1*	1*	0	1	0	1	0	1*	6
Family Services/Counseling	0	1	1	1	0	1*	-	0	1*	5
Parenting Skills	1	1	1	0	1*	1*	1	0	1*	7
Relationship Counseling	1	0	1	1	1	-	-	1	1*	6
Sex Offender Counseling	0	1*	0	0	0	0	-	0	1*	2

***referred out instead of on-site**

Support and services

All RRCs reported that they have employment and job placement/vocational counseling services. Two sites reported referrals in employment and two sites reported referrals for job placement and vocational counseling. We learned from site visits that although employment services were widely available, some agencies had only one employee do this work and others worked through case managers with large caseloads. Other sites had special resource centers as part of their program. Eight sites noted educational services and one did not. Seven sites provided housing services. Six sites marked vocational services and four of these sites referred out. Five sites mentioned work release and financial services. Four sites had transitional housing and three sites included day reporting.

Table 5.5 – Treatment/Services Offered

Source: DS #41: Do any of the groups offered at your facility use any of the programs listed below? Check all that apply.

Reentry Service Topics	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8	Site 9	Total (N=9)
Educational	1	1*	1*	1	0	1	1*	1	1*	8
Employment	1	1*	1	1	1	1	1	1	1*	9
Access to Support and Entitlement Services	0	1*	1	1	0	1	0	0	1*	5
Financial	1	1	1	1*	1	1	1	1	1	9
Housing	0	1	1	1	0	1	1	1	1	7
Job Placement/Vocational Counseling	1	1*	1*	1	1	1	1	1	1	9
Transitional Housing/Halfway Back	0	1*	0	0	0	1	0	1	1	4
Vocational	1	1*	1*	1	0	0	1*	0	1*	6
Work Release	1	1*	1	0	0	1	0	0	1	5
Day Reporting	1	1*	0	0	0	0	0	1	0	3

*referred out instead of on-site

Health services

Table 5.6 shows that most health services are referred with 29 services mentioned among seven sites. HIV/AIDS testing, HIV Counseling, TB screening and physical health services were available in seven of the nine sites through onsite or referral. Five of the sites provide every service listed in Table 5.6 or refer to a provider. Three RRCs noted two or less health services. Two sites did not provide information on health services.

Table 5.6 – Treatment/Services Offered

Source: DS #41:Do any of the groups offered at your facility use any of the particular type of programs listed below? Check all that apply. Check the box if the topic is referred out.

Health Topics	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8	Site 9	Total (N=9)
HIV/AIDS Testing	1	1*	1*	1*	0	-	1*	1	1*	7
HIV/AIDS Counseling/ Services	1*	1*	1*	1*	1	-	1*	0	1*	7
TB Screening	1*	1*	1*	1*	0	1	1*	0	1*	7
Hepatitis C Screening	1*	1*	1*	1*	0	-	0	0	1*	5
Physical Health Services/Medical Care	1*	1*	1*	1*	0	-	1*	1*	1*	7

*referred out instead of on-site

Other services and behavioral topic totals

Mental health services were available in all nine RRCs. Two of the sites have mental health services on site and the remainder of the sites make referrals. Substance abuse education was offered in all nine sites; eight sites had onsite services and one site makes referrals. AA/NA was available onsite in six sites and referred out for two. Individual counseling was available in eight sites, with three sites providing it through referral. None of the sites used recreational therapy, and yoga/exercise was only available in two sites. For behavioral topics in general the RRCs ranged from an average of 17 (2 sites) to 31 (1 site). The average number of behavioral programs for the nine sites was 24 and referrals were 9.55.

Table 5.7 – Treatment/Services Offered

Source: DS #41:Do any of the groups offered at your facility use any of the particular type of programs listed below? Check all that apply. Check the box if the topic is referred out.

Other Topics	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8	Site 9	Total (N=9)
AA/NA	1	1*	1*	0	1	1	1	1	1	8
Art Therapy	1	0	0	0	0	0	0	0	0	1
Individual Counseling	1	1	1	1*	-	1	1*	1	1*	8
Mental Health	1	1	1*	1*	1*	1*	1*	1	1*	9
Mentoring	1*	0	1*	0	1*	0	1*	0	0	4
Recreational Therapy	0	0	0	0	0	0	0	0	0	0
Self-Esteem	1	1	1	0	1	1	0	0	1	6
Spirituality	1	1*	1	0	0	0	1	0	1*	5
Substance Abuse Education	1	1	1	1*	1	1	1	1	1	9
Yoga/Exercise	1	1	0	0	0	0	0	0	0	2
Physical Care	1	1*	1	1*	1	0	1*	0	1*	7
Cultural, Ethnic, or Gender Specific	1	1	1	0	1	0	1	0	1*	6
TOTAL PROGRAMS OFFERED	**29**	**30**	**29**	**21**	**17**	**20**	**23**	**17**	**31**	**24.11**

*referred out instead of on-site

What types of services are provided by RRCs and how?

