Maine Coastal Regional Reentry Center

Breaking the Cycle

Reducing Recidivism Through Risk Reduction

(A Study of MCRRC's Reentry Program Effectiveness)

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I. INTRODUCTION

All too often programs in corrections are created and retained for a "feel-good" purpose. With corrections agencies facing limited funding and scarce resources, it is imperative that reentry programs such as the one at the Maine Coastal Regional Reentry Center (MCRRC) periodically undergo critical examination: does the program deliver evidence-based interventions/programming?; does the program achieve desired outcomes, such as risk reduction?; does the program demonstrate a positive impact on reducing recidivism?; and does the program operate in a cost-effective manner?

This study examines the MCRRC's reentry program's effect on recidivism and risk reduction, and the impact risk reduction has on recidivism. In addition, an effort is made to quantify the MCRRC program's cost effectiveness by examining bed days saved and the program's efforts to collect monetary obligations imposed by the courts (fines, restitution, and child support) and by the program (room and board), and in-kind contributions (community service work programs).

Corrections in the punitive sense has history going back to biblical times while the work around reintegration and risk reduction is relatively young. Punitive corrections has traditionally been viewed as the most cost-effective through not providing treatment, services, and interventions. The long-standing position on these treatments, services, and interventions held that the associated costs did not enhance correctional operations or make facilities any safer for staff or inmates and, thus, were an unnecessary expense. Supported by research, the current view is that the beneficial impact of providing treatments, services, and interventions within a correctional setting actually extends beyond the correctional environment and into the communities that are served, contributing to increased public safety and reduced recidivism, which outweighs the associated costs.

BACKGROUND

In 2008 the Maine Board of Corrections (BOC) was established as a means to create a unified corrections system within the state. The BOC was born on the heels of numerous studies that included the Corrections Alternatives Advisory Committee, the Maine Pretrial Study, and the Sentencing Commission Study, among others, most of which indicated deficiencies in the criminal justice system, including select county jail facility operations. Since its creation by the Maine legislature, many iterations of the original unified system have emerged, but the purpose of the BOC has remained the same:

> *" … to promote public safety; establish a unified, efficient jail system that encourages collaboration among the counties, the department and the judicial branch; and develop and implement a coordinated correctional system that demonstrates sound fiscal management, achieves efficiencies, reduces recidivism and ensures the safety and security of correctional staff, inmates, visitors, volunteers and surrounding communities."*[1]

It was apparent – almost immediately – upon implementation of the new unified system that there would not be sufficient funding to continue operating the county jail facilities in the same manner as they had been. Operating budgets were established for each county by the BOC, and funding for the system became a bifurcated process involving both County and State funds.

[1] State Board of Corrections (2015, January 8). *Purpose of the Board.* Retrieved from http://www.maine.gov/corrections/BOC/purpose.htm

Historically, counties funded jail operations through the collection of tax assessments levied against each municipality located within the county, which – in turn – was reflected in each locale's mil rate and collected as part of residential/commercial property taxes. The statute creating the new unified system capped funding for the counties' jail operations at the amount assessed by the counties in 2008.[2] The statutory cap provided for these monies to be supplemented by funding from the State of Maine through an appropriation presented as part of the Governor's budget. The State has not met its obligation to appropriate sufficient monies to cover the funding gap in the operating budgets approved by the BOC that exceed the property tax funding cap. In addition, there is a statutory provision for establishing a fund for county corrections capital improvements; it should be noted that financing of the capital expenditure budget has not been forthcoming.[3]

As stated in its purpose, the BOC was tasked with finding efficiencies, reducing recidivism, and ensuring public safety. In its efforts to find system efficiencies, the BOC examined a number of county jail facilities for downsizing that would leave 'book and bail' services in those counties while actually housing inmates at larger, more cost-efficient facilities in other counties. Cost savings from operating the smaller, more efficient facilities would be redistributed by the BOC to help bridge the gap between approved budgets and available funds. Waldo County, with a high staff-to-inmate ratio and an inefficient linear facility built in the 1970's, was one of the facilities targeted for downsizing.

