

MIDAS Process Evaluation

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INTRODUCTION

The expansion of prison populations has been a concern of prison officials and legislators for a number of years. Construction and operation costs of prisons remain high; therefore, many states have shifted their resources to more cost effective sanctions. One such sanction is community supervision. This form of sanctioning has become a popular and less expensive alternative to prison. The use of community supervision means that states are releasing more offenders in the community through parole and probation. However, this alternative does not come without its problems. Consequently, while the number of individuals that are placed under some form of community supervision continues to grow, the resources available to community supervision agencies have failed to expand at the same rate (Petersilia, 2000). Gilford (2002) reports that while the number of correctional staff that handle individuals under community supervision roughly doubled from 1982 to 1999, the actual number of individuals under community supervision has tripled.

The struggle to provide adequate services and supervision to these offender populations has lead to concern about recidivism rates. Many of the offenders that are supervised in the community are returning to prison. With recidivism rates that range from 15 to 65 percent (Latessa & Smith, 2007), probation and parole violators are becoming an increasing part of the prison population (West & Sabol, 2008).

A study of parole violators conducted by the Pennsylvania Department of Corrections (PADOC) found that violators tend to have anti-social values and beliefs. Furthermore, parole violators have unrealistic expectations about life outside of prison, while simultaneously lacking the ability to adequately handle daily problems (Bucklen & Zajac, 2006). Based on the results of this study, the PADOC developed the Making Intelligent Decisions and Succeeding (MIDAS)

program for its parole violators. Specifically, MIDAS is supposed to target the anti-social attitudes of parole violators, and improve their social skills so they can adequately deal with day-by-day occurrences. By targeting these shortfalls, the goal is to reduce offender recidivism.

The University of Cincinnati was contracted by the PADOE to provide a process and outcome evaluation of the MIDAS program, which was piloted in three sites within the PADOE. The current report presents the findings from the process evaluation. This evaluation will focus on how the program operates, as well as the nature and quality of the services provided in all three pilot sites. Furthermore, the evaluation will focus on identifying the degree to which implementation of the program at the three sites adheres to the MIDAS program model.

The current report is divided into five sections. The first section provides a description of the MIDAS program as designed and how it was implemented across the three pilot sites. The second section provides a description of how the process evaluation was conducted. Within this section, detailed information is provided on the following: data regarding demographics of the treatment and control groups, a description of program delivery and implementation, and completion rates and demographical characteristics of completers and non-completers. The third section provides a summary of the findings from an Evidence-Based Correctional Program Checklist (CPC). The entire CPC report is included in Appendix B. The results of the process evaluation, together with characteristics of the program participants, are presented in the fourth section. Finally, the fifth section provides a summary of the report, which includes recommendations and conclusions.

THE MIDAS PROGRAM

The MIDAS program is designed to serve parole violators who display anti-social values and beliefs and lack the ability to adequately handle daily problems. The program aims to

increase knowledge acquisition and change the behavior of its participants. The MIDAS program is designed to be delivered through three-hour sessions, which meet every weekday, for ninety days.

The MIDAS program assesses its participants using several different assessment tools. Specifically, participants' level of risk is determined with the Level of Service Inventory-Revised (LSI-R) (Andrews & Bonta, 1995). Offenders are also assessed through a battery of tests that include: the Criminal Sentiments Scale-Modified (CSS-M), the Hostile Interpretations Questionnaire (HIQ), the Comprehensive Adult Student Assessment System (CASAS), the Tests of Adult Basic Education (TABE) and CareerScope Interest and Aptitude test. TABE is a diagnostic test that assesses an individual's skill levels in reading and math. CASAS is also used to diagnose basic math, reading, listening, writing, and speaking skills. CareerScope measures and individual's attraction to careers. The CSS-M (Shields & Simourd, 1991) and the HIQ (Mamuza & Simourd, 1997) were designed to measure anti-social attitudes.

To be eligible for MIDAS, parole violators are supposed to have a score of 21 or greater on the LSI-R, and be in need of adult basic education. Furthermore, the parole violators are required to have at least six months, but no more than twelve months, until their next parole review. Once determined eligible for the program participants are randomly assigned to either a control or a treatment group.

Individuals in the treatment group received all the MIDAS programs, which include basic education GED services, employment skills, MoneySmart financial education, and the Lifelines and Madison Heights curriculum. Individuals that are randomly selected and placed in the control group receive the usual services provided by PADOC. This suggests that control group participants can receive a service accessible to all inmates in that particular prison at that time.

At completion, both groups are re-assessed with the aforementioned assessments. The treatment group is re-assessed after completion of the MIDAS program, while control group participants are re-assessed three months after the initial assessment.

MIDAS was piloted in three State Correctional Institutions (SCIs). Implementation of the program started in February 2007 and was completed in March 2008. The participating institutions were SCI Dallas, SCI Somerset, and SCI Muncy. The first two institutions house male offenders, while SCI Muncy houses female offenders. The pilot was implemented in three cycles. Each cycle lasted three months and consisted of a different set of participants.

Description of Programing included in MIDAS

To realize its goals, the MIDAS curriculum is comprised of educational materials that are designed to prepare participants to obtain their GED, financial education curricula, employment skills materials, and curricula that aims to change their antisocial thinking and problems solving skills. The core programs include the *GED Test Preparation* materials, *FDIC Financial Education Curriculum MoneySmart* booklets, the *Job Interview Tips for People with Not-so-Hot Backgrounds* (Krannich, 2004) and *Best Resumes and Letters for Ex-Offenders* (Enelow & Krannich, 2006) books, the *Tools for Success Workbook*, the *Lifelines Workbook* and the *Madison Heights Workbook*.

The *Financial Education Curriculum* from *Money Smart* was developed by the Federal Deposit Insurance Corporation (FDIC) and includes financial education tips on money management, personal banking, loan applications and borrowing, and credit building and managing information. The *Tools for Success Workbook* provides educational materials on learning soft skills related to the construction industry. Finally, the *Lifelines* and *Madison Heights* curricula include video sets and workbooks that seek to promote pro-social critical

thinking and problem solving skills, as well as family literacy and pre GED education. The video lessons entail participants watching real-life scenarios on critical and serious issues and then using workbooks to provide feedback on these issues. In addition, these workbooks are used to improve the participants' writing, reading, communication, parenting, and family communication skills. The material is intended to empower the program's participants in their roles as parents, students, workers, and members of the community (Intelcom, 2002).

OVERVIEW OF THE PROCESS EVALUATION

This process evaluation addresses the following areas as they pertain to the MIDAS program: characteristics of its participants, implementation and adherence to the program's model, and quality of service delivery throughout the three pilot sites. Data for the process evaluation were obtained from each of the three pilot sites. Data collection began in December 2007 and concluded in May 2008. To comprise the sample for this evaluation, all sites collected and sent data on each of their participants after the completion of each MIDAS cycle. Each of the sites sent information regarding program participation, completion, and scores obtained from pre- and post-program assessments. Furthermore, demographic data on program participants were sent from the Pennsylvania Department of Corrections. Each site's service delivery was assessed using observations and interviews by a research team from the University of Cincinnati. The final sample included 208 MIDAS participants and 206 control group members.

Correctional Program Checklist

An Evidence-Based Correctional Program Checklist (CPC) is presented following the process evaluation in Appendix B. The CPC assesses correctional programs and how they rate in following the principles of effective intervention. The CPC is divided into two basic areas: content and capacity. The capacity area is designed to measure whether a correctional program

has the capability to deliver evidence-based interventions and services for offenders. The content area focuses on the substantive domains of Offender Assessment and Treatment Characteristics, and the extent to which the program meets the principles of risk, need, responsivity, and treatment—the principles of effective intervention. Research has shown that programs and treatments that adhere to the principles of effective intervention are the most effective in reducing offender recidivism (Andrews and Bonta, 2003). More detailed information regarding the CPC, as well as the results of the CPC are presented in Appendix B.

FINDINGS FROM THE PROCESS EVALUATION

Social Demographics of Program Participants

After the completion of all three phases at each site, there were 414 study group members. Table 1 displays the participants divided by pilot site and cycle in which they participated. SCI Somerset treated the largest proportion of MIDAS participants. Specifically, this site treated 102 MIDAS participants or 49 percent of the entire treatment group. SCI Dallas treated 66 MIDAS participants (32% percent of the treatment group), and SCI Muncy, which houses female offenders, treated 40 MIDAS participants (roughly 19% of the treatment group).

Table 2 presents demographic measures by group status.¹ Represented under each of the scales are the total number of individuals for whom the scores were made available. The percentages column represents the valid percentages for the sample of scores sent. Depending on the nature of the data, chi-square or independent t-test statistics were calculated to examine whether the control and the treatment groups differed significantly on demographic characteristics.

¹ Frequencies, percentages, and appropriate statistical analyses of these and other demographic characteristics are also made available for each of the pilot SCIs in Appendix A.

Table 1. Frequency and Percentage Distribution of Participants by Site and Phase

Site	Treatment (N=208)	%	Control (N=206)	%
<u>Muncy</u>				
Phase I	14	6.73	12	5.82
Phase II	14	6.73	12	5.82
Phase III	12	5.76	11	5.28
Total	40	19.23	35	16.82
<u>Dallas</u>				
Phase I	23	11.05	16	7.76
Phase II	28	13.46	28	13.59
Phase III	15	7.21	16	7.76
Total	66	31.73	60	29.12
<u>Somerset</u>				
Phase I	35	16.82	36	17.48
Phase II	34	16.34	42	20.39
Phase III	33	15.87	33	16.02
Total	102	49.04	111	53.88

Note: The percentages may not add to 100 % due to rounding

As shown in Table 2, the majority of the MIDAS participants in both groups were male (80.8% in the treatment group and 83% in the control group), and black (57.1% in the treatment group and 52% in the control group). Furthermore, both groups had similar age distributions (roughly 36 for each group). There were no significant differences between the control and treatment group on gender, age, or race.