Table 5.8 indicates the proportion of clients who receive referrals and contact services (estimated by RRC directors). Sites with a documented history of providing substance abuse treatment in-house, such as site 4 and 8, tend to refer more than 50% of their clients. All sites refer 50% or more of cases to prearranged appointments for mental health counseling. Personal contact with community services/programs prior to discharge was offered to all offenders in only one site and offered to less than half by one site. Two sites were uncertain about the percent referred. Name and contact of a sponsor was given in all cases by one site, in less than half by one site and two were unsure. Probation/ parole personal contact prior to discharge was a service given in all cases by two sites but three sites were unsure. In one site all residents were referred to vocation or educational programs in the community-this site had a "resource model" orientation. It might be important to compare the "resource model" with an onsite services model in terms of efficiency and effectiveness. Six sites referred less than half of the clients to vocation/education and two sites were unsure. Personal contact with vocational or education programs varied as

well, with six sites offering it to about half of their clients, one site providing it to all clients, and two sites were unsure.

Table 5.8 – Proportion of Residents Provided Services
Source: DS #38: How many residents are provided the following services/assistance at the time they are in the community corrections location?
0= none, 1 = less than half, 2= about half, 3= more than half, 4= all, 5=unsure

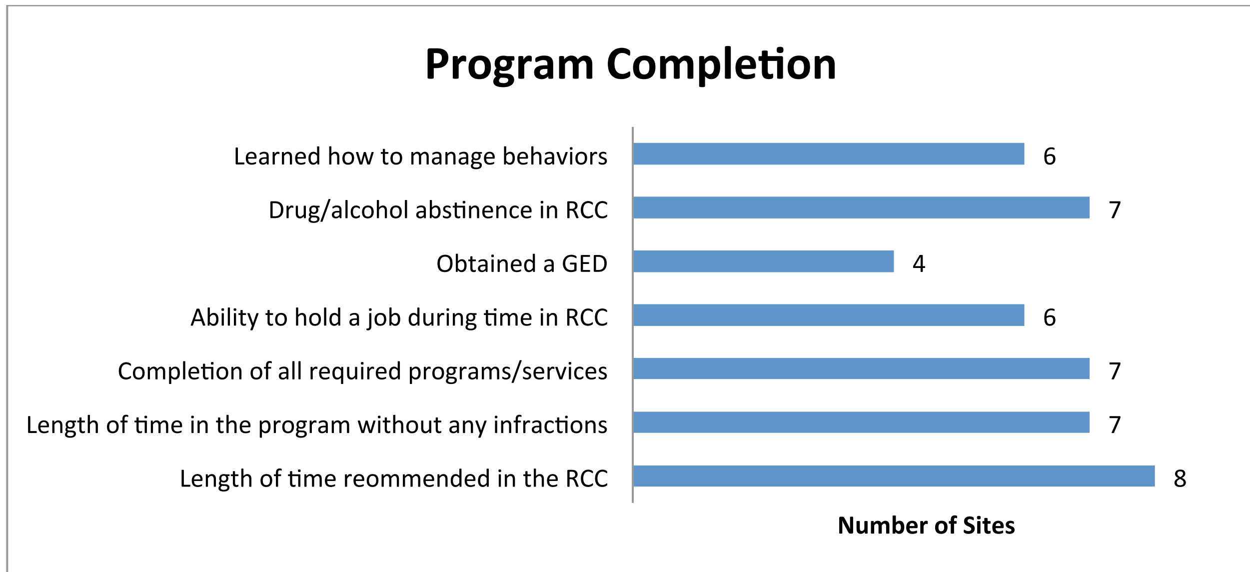
RRC Residents provided services	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8	Site 9
Referral to a substance abuse treatment program in the community	3	3	2	4	2	2	3	4	4
Pre-arranged appointment with community-based services programs (e.g., mental health, counseling)	2	2	2	2	2	3	2	2	3
Personal contact prior to discharge with community-based services program	2	5	2	2	1	2	4	5	2
Name and contact information of a 12-step sponsor/community sponsor	5	2	2	2	2	2	3	2	2
Personal contact prior to discharge with parole or probation agent who will be supervising in the community	5	5	4	6	5	5	5	4	5
Referral to a vocational or educational program in the community	4	5	2	2	2	2	5	2	2
Personal contact prior to release with employer, vocational, or educational program	2	5	4	5	5	5	5	2	4

Relationship between program completion and services

What did the directors say about program completion?

Directors in all RRCs noted similar program completion requirements, likely due to the fact that they must meet similar BOP requirements as well as state and local ones.

Figure 5.6 – Program Completion
Source: DS #39: What is an offender's program completion based on?



Conclusions

With respect to RRC services, RRCs provide the following types of functions:

- information gathering and support services
- assessing and measuring offender characteristics and progress
- communication with offender, the staff, agencies and the community
- modifying offender behavior
- direct educational, treatment and other services; and
- referral, outreach and advocacy for transitional services and support.

Six sites assess for risk and needs using the LSIR but other types of assessments were not widely used. With the exception of the LSIR, there is a dearth of use of assessment and reassessment, considering the variety of criminal and psychological problems that can be found in the population. For the sites that have a management information system that track assessment, reassessment and report on offender progress, it would seem that minimum standards can be developed on using assessment as a case management tool for RRCs in the future.