In June of 2009, an application was submitted to the BOC by Waldo County which proposed that the Sheriff's Office could efficiently utilize its facility for residential reentry services. The proposed plan addressed a number of the unified corrections system's goals at the time -- sound fiscal management, coordination with state and county corrections, and, most important, a reduction in recidivism. By its very nature, reducing recidivism improves the safety and security of staff, inmates, visitors, volunteers, and the communities where the inmates will be returning.

Waldo County's application was approved and in January 2010, the Maine Coastal Regional Reentry Center opened its doors to accept adult male inmates with a moderate, high, or maximum risk of reoffending as indicated by their Level of Service Inventory – Revised (LSI-R) assessment.[4,5] Initially, these inmates came primarily from the Maine Department of Corrections' (MDOC) facilities as well as county jails from within a six-county region.[6] Over time the program expanded to include direct sentencing of individuals to the MCRRC by the courts, inmates from counties outside the six-county region and some utilization by MDOC Probation as a graduated sanction. The MCRRC is a partnership between the Waldo County Sheriff's Office-Corrections, Volunteers of America-NNE, Waldo County Commissioners, Restorative Justice Project of the Midcoast, and the communities of Waldo County.

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[2] M.S.R.A Title 30-A, §701, Subsection 2A: Annual Estimates For County Taxes
3 M.S.R.A. Title 34-A, §1811: County Corrections Capital Improvement Fund
[4] The Level of Service Inventory-Revised (LSI-R) was developed by Don A. Andrews, Ph.D. and James Bonta, Ph.D., of Ottawa, Canada. The LSI-R is an objective, quantifiable instrument that provides a consistent and valid method of predicting risk to re-offend, and a reliable means of measuring offender change over time through reassessment.
[5] While previous offenses and recent conduct are considered as part of the program's admission process, the program categorically does not allow individuals convicted of sex offenses admission to the program.
[6] The original six counties included Hancock, Knox, Lincoln, Sagadahoc, Waldo, and Washington counties.

II. MCRRC REENTRY PROGRAM

MCRRC's residential reentry program (program) is designed for individuals who have a moderate, high, or maximum risk of reoffending; programming is tailored to the individual targeting his criminogenic risk factors with the goal of ensuring that upon release, each person's risk of reoffending is reduced.

The program utilizes the Risk-Need-Responsivity (RNR) model to assess, address, and reduce criminogenic behavior as well as the latest in evidence-based programming, cognitive behavioral therapy, and innovate risk-reduction strategies. Key to the program's success is a staff that successfully implements and supports evidence-based principles that contribute to positive treatment outcomes for the MCRRC's residents.

RISK-NEED-RESPONSIVITY MODEL[7]

Developed in the 1980s and first formalized in 1990, the RNR model has been used with increasing success to assess and rehabilitate criminals around the world. As suggested by its name, it is based on three principles:

- Risk Principle
- Need Principle
- Responsivity Principle

Risk Principle

Match the level of service to the offender's risk to reoffend.

Need Principle

Assess criminogenic needs and target them in treatment.

Responsivity Principle

Maximize the offender's ability to learn from a rehabilitative intervention by providing cognitive behavioral treatment and tailoring the intervention to the learning style, motivation, abilities, and strengths of the offender. There are two parts to the responsivity principle – general and specific responsivity.

- *General Responsivity* calls for the use of cognitive social learning methods to influence behavior. Cognitive social learning strategies are the most effective regardless of the type of offender. Core correctional practices such as prosocial modeling, the appropriate use of reinforcement and disapproval, and problem solving spell out the specific skills represented in a cognitive social learning approach.
- *Specific Responsivity* is a 'fine tuning' of the cognitive behavioral intervention. It takes into account strengths, learning style, personality, motivation, and bio-social (e.g., gender, race) characteristics of the individual.