Table 2. Frequency and Percent Distribution of Demographic Measures by Group Status

Characteristics	Treatment (N=208)		Control Group (N=206)	
	N	%	N	%
<u>Gender</u>				
Male	168	80.8	171	83.0
Female	40	19.2	35	17.0
$\chi^2 = .350; p = .554$				
<u>Age</u>				
Less than 29	66	31.9	64	31.7
30-39	71	34.3	72	35.6
40 and older	70	33.8	66	32.7
$\bar{x} = 36.0$	$\bar{x} = 36.1$		$\bar{x} = 36.0$	
$t = .131; p = .896$				
<u>Race[†]</u>				
White	45	22.0	64	31.7
Black	117	57.1	105	52.0
Hispanic	43	21.0	32	15.8
Native American	0	0.0	1	0.5
$\chi^2 = 5.535; p = .063$				

[†]The Native American category was not used in the analysis because it contains only one participant.

Table 3 presents the distribution of assessment measures divided by group membership. Several PADOE reports and the state’s sentencing directives served as guidelines for the development of the categories for the risk/needs assessment instruments (as well as the grouping categories for age and race) reported in the table. For example, while the LSI-R also has risk categories of low-moderate and moderate-high, for the purposes of this process evaluation the offender scores are grouped as low, medium, and high risk. The same method is used with the TCU Addictions II Scale, the Criminal Sentiments Scale, and the Hostile Interpretations Questionnaire. Scores for the Static 99 assessment are not presented, as scores for only five individuals were made available.

Referring to the LSI-R Risk/Need assessment scores, the majority of the sample fell under the high-risk category for each group (45.9 % and 50.0% for the treatment group and control group, respectively). The medium risk category contained the next highest amount of offenders, followed by the low risk category.² Approximately 38 percent of MIDAS group participants scored in the medium category of the TCU Addictions scales, and about 39 percent of control group participants scored in the low category. This difference was not statistically significant. For the CSS-M, roughly 48 percent of the control group participants scored high, while 35 percent of MIDAS group participants scored low. Again, this difference was not statistically significant. Finally, HIQ scores indicated that 43 percent of the treatment group were scored as medium risk, while the roughly 51 percent of the control group were scored as high risk. This difference was statistically significant. Specifically, the control group was more likely to score higher on the HIQ than the treatment group.

² While the MIDAS program was designed for medium and high risk individuals, some low risk individuals were included in the sample. LSI-R risk levels were based on Pennsylvania's LSI-R cutoff criteria (Pennsylvania Department of Corrections, 2006).

Table 3. Frequency and Percent Distribution of Assessment Measures by Group Status

Scale	Treatment Group (N=208)		Control Group (N=206)	
	N	%	N	%
<u>LSI-R Risk/Need Levels</u>				
Low Risk	26	12.6	29	14.4
Medium Risk	86	41.5	72	35.6
High Risk	95	45.9	101	50.0
$\chi^2 = 1.527; p = .466$				
<u>TCU Addiction Scale</u>				
Low	25	34.2	21	38.9
Medium	28	38.4	15	27.8
High	20	27.4	18	33.3
$\chi^2 = 1.576; p = .455$				
<u>CSS-M Scale</u>				
Low	26	35.1	20	32.3
Medium	24	32.4	12	19.4
High	24	32.4	30	48.4
$\chi^2 = 4.425; p = .109$				
<u>HIQ Scale*</u>				
Low Risk	13	18.6	17	27.0
Medium Risk	30	42.9	14	22.2
High Risk	27	38.6	32	50.8
$\chi^2 = 6.425; p = .040$				

*p<.05

Note: Independent t-tests were calculated using the continuous scores of each scale. The results were as follows: LSI-R (t = -.130; df = 407; p = .897); TCU (t = .135; df = 125; p = .893); CSS-M (t = -2.097; df= 134; p = .038); HIQ (t = -.731; df = 131; p = .466).

Criminal Offense Information

Table 4 depicts present offense types for both the treatment and control group.³ The offense categories follow the Pennsylvania Department of Corrections Offense Code. Offenses

³ See Appendix A for offense frequencies for each of the participating pilot correctional institutions.

such as murder, aggravated assault, and criminal homicide fall under the “Violent” category of criminal offense groupings, while simple assault and intimidation of witness/victim are grouped under the “Other Violent” category. In addition, offenses such as “Escape” and “Probation Violation” are grouped under the category “Institution/Sentence Related” offenses.

According to Table 4, the most common present offense for treatment group members was “violent” (38.2%), followed by “drug related” (24.6%) and “property related” (19.3%). For the control, the most common present offense was “drug related” (32.2%), followed by “violent” (30.7%) and “property related” (16.3%). There was no significant difference between the two groups in the distribution of present offense types.

Table 4. Present Offense Frequency by Group Status

Offense Type	Treatment Group (N=208)		Control Group (N=206)	
	N	%	N	%
Violent	79	38.2	62	30.7
Other Violent	8	3.9	12	5.9
Property Related	40	19.3	33	16.3
Drug Related	51	24.6	65	32.2
Public Order	16	7.7	15	7.4
Sex Related	6	2.9	7	3.5
Institution/Sentence Related	7	3.4	8	4.0

$\chi^2 = 5.326; p = .503$

Treatment Activity

The following section concentrates on the way that the MIDAS program was implemented throughout all three institutions. Referrals for eligible participants came to the institutions from the PADOCC's Central Office. All participants were to receive all the treatment modules from the MIDAS program. Once determined eligible for the program, offenders were randomly assigned to the treatment or control group. There were however, instances in which the offender was part of the treatment group and was moved into the control group after verifying possession of a high school diploma or a GED.⁴

The delivery of the treatment modules was conducted through the correctional institution schoolteachers. Counselors and school principals were also involved in treatment delivery. Classes were scheduled in two groups in all three pilot sites. Specifically, one was scheduled in the morning and one in the afternoon in order to accommodate the participants' schedules. Sites differed somewhat in delivering of modules. For example, SCI Muncy did not use *Tools for Success*, but used some additional materials from PBS Literacy Clinic on Math, Literacy and Employment, as well as Videos from ALMA-Adult Literacy Media Alliance to assist in the Financial and Social curricula delivery. Furthermore, SCI Somerset used additional materials for the financial curriculum by adding topics such as money and retirement (from the Heinz foundation).

The three pilot sites also differed in the assessment tests they used. Initially, some of the materials arrived late; thus the CASAS Critical Thinking Assessments for Employability were not administered prior to the start of the program, and, consequently, were not administered post program completion at any of the sites. Furthermore, while SCI Muncy and SCI Dallas

⁴ There were 10 individuals that were labeled as having previously obtained a high school diploma or GED. Part of the criteria for being eligible for MIDAS was less than a high school diploma; nevertheless, these individuals remained in the sample. Findings do not change when these individuals are removed from the analyses.

administered the CASAS Assessment Battery Tests for Reading and Math pre and post treatment, SCI Somerset did not administer this test. SCI Somerset administered the CASAS Occupation Specific Tests 1 and 2, while the other two institutions did not. Table 5 presents the frequency and percentages of treatment group completers of the remaining tests administered by the institutions.

Sanctions and Rewards for Participants

Although the pilot institutions used the same incentive to encourage offenders to participate in the MIDAS program (\$0.25 per hour to participate), they differed in their tactics to discourage nonparticipation. Specifically, SCI Somerset's counselor and the school principal had numerous consulting sessions with offenders who refused to participate in the program, or decided not to finish the treatment modules once they were part of it. During the first phase of the program the principal hinted at possible write-ups or other sanctions if the eligible offenders refused to participate in the pilot. In addition, during the second phase an eligible offender who refused to participate was given thirty days of cell restriction. SCI Dallas had similar policies. At this site, attendance was mandatory and if a participant missed too many classes he could be removed from the program and required to start over. Loss of employment was also a sanction for not attending class. In contrast, SCI Muncy had a volunteer policy for program participation. Eligible offenders were informed about the program and were given the opportunity to participate. No sanctions were enforced against those who opted not to participate in the program, or decided not to finish treatment once part of the MIDAS pilot.

Table 5. Treatment Group Participant Completion of Modules by Institution

Scale	SCI Dallas (n=66)	%	SCI Somerset (n=102)	%	SCI Muncy (n=40)	%
<u>Money Smart</u>						
Completed	37	56.1	0	0.0	9	34.6
n	66		0		26	
<u>Career Scope</u>						
Completed	41	100.0	0	0.0	32	94.1
n	41		0		34	
<u>Tools for Success</u>						
Completed	57	86.4	0	0.0	28	70.0
n	66		0		40	
<u>TABE Math</u>						
Completed	58	87.9	99	97.1	39	94.2
n	66		102		40	
<u>TABE Reading</u>						
Completed	58	87.9	99	97.1	39	94.2
n	66		102		40	

Program Completion

Table 6 displays the treatment group's completion status by location and phase. The largest number of participants who completed the program came from SCI Somerset (71.6% total from all Phases), while SCI Dallas had the lowest number of program completers (53%). The percentage of participants who completed the program at SCI Muncy was almost 68 percent. The highest number of non-completers came from Phase II of SCI Dallas, where nearly 48 percent of treatment group participants did not complete the program. There were significant differences between completers and not completers across sites. More specifically, clients from SCI Somerset were more likely to have completed the program than clients from the other sites ($\chi^2 = 6.192$; $p = .05$). There were no significant differences in completion percentages across phases of MIDAS.

Table 7 presents the frequency distribution and percentages of reasons for not completing the program disaggregated by piloting institution. There were 73 individuals who did not complete the program, but reasons for non-completion were available for only 63 of the participants. The most common reason for not completing the program is that the participants were paroled before program completion (32.2% of SCI Dallas participants, 24.1% of Somerset participants, and 15.4% of SCI Muncy participants). Additional reasons for non-completion were cell isolation (16 participants across sites) and quitting the program (9 participants across sites).