RRCs attempt to change and motivate individuals by providing programs that get to the root cause of criminal behavior. All of the programs reported that they target criminal thinking patterns and the most frequently mentioned methods were attending groups. Six RRCs address criminal peers by pointing out criminal peer characteristics and six of the nine sites indicated that groups were used to help residents with peer issues. There was some staff training evident in site visits around motivational interviewing and behavioral change, and these are promising practices that need more evaluation.

With respect to substance abuse, six of the sites used groups but mentoring and abstention was mentioned by three sites. All of the sites involve residents in discussing substance abuse issues and eight of the sites use self help groups, staff discussion, and staff assistance in their methods. With respect to violence, seven sites help residents determine their violent behavior issues and six sites reported staff discussion methods. With respect to employment and job training, all of the RRCs are offering assistance and many also offer referrals. Innovative projects with businesses and job training organizations are underway in three sites. All of the foregoing topics need more evaluation to see which of the current efforts are most effective. With respect to the wide reliance on referrals, especially in the health and mental health areas, a deeper look is needed to see whether referrals are the most productive way to meet the needs of RRC clients and if so, how referral outcomes can be measured as compared to onsite services.

Recommendations about improving RRC services

For the following recommendations to be implemented, treatment and services need to be driven by measured outcomes and performance results/feedback in order to improve services.

1. RRCs should develop a core list of services, standards and methodologies that cover both organizational and individual functions. These should be evidence-based.
2. Services should be linked to key objectives that are articulated in a performance work statement for each RRC.
3. The statement of work should be revised to include key factors within a performance work statement and specified acceptable methods of acting to achieve the key objective.
4. All services should be based on measurable outcomes and should include performance measurement standards, goals, and objectives as part of their implementation plan.
5. Services should be based on safety, accountability and behavioral change considerations.
6. Offender risk levels, risk assessment and reassessment should be integrated into all programs and IPPs.
7. Staff should utilize evidence-based curricula and be trained in communication, problem solving and motivational techniques so as to gather more information about their clients' needs, risks, and behaviors and to help their clients develop strategies for change.
8. RRCs must improve the varying levels of staff understanding of the fundamentals of correctional behavioral management and motivational tools. Agency leadership should seek to raise the level of understanding through training, hiring and management support.

The "What Works in Community-Based Residential Reentry Centers (RRCs)" study was designed to examine technical violation and release rates of offenders that participated in select RRCs. Since data on the activities of individuals while at the RRC, such as the programming received was not consistently available in electronic format, the study relied upon data from the Bureau of Prisons (BOP) and Administrative Office of the Courts (AO) to examine patterns, technical violations and rearrest rates for offenders.

The results of this project are reported in seven different monographs:

1. What is the impact of "performance-contracting" for offender supervision services?
2. Measuring Performance – The Capacity of Residential Reentry Centers (RRCs) to Collect, Manage, and Analyze Client-Level Data
3. What organizational factors are related to improved outcomes?
4. How do staff hiring, retention, management and attitudes affect organizational climate and performance in RRCs?
5. What services are provided by RRCs?
6. Technical Violation Rates and Rearrest Rates on Federal Probation after Release from a RRC Site Visits
7. Overview of Site Observations

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This study was funded by a cooperative agreement #07EPI16GJT3 from the U.S. Department of Justice, Federal Bureau of Prisons, and the National Institute of Corrections. The researchers gratefully acknowledge the collaborative contributions by federal staff from the Administrative Office of the Courts Federal Pretrial and Probation Services, the International Community Corrections Association and the Administration of Justice Department of George Mason University. Contributing Authors and Researchers include: Mary Shilton MS, JD, Jessica Rexroat, Amy Mericle PhD, Faye Taxman PhD and Jane Browning.

Information about the Project: Both PB and CB contractors participated in the study. Four sites were performance-based (PB) and five sites were compliance-based (CB). The preliminary study findings point to a few variations between performance-based contract sites and compliance-based sites. The experiences of 9 RRC sites and nearly 40,000 individual case histories were examined with the goal of providing details concerning the following:

- Does performance contracting stimulate contractors to develop evidence-based practices, provide better treatment services or become more efficient?
- What types of offenders are released into communities—to the streets, to residential centers, through home confinement or a mix of all of these?
- What happens to individuals who are transitioned through halfway houses or residential reentry centers?
- Does RRC monitoring, case management or treatment reduce the risk of future criminal conduct?
- How should other nonresidential transitional services and monitoring such as home confinement be used?
- What types of services motivate former inmates to live crime free?
- Are Residential Reentry Centers (RRC) geared to provide services that reduce risk of future crimes?
- How do RRCs know if they are successful in attaining their goals?
- What motivates and inspires some contractors to achieve results that improve outcomes?

For further information about the project contact Faye Taxman (ftaxman@gmu.edu), George Mason University at 703-993-8555 or Jane Browning, International Community Corrections Association at 301-585-6090.