Table 6. Treatment Group Completion Status by Location and Phase

Site*	Completers (N=135)		Non-Completers (N=73)	
	N	%	N	%
<u>SCI Muncy</u>				
Phase I	10	25.0	4	10.0
Phase II	9	22.5	5	12.5
Phase III	8	20.0	4	10.0
Percent Completed = 67.5				
<u>SCI Dallas</u>				
Phase I	13	19.7	10	15.2
Phase II	13	19.7	15	22.7
Phase III	9	13.6	6	9.1
Percent Completed = 53.0				
<u>SCI Somerset</u>				
Phase I	22	21.6	13	12.7
Phase II	29	28.4	5	4.9
Phase III	22	21.6	11	10.8
Percent Completed = 71.6				

* $\chi^2 = 6.192$; $p = .045$. Participants from SCI Somerset were more likely to complete the program than participants from other sites. There was no difference across phases ($\chi^2 = .345$; $p = .842$).

Note: Column percentages represent the overall percent of completers or non-completers for each phase. For example, for SCI Muncy, 10 people successfully completed the program in phase one and there was a total of 40 treatment group participants across all three phases. Thus, 25 percent (10/40) of the all completers for SCI Muncy were in phase I.

Table 7. Treatment Group Reasons for Non-Completion by Institution

Dropout Reasons	SCI Dallas (N=31)		SCI Somerset (N=29)		SCI Muncy (N=13)	
	N	%	N	%	N	%
Paroled	10	32.3	7	24.1	2	15.4
Cell Isolation	5	16.1	8	27.6	3	23.1
Verified GED	5	16.1	0	0.0	0	0.0
Verified H.S Diploma	1	3.2	0	0.0	0	0.0
Transferred to Other Program Or Institution	2	6.5	3	10.3	1	7.7
Misconduct	4	12.9	0	0.0	0	0.0
Quit	4	12.9	2	6.9	3	23.1
Medical Reason	0	0.0	1	3.4	0	0.0
Deceased	0	0.0	1	3.4	0	0.0
Cannot Read	0	0.0	1	3.4	0	0.0
Reason Not Given	0	0.0	6	20.7	4	30.8

Table 8 depicts frequency and percentage distributions of demographic characteristics for program completers and non-completers.⁵ Most of the participants who completed the program (35.6%) fell under the 40 and older age category. Most non-completers (38.9%) were in the 30-39 age category. The statistics presented in Table 8 show that the two groups were similar in the distribution of the other demographic characteristics, with the majority of both groups being male and black. There were no statistical differences between completers and non-completers on age, race, or gender.

Table 8. Demographic Characteristics of Treatment Group Completers vs. Non-Completers

Characteristics	Completers (N=135)		Non-Completers (N=73)	
	N	%	N	%
<u>Age (N=207)</u>				
Less than 29	44	32.6	22	30.6
30-39	43	31.9	28	38.9
40 and older	48	35.6	22	30.6
$\bar{x} = 36.1$	$\bar{x} = 36.5$		$\bar{x} = 35.3$	
t = .819; p = .414				
<u>Race (N=205)</u>				
White	26	19.5	19	26.4
Black	76	57.1	41	56.9
Hispanic	31	23.3	12	16.7
$\chi^2 = 1.978$; p = .372				
<u>Gender</u>				
Male	108	80.0	60	82.2
Female	27	20.0	13	17.8
$\chi^2 = .147$; p = .702				

⁵ See Appendix A for the frequency and percentage distributions of demographic characteristics for program completers and non-completers disaggregated by site.

Table 9 presents the frequency and percent distribution of the assessment measures for the program completers and non-completers. The majority of the completers were medium risk (43.7%) on the LSI-R, while about half of the non-completers fell under the high-risk category. Most of the completers (42.0%) scored low on the TCU scale, while the majority of non-completers scored in the medium range (52.2%).⁶ For the CSS-M, most completers (37.7%) scored in the low category, while most non-completers (38.1%) scored in the high category. Finally, on the HIQ Scale most completers (46.9%) fell into the medium risk category, while most non-completers (47.6%) fell into the high risk category. There were no statistical differences between completers and non-completers of MIDAS on LSI-R risk or CSS-M score. Statistical analyses could not be conducted on the TCU Addictions scale or HIQ scale because of small cell values

⁶ An independent t-test found a significant difference between the score distribution of completers and non-completers for the TCU assessment. Specifically, completers of the MIDAS program had significantly lower scores on the TCU assessment when compared to non-completers.

Table 9. Frequency and Percent Distribution of Assessment Measures for Treatment Group Completers vs. Non-Completers

Scale	Completers (N=135)		Non-Completers (N=73)	
	N	%	N	%
<u>LSI-R Risk/Need Levels</u> (N=207)				
Low Risk	18	13.3	8	11.1
Medium Risk	59	43.7	27	37.5
High Risk	58	43.0	37	51.4
$\chi^2 = 1.346; p = .510$				
<u>TCU Addiction Scale[†]</u> (N=73)*				
Low	21	42.0	4	17.4
Medium	16	32.0	12	52.2
High	13	26.0	7	30.4
<u>CSS-M Scale (N=74)</u>				
Low	20	37.7	6	28.6
Medium	17	32.1	7	33.3
High	16	30.2	8	38.1
$\chi^2 = .657; p = .720$				
<u>HIQ Scale (N=70)[†]</u>				
Low Risk	9	18.4	4	19.0
Medium Risk	23	46.9	7	33.3
High Risk	17	34.7	10	47.6

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five. Note: Independent t-tests were calculated using the continuous scores of each scale. The results were as follows: LSI-R (t = -.319; df = 205; p = .750); TCU (t = -2.086; df = 71; p = .041); CSS-M (t = -1.174 df = 72; p = .244); HIQ (t = -1.238; df = 68; p = .226).

SUMMARY OF FINDINGS FROM THE CPC

While the full CPC report is provided in Appendix B, the following is a summary of the findings:

- Overall, the MIDAS program rating received a score of 43 percent. This score falls into the “Ineffective” category.
- The “Capacity” score, which is designed to measure whether the program has the capability to deliver evidence based interventions and services for offenders, was 60 percent. This score falls into the “Effective” category.
- The “Content” score, which focuses on the substantive domains of assessment and treatment, was 34 percent. This score falls into the “Ineffective” category.
- Program leadership and offender assessment domains scored as highly effective; staff and quality assurance domains scored as “Needs Improvement”; and the treatment characteristics domain scored as “Ineffective.”
- As it now exists, the MIDAS program is more educational than cognitive behavioral. It is recommended that the program have a clear model based on research (i.e., a cognitive behavioral approach within a structured skill building model), and that all staff are trained in the application and practice of this model.

SUMMARY OF PROCESS EVALUATION FINDINGS

This section provides a summary of the findings from the current process evaluation. The typical program participant is male, black, and has an average age of 36. Furthermore, the typical participant scores high on the LSI-R. While much of the data for the Criminal Sentiments Scale, the Static 99, the TCU Addictions II Scale and the Hostile Interpretations Questionnaire were not available for all offenders, frequency and percentage distributions were computed with the accessible scores. There were no significant differences between the participants belonging to either group on any of the assessment instruments, with the exception of the HIQ.

As designed in the MIDAS treatment modality, all program participants that were part of the treatment group received the same services. Participants completed treatment services that

targeted education, financial skills, family and communication skills, and employability skills. The delivery of the MIDAS modules was very similar across all three sites, although some differences existed in the curricula offered in each of the pilot sites.

For eligible MIDAS participants, the three pilot sites differed in their enrollment and attendance practices. SCI Dallas and SCI Somerset had a mandatory attendance policy for eligible offenders (randomly assigned to the treatment group), while participation in MIDAS was voluntary at SCI Muncy. As a result, the mandatory institutions were also likely to administer sanctions for non-participation, while SCI Muncy did not sanction non-participation in the program. Commonly used sanctions were loss of privileges, such as a job, cell restriction, and mandatory re-enrollment in the program if attendance was poor.

Information was also obtained on program completion rates. Sixty-five percent of the treatment group completed the program, although completion rates varied among pilot sites. The SCI Somerset site had the highest completion rates with almost 72 percent of their participants completing the program, while SCI Muncy had almost a 68 percent completion rate, followed by SCI Dallas with a 53 percent completion rate. Typically, participants did not complete the program because they were re-paroled. Other major reasons for non-completion were being sanctioned to cell restriction and voluntarily quitting the program.

Comparing the characteristics of participants who completed the program versus those who did not revealed that the two groups did not demonstrate many key differences. Both completers and non-completers had the same characteristics of the typical program participants. As such, the typical participant from each of the groups was black, committed a violent crime and scored high on the LSI-R. Furthermore, statistical analyses reported no differences between program completers and non-completers.

In addition, this evaluation also included an Evidence-Based Correctional Program Checklist (CPC) that examined how the program adhered to the principles of effective intervention. The CPC also provided specific recommendations for the MIDAS program to encourage a closer resemblance to the ideal correctional program. CPC results scored the program as ineffective; however, The “Capacity” score, which is designed to measure whether the program has the capability to deliver evidence based interventions and services for offenders, fell into the effective category, while the “Content” score, which focuses on the substantive domains of assessment and treatment, fell into the ineffective category. This suggests that program has the tools in place to deliver successful interventions, but the services lack the necessary content to produce changes. The full CPC report is included in Appendix B.

Overall, the evaluation indicates that the three sites in which MIDAS was piloted are following the program design for the most part. The data and site visitations indicated that there were some problems implementing the program as designed. As one example, the program was designed for medium and high risk individuals, yet slightly over 13 percent of the sample was categorized as low risk on the LSI-R. Additionally, sites differed slightly on the curricula they used during program implementation, and in administering of the assessment tests. Also, much of the risk/need assessment data were not available. However, the majority of the participants met the eligibility criteria to receive the treatments offered by MIDAS.

This is one of two reports evaluating the effectiveness of the MIDAS program. The outcome evaluation will focus on re-incarceration and re-arrest rates, employment and job retention rates, educational progress, and attainment of pro-social life and financial management skills.

Appendix A

Table A-1. Frequency and Percent Distribution of Demographic Measures by Group Type (Control or Treatment) for SCI

Dallas

Scale	Treatment (N=66)	%	Control (N=60)	%	Total Sample (N=126)	%
<u>Age</u>						
21-24	4	6.1	1	1.8	5	4.1
25-29	14	21.2	6	10.5	20	16.3
30-34	8	12.1	10	17.5	18	14.6
35-39	10	15.2	13	22.8	23	18.7
40-44	15	22.7	10	17.5	25	20.3
45-49	5	7.6	7	12.3	12	9.8
50-54	4	6.1	5	8.8	9	7.3
55-59	5	7.6	4	7.0	9	7.3
60-64	0	0.0	0	0.0	0	0.0
65 and over	1	1.5	1	1.8	2	1.6
Total	66	100.0	57	95.0	123	97.6
t= -1.070; p=.287						
<u>Race</u>						
White	14	21.9	13	28.2	27	22.3
Black	39	60.9	33	57.9	72	59.5
Hispanic	11	17.2	11	19.3	22	18.2
Native American	0	0.0	0	0.0	0	0.0
Total	64	97.0	57	95.0	121	96.0
$\chi^2 = .133$; p=.936*						

*The Native American category was not used in the analysis because it contains only one participant.

Table A-1. Frequency and Percent Distribution of Demographic Measures by Group Type (Control or Treatment) for SCI

Dallas cont.

Scale	Treatment (N=66)	%	Control (N=60)	%	Total Sample (N=126)	%
<u>LSI Risk/Need Levels</u>						
Low Risk	8	12.1	5	8.8	13	10.6
Medium Risk	23	34.8	28	49.1	51	41.5
High Risk	35	53.0	24	42.1	59	48.0
Total	66	100.0	57	95.0	123	97.6
$\chi^2 = 2.589; p = .274$						
<u>TCU Addiction Scale[†]</u>						
Low	8	29.6	7	41.2	15	34.1
Medium	12	44.4	9	52.9	21	47.7
High	7	25.9	1	5.9	8	18.2
Total	27	40.9	17	28.3	44	34.9

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five.

Table A-1. Frequency and Percent Distribution of Demographic Measures by Group Type (Control or Treatment) for SCI

Dallas cont.

Scale	Treatment (N=66)	%	Control (N=60)	%	Total Sample (N=126)	%
<u>CSS-M Scale</u>						
Low	9	40.9	5	27.8	14	35.0
Medium	5	22.7	5	27.8	10	25.0
High	8	36.4	8	44.4	16	40.0
Total	22	33.3	18	30.0	40	31.7
$\chi^2 = .750; p = .687$						
<u>HIQ Scale[†]</u>						
Low Risk	6	31.6	4	21.1	10	26.3
Medium Risk	5	26.3	5	26.3	10	26.3
High Risk	8	42.1	10	52.6	18	47.4
Total	19	28.8	19	31.7	38	30.2

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five.

Table A-2. Frequency and Percent Distribution of Demographic Measures by Group Type (Control or Treatment) for SCI

Somerset

Scale	Treatment (N=102)	%	Control (N=111)	%	Total Sample (N=213)	%
<u>Age</u>						
21-24	11	10.8	13	11.8	24	11.3
25-29	24	23.5	33	30.0	57	26.9
30-34	25	24.5	23	20.9	48	22.6
35-39	14	13.7	16	14.5	30	14.2
40-44	13	12.7	9	8.2	22	10.4
45-49	5	4.9	8	7.3	13	6.1
50-54	5	4.9	5	4.5	10	4.7
55-59	3	2.9	2	1.8	5	2.4
60-64	1	1.0	0	0.0	1	.5
65 and over	1	1.0	1	.9	2	.9
Total	102	100.0	110	99.1	212	99.5
t=1.204; p=.230						
<u>Race</u>						
White	23	22.5	36	32.7	59	27.8
Black	52	51.0	55	50.0	107	50.5
Hispanic	27	26.5	19	17.3	46	21.7
Native American	0	0.0	0	0.0	0	0.0
Total	102	100	110	99.1	212	99.5
$\chi^2=4.044$; p=.132*						

*The Native American category was not used in the analysis because it contains only one participant.

Table A-2. Frequency and Percent Distribution of Demographic Measures by Group Type (Control or Treatment) for SCI

Somerset cont.

Scale	Treatment (N=102)	%	Control (N=111)	%	Total Sample (N=213)	%
<u>TCU Addiction Scale</u>						
Low	15	41.7	12	46.2	27	43.5
Medium	12	33.3	5	19.2	17	27.4
High	9	25.0	9	34.6	18	29.0
Total	36	35.3	26	23.4	62	29.1
$\chi^2=1.646; p=.439$						
<u>LSI Risk/Need Levels</u>						
Low Risk	14	13.7	21	19.1	35	16.5
Medium Risk	44	43.1	30	27.3	74	34.9
High Risk	44	43.1	59	53.6	103	48.6
Total	102	100.0	110	99.1	212	99.5
$\chi^2=5.940; p=.051$						

Table A-2. Frequency and Percent Distribution of Demographic Measures by Group Type (Control or Treatment) for SCI

Somerset cont.

Scale	Treatment (N=102)	%	Control (N=111)	%	Total Sample (N=213)	%
<u>CSS-M Scale[†]</u>						
Low	9	31.0	8	27.6	17	29.3
Medium	12	41.4	2	6.9	14	24.1
High	8	27.6	19	65.5	27	46.6
Total	29	28.4	29	26.1	58	27.2
$\chi^2=11.683; p=.003$						
<u>HIQ Scale[†]</u>						
Low Risk	3	10.7	8	27.6	11	19.3
Medium Risk	17	60.7	7	24.1	24	42.1
High Risk	8	28.6	14	48.3	22	38.6
Total	28	27.5	29	26.1	57	26.8
$\chi^2=8.061; p=.018$						

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five.

Table A-3. Frequency and Percent Distribution of Demographic Measures by Group Type (Control or Treatment) for SCI

Muncy

Scale	Treatment (N=40)	%	Control (N=35)	%	Total Sample (N=75)	%
<u>Age</u>						
21-24	3	7.7	1	2.9	4	5.4
25-29	10	25.6	10	28.6	20	27.0
30-34	4	10.3	6	17.1	10	13.5
35-39	10	25.6	4	11.4	14	18.9
40-44	7	17.9	6	17.1	13	17.6
45-49	4	10.3	6	17.1	10	13.5
50-54	1	2.6	0	0.0	1	1.4
55-59	0	0.0	2	5.7	2	2.7
60-64	0	0.0	0	0.0	0	0.0
65 and over	0	0.0	0	0.0	0	0.0
Total	39	97.5	35	100.0	74	98.7
t=-.811; p=.420						
<u>Race[†]</u>						
White	8	20.5	15	42.1	23	31.1
Black	26	66.7	17	48.6	43	58.1
Hispanic	5	12.8	2	5.7	7	9.5
Native American	0	0.0	1	2.9	1	1.4
Total	39	97.5	35	100.0	74	98.7

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five.

Table A-3. Frequency and Percent Distribution of Demographic Measures by Group Type (Control or Treatment) for SCI

Muncy cont.

Scale	Treatment (N=40)	%	Control (N=35)	%	Total Sample (N=75)	%
<u>TCU Addiction Scale[†]</u>						
Low	2	20.0	2	18.2	4	19
Medium	4	40.0	1	9.1	5	23.8
High	4	40.0	8	72.7	12	57.1
Total	10	25.0	11	31.4	21	28.0
<u>LSI-R Risk/Need Levels[†]</u>						
Low Risk	4	10.3	3	19.1	7	9.5
Medium Risk	19	48.7	14	27.3	33	44.6
High Risk	16	41.0	18	53.6	34	45.9
Total	39	97.5	35	99.1	74	98.7

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five.

Table A-3. Frequency and Percent Distribution of Demographic Measures by Group Type (Control or Treatment) for SCI

Muncy cont.

Scale	Treatment (N=40)	%	Control (N=35)	%	Total Sample (N=75)	%
<u>CSS-M Scale[†]</u>						
Low	8	34.8	7	46.7	15	39.5
Medium	7	30.4	5	33.3	12	31.6
High	8	34.8	3	20.0	11	28.9
Total	23	57.5	15	42.9	38	50.7
<u>HIQ Scale[†]</u>						
Low Risk	4	17.4	5	33.3	9	23.7
Medium Risk	8	34.8	2	13.3	10	26.3
High Risk	11	47.8	8	53.3	19	50.0
Total	23	57.5	15	42.9	38	50.7

$\chi^2=2.617$; $p=.270$

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five.

Table A-4. Offense Frequency by Group Type for SCI Dallas

Scale	Treatment (N=66)	%	Control (N=57)	%	Total Sample (N=123)	%
<u>Offense Type</u>						
Violent	19	28.8	15	26.3	34	27.6
Other Violent	3	4.5	2	3.5	5	4.1
Property Related	15	22.7	12	21.1	27	22.0
Drug Related	13	19.7	20	35.1	33	26.8
Public Order	10	15.2	6	10.5	16	13.0
Sex Related	1	1.5	2	3.5	3	2.4
Institution/Sentence Related	5	7.6	0	0.0	5	4.1
Total Offenses	66	100.0	57	100.0	123	100.0

Table A-5. Offense Frequency by Race for the Full Sample of SCI Dallas (N=123)

Scale	White	Black	Hispanic	Native American
<u>Offense Type</u>				
Violent	2	25	6	0
Other Violent	1	3	1	0
Property Related	8	14	4	0
Drug Related	3	23	7	0
Public Order	10	4	2	0
Sex Related	1	2	0	0
Institution/Sentence Related	2	1	2	0
Total Offenses	27	72	22	0

Table A-6. Offense Frequency by Group Type for SCI Somerset

Scale	Treatment (N=102)	%	Control (N=110)	%	Total Sample (N=212)	%
<u>Offense Type</u>						
Violent	42	41.2	37	33.6	79	37.3
Other Violent	4	3.9	7	6.4	11	5.2
Property Related	17	16.7	13	11.1	30	14.2
Drug Related	30	29.4	35	31.8	65	30.7
Public Order	5	4.9	7	6.4	12	5.7
Sex Related	3	2.9	5	4.5	8	3.8
Institution Sentence Related	1	1.0	6	5.5	7	3.3
Total Offenses	102	100.0	110	100.0	212	100.0

Table A-7. Offense Frequency by Race for the Full Sample of SCI Somerset (N=212)

Scale	White	Black	Hispanic	Native American
<u>Offense Type</u>				
Violent	23	42	14	0
Other Violent	7	1	3	0
Property Related	15	12	3	0
Drug Related	4	43	18	0
Public Order	3	5	4	0
Sex Related	4	2	2	0
Institution Sentence Related	3	2	2	0
Total Offenses	59	107	46	0

Table A-8. Offense Frequency by Group Type for SCI Muncy

Scale	Treatment (N=39)	%	Control (N=35)	%	Total Sample (N=74)	%
<u>Offense Type</u>						
Violent	18	46.2	10	28.6	28	37.8
Other Violent	1	2.6	3	8.6	4	5.4
Property Related	8	20.5	8	22.9	16	21.6
Drug Related	8	20.5	10	28.6	18	24.3
Public Order	1	2.6	2	5.7	3	4.1
Sex Related	2	5.1	0	0.0	2	2.7
Institution/Sentence Related	1	2.6	2	5.7	3	4.1
Total Offenses	39	100.0	35	100.0	74	100.0

Table A-9. Offense Frequency by Race for the Full Sample of SCI Muncy (N=74)

Scale	White	Black	Hispanic	Native American
<u>Offense Type</u>				
Violent	3	20	5	0
Other Violent	3	0	1	0
Property Related	8	7	1	0
Drug Related	5	12	0	1
Public Order	2	1	0	0
Sex Related	0	2	0	0
Institution/Sentence Related	2	1	0	0
Total Offenses	23	43	7	1

Table A-10. Demographic Characteristics of Completers vs. Non-Completers for SCI Dallas (N=66)

Scale	Completers (N=35)	%	Non-Completers (N=31)	%
<u>Age</u>				
21-24	1	2.9	3	9.7
25-29	7	20.0	7	22.6
30-34	4	11.4	4	12.9
35-39	3	8.6	7	22.6
40-44	10	28.6	5	16.1
45-49	3	8.6	2	6.5
50-54	3	8.6	1	3.2
55-59	3	8.6	2	6.5
60-64	0	0.0	0	0.0
65 and over	1	2.9	0	0.0
Total	35	100.0	31	100.0
t=-2.115; p=.038*				
<u>Race^{††}</u>				
White	6	18.2	8	25.8
Black	21	63.6	18	58.1
Hispanic	6	18.2	5	16.1
Native American	0	0.0	0	0.0
Total	33	100.0	31	100.0
$\chi^2 = .545; p = .761$				
<u>LSI Risk/Need Levels[†]</u>				
Low Risk	2	5.7	6	19.4
Medium Risk	12	34.3	11	35.5
High Risk	21	60.0	14	45.2
Total	35	100.0	31	100.0

*p<.05

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five.

^{††}The Native American category was not used in the analysis.

Table A-10. Demographic Characteristics of Completers vs. Non-Completers for SCI

Dallas (N=66) cont.

Scale	Completers (N=35)	%	Non- Completers (N=31)	%
<u>TCU Addiction Scale[†]</u>				
Low	7	43.8	1	9.1
Medium	6	37.5	6	54.5
High	3	18.8	4	36.4
Total	16	100.0	11	100.0
<u>CSS-M Scale[†]</u>				
Low	5	38.5	4	44.4
Medium	4	30.8	1	11.1
High	4	30.8	4	44.4
Total	13	100.0	9	100.0
<u>HIQ Scale[†]</u>				
Low Risk	3	27.3	3	37.5
Medium Risk	3	27.3	2	25.0
High Risk	5	35.5	3	37.5
Total	11	100.0	8	100.0

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five.

Table A-11. Demographic Characteristics of Completers vs. Non-Completers for SCI

Somerset (N=102)

Scale	Completers (N=73)	%	Non- Completers (N=29)	%
<u>Age</u>				
21-24	7	9.6	4	13.8
25-29	21	28.8	3	10.3
30-34	15	20.5	10	34.5
35-39	9	12.3	5	17.2
40-44	9	12.3	4	13.8
45-49	5	6.8	0	0.0
50-54	4	5.5	1	3.4
55-59	2	2.7	1	3.4
60-64	1	1.4	0	0.0
65 and over	0	0.0	1	3.4
Total	73	100.0	29	100.0
t=.403; p=.688				
<u>Race^{††}</u>				
White	14	19.2	9	31.0
Black	38	52.1	14	48.3
Hispanic	21	28.8	6	20.7
Native American	0	0.0	0	0.0
Total	73	100.0	29	100.0
$\chi^2 = 1.864$; p=.394				
<u>LSI-R Risk/Need Levels[†]</u>				
Low Risk	13	17.8	1	3.4
Medium Risk	31	42.5	13	44.8
High Risk	29	39.7	15	51.7
Total	73	100.0	29	100.0

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five.

^{††}The Native American category was not used in the analysis.

Table A-11. Demographic Characteristics of Completers vs. Non-Completers for SCI

Somerset (N=102) cont.

Scale	Completers (N=73)	%	Non- Completers (N=29)	%
<u>TCU Addiction Scale</u> [†]				
Low	12	44.4	3	33.3
Medium	8	29.6	4	44.4
High	7	25.9	2	22.2
Total	27	100.0	9	100.0
<u>CSS-M Scale</u> [†]				
Low	8	36.4	1	14.3
Medium	8	36.4	4	57.1
High	6	27.3	2	28.6
Total	22	100.0	7	100.0
<u>HIQ Scale</u> [†]				
Low Risk	3	15.0	0	0.0
Medium Risk	13	65.0	4	50.0
High Risk	4	20.0	4	50.0
Total	20	100.0	8	100.0

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five.

Table A-12. Demographic Characteristics of Completers vs. Non-Completers for SCI

Muncy (N=39)

Scale	Completers (N=27)	%	Non- Completers (N=12)	%
<u>Age</u>				
21-24	2	7.4	1	8.3
25-29	6	22.2	4	33.3
30-34	4	14.8	0	0.0
35-39	8	29.6	2	16.7
40-44	2	7.4	5	41.7
45-49	4	14.8	0	0.0
50-54	1	3.7	0	0.0
55-59	0	0.0	0	0.0
60-64	0	0.0	0	0.0
65 and over	0	0.0	0	0.0
Total	27	100.0	12	100.0
t=-.416; p=.680				
<u>Race[†]</u>				
White	6	22.2	2	16.7
Black	17	63.0	9	75.0
Hispanic	4	14.8	1	8.3
Native American	0	0.0	0	0.0
Total	27	100.0	12	100.0
<u>LSI-R Risk/Need Levels[†]</u>				
Low Risk	3	11.1	1	8.3
Medium Risk	16	59.3	3	25.0
High Risk	8	29.6	8	66.7
Total	27	100.0	12	100.0

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five.

Table A-12. Demographic Characteristics of Completers vs. Non-Completers for SCI

Muncy (N=39) cont.

Scale	Completers (N=27)	%	Non- Completers (N=12)	%
<u>TCU Addiction Scale</u> [†]				
Low	2	28.6	0	0.0
Medium	2	28.6	2	66.7
High	3	42.9	1	33.3
Total	7	100.0	3	100.0
<u>CSS-M Scale</u> [†]				
Low	7	38.9	1	20.0
Medium	5	27.8	2	40.0
High	6	33.3	2	40.0
Total	18	100.0	5	100.0
<u>HIQ Scale</u> [†]				
Low Risk	3	16.7	1	20.0
Medium Risk	7	38.9	1	20.0
High Risk	8	44.4	3	60.0
Total	18	100.0	5	100.0

[†]Chi-square analyses could not be conducted on these variables because a cell value was less than five.

Appendix B

Draft Report

Evidence-Based Correctional Program Checklist[®]

Making Intelligent Decisions and Succeeding (MIDAS) Program

SCI Dallas, SCI Somerset, SCI Muncy, CA

Conducted September, 2007

CONTEXT AND SCOPE OF THE EVALUATION

Research in the field of corrections suggests that cognitive behavioral and social learning models of treatment for offenders are associated with considerable reductions in recidivism, whereas more “traditional” approaches (e.g., incarceration, boot camps, 12-step programs, etc.) are not (Gendreau, 1996; Smith, Goggin & Gendreau, 2005).

The objective of this assessment is to conduct a detailed review of services and program materials, and to compare the current practices with the literature on “best practices” in corrections. More specifically, this assessment will determine whether the treatment interventions are consistent with the research literature on evidence-based practices and the principles of effective intervention (see Andrews & Bonta, 2003 for a review). Recommendations to enhance the effectiveness of the services delivered by the Making Intelligent Decisions and Succeeding (MIDAS) program are offered in what follows.

SUMMARY OF THE PROGRAM

MIDAS is a program designed for the Pennsylvania Department of Corrections (PADOC) parole violators. To participate in the program the parole violators are required to have a score of 21 or greater on the LSI-R. Furthermore, to be eligible, participants are required to have at least six months, but no more than twelve months, before their parole review. The program is designed to target the offenders’ lack of pro-social skills in various areas including relationships, employment, and money management. The program is offered for three hours every weekday and lasts 90 days.

MIDAS was piloted in three State Correctional Institutions (SCIs): SCI Dallas, SCI Somerset, and SCI Muncy. Both SCI Dallas and SCI Somerset house male offenders, while SCI Muncy is a women's correctional institution.

PROCEDURES

Description of the Evidence-Based Correctional Program Checklist (CPC)

The CPC is a tool designed to assess correctional programs,⁷ and is used to ascertain how closely these interventions adhere to the principles of effective intervention. Several recent studies conducted by the University of Cincinnati, on both adult and juvenile samples, were used to develop and validate the indicators included on the CPC.⁸ These studies yielded strong correlations with outcome between individual items, domain scores, as well as overall scores (Holsinger, 1999; Lowenkamp, 2003; Lowenkamp & Latessa, 2003; Lowenkamp & Latessa, 2005a; Lowenkamp & Latessa, 2005b).

The CPC is divided into two basic areas: (1) CAPACITY and (2) CONTENT. The CAPACITY area is designed to measure whether or not a correctional program has the capability to deliver evidence-based interventions and services for offenders. There are three sub-components in this area: (1) LEADERSHIP AND DEVELOPMENT, (2) STAFF CHARACTERISTICS, and (3) QUALITY ASSURANCE. On the other hand, the CONTENT area focuses on the substantive domains of OFFENDER ASSESSMENT and TREATMENT. The CPC includes a total of 77 items and 83 points as some items are weighted. Both areas and

⁷ The CPC is modeled after the Correctional Program Assessment Inventory developed by Gendreau and Andrews (1996); however, the CPC includes a number of items not contained in the CPAI. In addition, items were deleted that were not found to be positively correlated with recidivism.

⁸These studies involved over 40,000 offenders (both adult and juvenile), and over 400 correctional programs, ranging from institutional to community-based. All of the studies are available on our website (www.uc.edu/criminaljustice). A large part of this research involved the identification of program characteristics that were correlated with outcome.

all domains are scored and rated as either HIGHLY EFFECTIVE (65% to 100%); EFFECTIVE (56% to 64%); NEEDS IMPROVEMENT (46% to 55%); or INEFFECTIVE (45% or less).

The scores in all five domains are then totaled and the same scale is used for the overall assessment score. It should be noted that not all of the five domains are given equal weight, and some items may be considered NOT APPLICABLE in which case they are not included in the scoring.

There are several limitations to the CPC that should be discussed. First, the instrument is based on an “ideal” type. The criteria have been developed from a large body of research and knowledge that combines the best practices from the empirical literature on “what works” in reducing recidivism. Second, as with all applied research, objectivity and reliability are important considerations. Although steps are taken to ensure that the information that is gathered is accurate and reliable, decisions about the information and data gathered are invariably made by the assessor given the nature of the process. Third, the process is time-specific; that is, the results describe the program at the time of the assessment. Changes or modifications may be under development, but only those activities and processes that are present at the time of the review are scored. Fourth, the process does not take into account all system issues that can affect the integrity of the program. Lastly, the process does not address why a problem exists within a program.

Despite these limitations, there are a number of advantages to this process. First, the criteria are based on empirically-derived principles of effective intervention. Second, the process provides a measure of program integrity and quality; in other words, it provides insight into the “black box” of the program, and this is something that an outcome study alone does not provide. Third, the results can be ascertained relatively quickly. Fourth, it identifies both the strengths

and weaknesses of the intervention. It provides the program with feedback regarding what it is doing that is consistent with the research on effective interventions, as well as those areas that need improvement. Fifth, it generates some useful recommendations for program improvement. Finally, it allows for comparisons with other programs that have been assessed using the same criteria. Since program integrity and quality can change over time, it allows a program to reassess its progress at a later date.

Norm Information

Researchers at the University of Cincinnati have assessed over 550 programs nationwide, and have developed a large database on correctional intervention programs.⁹ Approximately 7 percent of the programs assessed have been classified as HIGHLY EFFECTIVE, 18 percent have been classified as EFFECTIVE, 33 percent have been classified as NEEDS IMPROVEMENT, and 42 percent have been classified as INEFFECTIVE.¹⁰

Assessment Process

The assessment process consisted of a series of structured interviews with staff members and program participants during on-site visits to SCI Dallas, SCI Somerset and SCI Muncy in August, 2007. Additionally, data were gathered via the examination of relevant program materials. Finally, evaluators observed treatment groups. Three evaluators conducted the various interviews and observations. Data from the various sources were then combined to generate a consensus CPC score and the specific recommendations in what follows.

Of note, because MIDAS was piloted in three locations, the scores of this CPC are a combination of the observations at all locations.

⁹ Several versions of the CPAI were used prior to the development of the CPC. Scores and averages have been adjusted as needed.

¹⁰ The previous categories used were VERY SATISFACTORY, SATISFACTORY, NEEDS IMPROVEMENT, and UNSATISFACTORY.

PROGRAM LEADERSHIP AND DEVELOPMENT

The first sub-component of this section examines the qualifications and involvement of the program director (i.e., the individual responsible for overseeing the daily operations of the program), his/her qualifications and experience, his/her current involvement with the staff and the program participants, as well as the development, implementation, and support (i.e., both organizational and financial) for the program.

The second sub-component of this section concerns the initial design of the program. Effective interventions are designed to be consistent with the literature on effective correctional treatments, and program components should be piloted before full implementation. The values and goals of the program should also be consistent with existing values in the community and/or institution, and it should meet an identified need. Lastly, the program should be perceived as both cost effective and sustainable.

The MIDAS program was delivered through the State Correctional Institutions' schools. In SCI Dallas Marty Walsh was the School Principal and was identified as the Program Director. In SCI Somerset, Michael Pribish was the School Principal and was identified as the Program Director. In SCI Muncy, Richard Shuler was the School Principal and was identified as the Program Director. Furthermore, Mary Jane Londis, the Acting Director of the Bureau of Corrections Education, was supervising the MIDAS implementation in all three pilot sites and was also interviewed for the purposes of this CPC.

Strengths:

The first area concerns the qualifications and involvement of the program director or the person responsible for overseeing the daily service operations in the facility. All three school

principals and Ms. Londis have the adequate education and extensive experience in working with offender populations. Furthermore, all three principals are directly involved in hiring staff.

The program was designed as a result of a study done by the Pennsylvania Department of Corrections regarding the needs of parole violators. The study cited some relevant research conducted on an offender population and provided directives on what the model of the MIDAS program should be.

The program is being piloted in multiple sites on both male and female populations and with a control and a treatment group.

Treatment groups are single sex groups.

Areas that Need Improvement:

While it is evident that some staff and the program designers are familiar with the “what works” literature, this knowledge is not being disseminated among staff members that facilitate treatment groups.

Program directors are not actively involved in training and active supervision of staff. Furthermore, none of the program directors are involved in direct treatment delivery. Supervision of service delivery staff is not systematic and continuous.

Rating: HIGHLY EFFECTIVE

Recommendations:

- It is important for the program to have a clear model based on relevant research findings. Furthermore, it is important that all staff members have a thorough understanding of the “what works” literature. A literature search on “what works” should be conducted and it should include major criminological and psychological journals, as well as key texts. Some examples of these texts are: *Correctional Counseling and Rehabilitation* by Patricia Van Voorhis, Michael Braswell, and David Lester, *Choosing Correctional Options That Work Defining the Demand and Evaluating the Supply* edited by Alan Harland, and *Contemporary Behavior Therapy* by Michael Spiegler and David Guevremont. Journals to be regularly reviewed should, at a minimum, include: *Criminal Justice and Behavior*, *Crime and Delinquency*, and *The Journal of Offender*

Rehabilitation. Collectively, these sources will provide information about assessment and programming that can be applied to groups and services delivered by the program. It is important that the core program and all of its components be based on a coherent theoretical model with empirical evidence demonstrating its effectiveness at reducing recidivism among offender populations (i.e., cognitive behavioral and social learning therapies).

- The director of the program should be involved in regularly delivering services to clients. This may include co-facilitating treatment groups to ensure they are operating as designed or supervising a small caseload of clients. This direct involvement in service delivery will help ensure the director is in touch with the population the program serves, is aware of the challenges staff encounter, and the resources needed to adequately perform staff duties.
- The director should be directly involved in training and supervising staff who work for the program. The director should adopt a theoretical framework to guide the services being delivered at the facility. All staff should then be trained on the purpose and mission of the program and supervised to ensure they are providing services that fall within the theoretical framework. Supervision could occur by increasing the frequency of staff meetings or developing and participating in treatment team/clinical meetings.

STAFF

This domain concerns the qualifications, experience, stability, training, supervision, values, and involvement of the program staff. Staff members considered in this section include all full-time and part-time internal and external providers who conduct groups or provide direct service/treatment to the residents. Excluded from this group are security and support staff, as well as the program director (who was evaluated in the previous section).

Strengths:

All staff members are required to abide by the institution's code of ethics. Staff have input into the program and are able to modify the program structure. They are able to bring new ideas to the treatment and implement changes in the treatment modality. Our observations, interviews, and staff surveys indicated that staff are supportive of the goals and values of the treatment program.

Areas in Need of Improvement:

While all service delivery staff had at least an associate's degree, it was not always in a helping profession. Because most of the treatment modules are being delivered by school staff, most of the service delivery staff had degrees in education or in business and financial related areas (coincidentally these staff members were selected to deliver the financial modules of the program).

While the director and all staff indicated that they have an "open door" and informal policy on discussing administrative and offender treatment issues, formal staff meetings are not held consistently.

All full time staff receive a considerable amount of on-going training. However, training consists primarily of program procedures and safety issues. There is not an adequate amount of training pertaining to theory and practice of the interventions employed by the program, or treatment modalities such as anger management or behavioral techniques. Furthermore, several staff members from all three institutions indicated that there was no training on the interventions to be offered prior to implementing the MIDAS pilot.

Treatment facilitators do not receive regular clinical supervision by a licensed clinician.

Evaluation: NEEDS IMPROVEMENT

Recommendations:

- Service delivery staff should receive formal training in the theory and practice of the interventions employed by the program. It is especially important that all staff that are conducting groups and using curricula be thoroughly trained on the proper application of the material. Staff training should also include a review of the principles of effective interventions, behavioral strategies and the application of reinforcement (both negative and positive), group facilitating, treatment planning, risk and need factors related to criminal conduct, and the use and interpretation of assessment instruments. Staff should receive a minimum of 40 hours per year of training in these areas. \

- Staff should be required to attend at least bi-monthly staff meetings to discuss new intakes, case reviews, problems, programming, phase advancement, and discharges/terminations.
- All staff should be regularly assessed on clinical and service delivery skills. This can be accomplished through regular clinical supervision from a licensed clinician such as an MSW or a psychologist.

OFFENDER ASSESSMENT

The extent to which offenders are appropriate for the service provided and the use of proven assessment methods is critical to effective treatment programs. Effective programs assess the risk, need, and responsibility of offenders, and then provide services and treatment accordingly. The Offender Assessment domain examines three areas regarding assessment: selection of offenders, the assessment of risk, need, and personal characteristics of the offender, and the manner in which these characteristics are assessed.

Strengths:

All program participants are assessed on their risk/need factors through the LSI-R. Furthermore, data indicated that many participants risk and need levels are assessed through multiple standardized assessments such as the HIQ, the CSS-M and the TCU Addictions Scale. The program targets higher risk offenders with more than 70% of the sample having a score of 21 or higher on the LSI-R. The program has developed and follows rational criteria that exclude certain types of offenders. As such, the staff interviews and data indicated that the clients served by the program appeared appropriate for the services provided.

Areas in Need of Improvement:

The offenders' responsibility factors are not assessed by the program.

Evaluation: HIGHLY EFFECTIVE

Recommendations:

- Responsivity factors that may affect treatment, such as level of motivation and readiness to change, intelligence, depression, anxiety, or verbal ability, should be assessed upon intake using standardized and objective instruments that distinguishes levels. The program may wish to implement some of the following assessments: the *Jesness Inventory* (measures antisocial personalities), an IQ test (*Culture Fair IQ test*), Texas Christian University's Institute of Behavioral Research's *Desire For Help, Treatment Readiness*, or *External Pressures* scales (measures motivational levels), *Beck's Anxiety Inventory* (measures anxiety), and *Beck's Depression Inventory* (measures depression). Once assessed, this information should be incorporated into treatment plans. Assessment of responsivity factors allows staff to alter the style of service delivery to address the key offender characteristics within the same group treatment setting. Texas Christian University Institute of Behavioral Research has developed a number of assessment tools in this regard, including several that address readiness to change and other responsivity factors. These are available from their web site: www.ibr.tcu.edu.

TREATMENT CHARACTERISTICS

This domain of the CPC examines whether or not the program targets criminogenic behavior, the types of treatment used to target these behaviors, specific treatment procedures, the use of positive reinforcement and punishment, the methods used to train offenders in new pro-social skills, and the provision and quality of aftercare services. Other important elements of effective intervention include matching the offender's risk, needs, and personal characteristics with appropriate treatment programs, treatment intensity, and staff. Finally, the use of relapse prevention strategies designed to assist the offender in anticipating and coping with problem situations is considered.

Strengths:

The length of MIDAS is 3 months, which is within the minimum recommended length of treatment for the vast majority of offenders. All classes/treatment groups are always monitored and facilitated by staff members. The rate for successful program completion should range between 65% and 85%, indicating that clients do not indiscriminately complete or get terminated

from the program. The successful program completion rate for MIDAS is 75.8%. The program has a fixed set of curricula that are to be used by service delivery staff.

Areas in Need of Improvement:

Effective correctional programs have clearly outlined criteria for successful termination. The only criterion of successful termination outlined by MIDAS is the completion of the 3 month treatment period. There is no evidence of objective assessment of the acquisition of pro-social skills and attitudes prior to determination of discharge. Treatment staff does not consistently use the structured curricula in the delivery of the treatment modalities. Furthermore, staff supplement their own material with the curricula, which contributes to program drift.

Effective correctional treatment programs vary the level of service according to the level of the client's risk. The program does not vary treatment modality intensity or duration according to the risk level of the offender. Therefore, higher risk offenders do not receive longer or more intensive treatment than the lower risk program participants.

The most effective programs are based on behavioral, cognitive-behavioral, and social learning theories. The Madison Heights and Lifeline curricula do target thinking errors somewhat and do involve cognitive restructuring components, however the behavioral and skill building components are lacking.

It is important for the majority of a program's treatment targets to be criminogenic. Equally important is the "density" of such targets, or the amount of time spent targeting criminogenic versus non-criminogenic needs. While the program does offer some treatment that targets criminogenic needs, these programs encompass less than 50% of all treatment. The majority of treatment targets are not criminogenic. Most of program modalities target non-criminogenic areas such as money management, independent living skills, education, and

parenting. In short, the MIDAS program was more education based, focusing on non-criminogenic targets. While it is appropriate to address these issues, the density at which criminogenic needs are targeted should be increased. This can be addressed by shifting the focus of MIDAS from an educational program towards a focus of treatment that targets criminogenic needs.

Therapeutic groups should not exceed 8 to 10 clients per facilitator. Currently the group size at the three sites exceeds this range. Most of the observed groups were structured as educational classes. Moreover, there does not appear to be a systematic matching of offenders to groups and staff based on responsivity characteristics obtained through standardized assessments.

If correctional programming hopes to increase offenders' engagement in prosocial behaviors, they have to be taught skills in how to do so. Staff would benefit from training in the area of modeling and teaching skills. Currently, pro-social skills are not demonstrated to offenders to ensure they practice accurately. Role-play is not occurring in groups.

One way to bring about behavioral change is to reinforce appropriate or pro-social behaviors. The most effective way to do this is for the *application* of reinforcers to outweigh punishers by a ratio of at least 4:1. Program participants are given certificates upon completion, and offenders are paid \$ 0.25 cents a day to be part of the program, but those appear to be the only reinforcers used by the program. On the other hand, an offender can be sent to cell restriction if not in compliance with the program's rules. Furthermore, the use of reinforcers and punishers should be to assist staff in modifying the behavior of the participants to a pro-social behavior. The current rewards and punishers appear to apply only to program participation. Finally, aftercare is an important component of a residential program to insure successful

transition into the community at discharge. The MIDAS program does not include an aftercare component.

Rating: INNEFFECTIVE

Recommendations:

- It is recommended that MIDAS adopt a structured cognitive behavioral approach within a structured social learning model throughout the program. Interventions based on these approaches are very structured and emphasize the importance of modeling and behavioral rehearsal techniques that engender self-efficacy, challenge of cognitive distortions, and assist offenders in developing good problem solving and self-control skills. These strategies have been demonstrated to be effective in reducing recidivism. The program needs to replace “processing groups” with a facilitated, curriculum driven, directive, skill building, and cognitive behavioral approach throughout the facility.
- Participants of the program should be systematically trained in behavioral rehearsal techniques. That is, they should be trained to observe and anticipate problem situations, and plan and rehearse alternative pro-social responses in increasingly difficult situations. This should be an integral part of the treatment, and should be routinely done throughout all components of the program. Perhaps the most efficient method for incorporating the techniques is the use of the quarter rule. That is, the first quarter of each session should review the homework that was provided from the last session. The second quarter should emphasize the introduction of the skill with the facilitators correctly modeling the skill and encouraging buy-in from the clients. The third quarter should be used to allow the client to practice the new skill with the emphasis being on the steps of the skill and not the playacting. The last quarter provides the graduated rehearsal in which the practicing of the skill becomes more difficult. While the easiest technique to practice a skill is through role-playing, additional techniques may also be used, including playing games that focus on skills and journaling.
- The use of behavioral strategies to assist offenders in developing pro-social skills needs to be increased. The basic approach to teaching skills includes: (1) defining the skills to be learned, (2) modeling the skill for the client, (3) rehearsing/role-playing the skill, (4) practicing the skill in increasingly difficult situations, and (5) providing constructive feedback. The identification of high-risk situations and subsequent skill training to avoid or manage such situations should be a routine part of all programming. Once taught in the group (or individual) setting, participants should be required to complete homework assignments that involve practicing skills in the milieu.
- It is imperative that staff follow detailed structured curricula for all of the primary treatment components, and manuals should be reviewed periodically by the staff, updated as needed, and used consistently. These manuals should detail the goals of the group, the content of the groups, and the recommended teaching methods. These manuals should be very structured so that any staff could facilitate the group by knowing the lesson number

or group topic. They should also include exercises or homework assignments that provide the juveniles with the opportunity to practice newly acquired behaviors in increasingly difficult situations (e.g., job interviews, conflicts, and family). Manuals facilitate staff training, quality assurance, and promote consistency in service delivery. All staff should consistently use the manuals in the facilitation of the treatment groups. A general curriculum to consider is *Thinking for a Change* (available from the National Institute of Corrections). It would also be beneficial to explore additional curricula that could address specific criminogenic needs such as aggression and substance abuse (e.g. *Aggression Replacement Training* and *Drug Treatment Program* (also available from NIC). These curricula will help provide structure to the groups, will facilitate consistency and development of skill activities and will help the program develop a more consistent cognitive behavioral model.

- Offenders who are at higher risk for recidivism by definition have more criminogenic needs. These clients should be required to attend additional treatment groups, dictated by needs identified through the assessment process. Thus, clients identified overall as high risk for recidivism would have longer and more intensive treatment.
- The number of reinforcers should be increased so that reinforcers outweigh punishers by a ratio of at least 4 to 1. Increasing the range or types of reinforcers used will assist with ratio improvement. Reinforcements should include social praise, tokens, certificates, and removal of aversive stimuli. One way to increase the range is to solicit desired reinforcements from the program participants. Reinforcements should also be tied to long-term pro-social behavior. Finally, staff should be consistent in the application of reinforcers and punishers. For punishers to achieve maximum effectiveness they should be administered in the following manner: escape is impossible, maximum intensity, earliest point in the deviant response, after every occurrence, immediate, alternative prosocial behaviors provided after punishment administered, and variation in the punishers. Staff should also be trained to look for negative consequences of punishment (emotional reactions, avoidance/aggression toward punishers, increased use of future punishment by offender, etc.).
- Participants and staff should be matched based on personal characteristics and responsivity characteristics (e.g., staff that work best with low functioning offenders should be assigned these cases). Participants should be assigned to groups that match best with their style of learning, motivational levels, intelligence, and other important responsivity characteristics. Once responsivity assessment tools are adopted, these tools should drive such matching.
- Treatment groups should not exceed 8 – 10 clients per facilitator, unless specifically noted in curricula used by the program.
- MIDAS should have clearly outlined criteria to determine when a participant is ready to be discharged from the program. Currently, the only completion criteria is participation in the program for 90 day. There is no consistent measurement of the acquisition of pro-

social attitudes and behaviors. Standardized instruments can be used for pre-post testing as a measure of change in attitude. Likewise, behavioral assessments can be used as pre-post tests to measure change in behavior while in the program.

- All clients should receive aftercare and these services should be arranged and planning for these services conducted before the offenders leave the program. Moreover, the aftercare component should be based on a cognitive-behavioral model.

QUALITY ASSURANCE

This domain examines the quality assurance and evaluation processes used to monitor how well the program is functioning. This includes both internal and external quality assurance mechanisms.

Strengths:

Client satisfaction surveys can be an effective tool for assessing the services provided as it affords participants with the opportunity to offer feedback. While these are mainly used for minor programmatic changes, client satisfaction surveys offer insight into how well the program is perceived by the participants. All sites had surveyed participants on program satisfaction.

Areas in Need of Improvement:

Offenders are currently not reassessed periodically with an objective standardized instrument. While they are administered the LSI-R prior to entering the program, the participants are currently not administered an on risk/need targets after completion of the program.

Rating: NEEDS IMPROVEMENT

Recommendations:

- Internal quality assurance should include systematic file reviews, client feedback, and monitoring of service delivery. Groups that are offered to the offenders should be observed periodically, with structured feedback given to facilitators and therapists. Increased monitoring would also assist administrators in having clear knowledge of the quality of the services being delivered.
- Reassessment using standardized assessment instruments is recommended.

OVERALL PROGRAM RATING

MIDAS receives an overall score of 43 percent on the CPC, which falls into the **INNEFFECTIVE** category. The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence based interventions and services for offenders is 60 percent, which falls into the **EFFECTIVE** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is 34 percent. This falls into the **INEFFECTIVE** category.

CONCLUSION

The recommendations made in each of the five CPC domains should assist the program in making necessary changes to increase program effectiveness. We recommend that care should be taken not to attempt to address all recommendations at once. In our experience, the correctional programs that find this assessment process most useful are the ones that prioritize need areas and then develop action plans to systematically address such needs. Previous programs have also been successful in improving the provision of services by formulating committees charged with developing strategies for delivering evidence-based programming.

Figure 1: MIDAS CPC Domain Scores

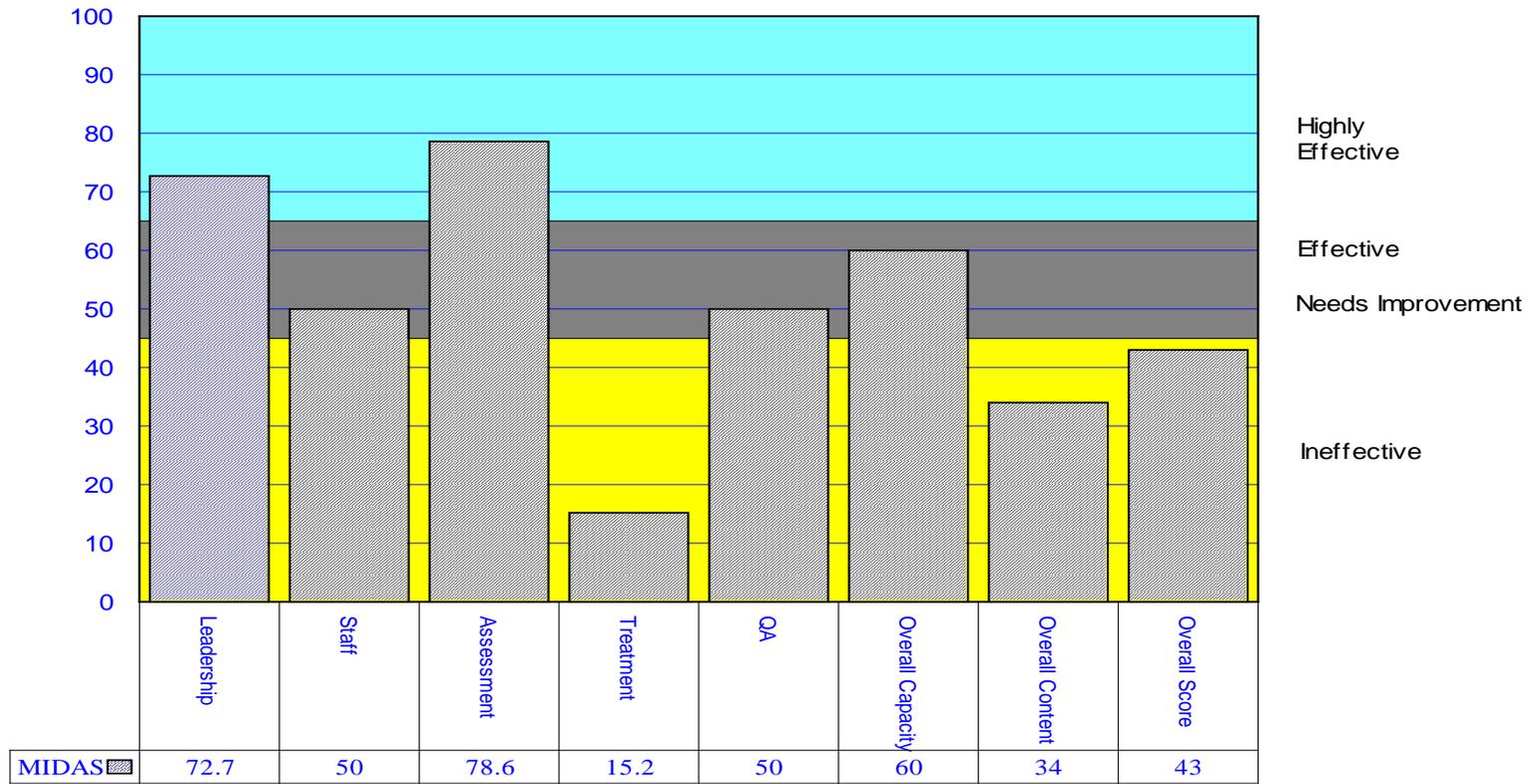
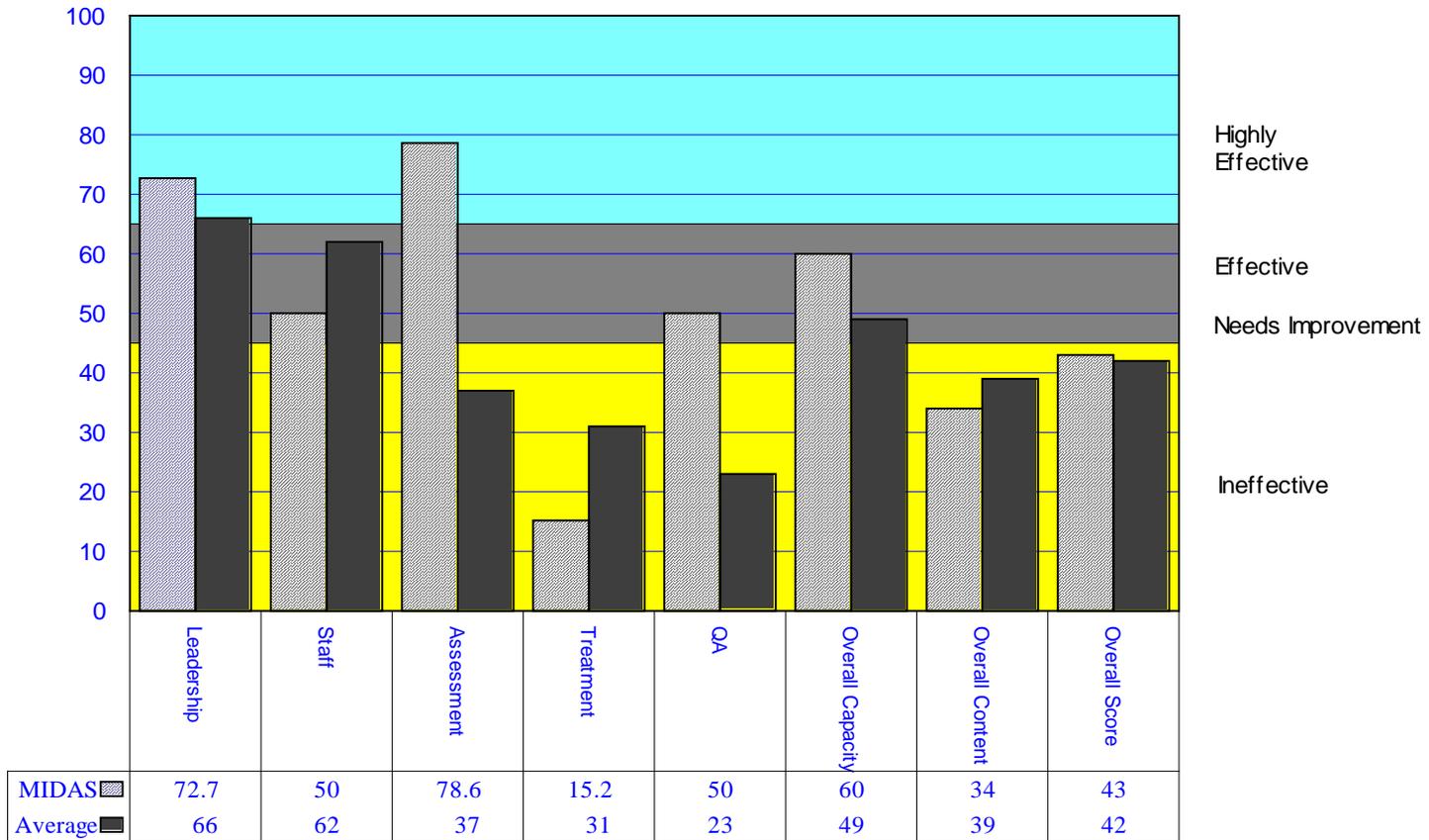


Figure 2: MIDAS CPC Scores Compared to Average Scores*



*The average scores are based on 456 results across a wide range of programs. **Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.**

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