LEVEL OF SERVICE INVENTORY – REVISED

The program uses the LSI-R – a validated objective, quantifiable risk/needs assessment that

[7] D.A. Andrews, and Bonat, J. *Risk-Need-Responsivity Model for Offender Assessment and Rehabilitation*. © Her Majesty the Queen in Right of Canada. 2007.

provides a consistent and valid method of predicting risk to reoffend and a reliable means of measuring offender change over time through reassessment. In addition to measuring the risk to reoffend, it identifies the static risk factors and the dynamic risk factors (also referred to as criminogenic needs or criminogenic risk factors) that elicit criminogenic behaviors. The LSI-R categorizes these risk factors into 10 domains that include:

- Criminal History
- Education/Employment
- Finances
- Family/Marital
- Accommodations
- Leisure/Recreation
- Companions
- Alcohol/Drugs
- Emotional/Personal
- Attitudes/Orientation

Some of these domains are dynamic and can change so as to effect a positive outcome (decreased risk), while others are static and can only change in one direction (increased risk) and are immutable to treatment intervention. For example, dynamic domains would be a person who is unemployed (employment domain) and has unmanageable debt (finances domain). Employment has the potential to change both of these domains. A person's criminal history is an example of a static domain – it will not change in a positive direction.

The LSI-R measures the level of risk for recidivism for an individual. Each domain receives its own score, which are then tallied to create a total score that indicates a person's risk level. Table I.1 outlines the LSI-R's risk levels and corresponding total scores. By lowering scores on individual domains, the total score is reduced and, hence, a person's risk to reoffend is also lowered.

Table I.1: LSI-R Risk Level and Total Scores

Risk Level	Total Scores (Range)
Administrative	≤13
Low	14 – 20
Moderate	21 – 25
High	26 – 31
Maximum	≥32

MENTORS

Mentoring is viewed as an important component of the program, providing additional opportunities for residents to receive psychosocial support on a one-on-one basis. It is intended to afford residents a personalized means to further develop knowledge and skills learned in the program through a prosocial relationship. Mentors are assigned early in the program and the mentor is expected to continue a supportive relationship with the resident during his first 90 days following post-program release. It is important to note that the mentor/mentee relationship may not always be a good fit and there may be a need to change mentors.

III. METHODOLOGY

The study sought to understand the program's impact on recidivism rates and changes in risk levels for residents who successfully completed the program.

STUDY POPULATION

The first step required identifying the sample that would comprise the study population, which would be the subject of this study. The study population includes every resident since the program's inception who was admitted to and successfully completed the program and returned to the community. It does not include those residents who were prematurely terminated from the program due to program violations or voluntary withdrawal. It is based on a single point-in-time snapshot of residents who were released from the program between 05/01/2010 and 11/25/2014). The study population includes 126 male residents.

DATA SOURCE

The second step was to collect data that provided the necessary data/information to describe and analyze the study population in a format that would lend itself to analysis.

Study Population Profile

MCRRC case records were used to create a profile of the study population that looked at:

- Demographics
- Level of Service Inventory – Revised
- Program duration

Recidivism Rates

For purposes of establishing recidivism rates, the analysis is premised on data/information obtained from the Maine State Bureau of Identification (SBI), which provided data regarding new arrests or convictions resulting in a resident's incarceration occurring post-program release. Additional data that supplemented or clarified the SBI data were obtained through the following sources:

- Maine Correctional Information System (CORIS®[8])
- Courts
- District Attorneys' Offices

The SBI records most arrests for criminal offenses and records all conviction data for individuals subject to Maine's criminal justice system.

While every effort was made to assure the accuracy of this study, there was one limiting factor in the data. Any resident who left the state of Maine and committed a criminal offense in other states would not be known to this study. Therefore, for purposes of this study, these residents

[8] MDOC utilizes CORIS, which is a web-based offender management system that enables jurisdictions to manage offenders under community and institutional supervision. CORIS implements a single electronic offender record and centralized database that authorized stakeholders may use to obtain a thorough view of the offender's history, current status, risk profile, and sentencing/release information. (2015, January 22). Retrieved from http://www.coris.net

are included as non-reoffenders.

Risk Reduction Rates

For purposes of establishing risk reduction rates, the study relied on LSI-R scores obtained from assessments conducted by the MDOC and MCRRC upon admission to and completion of the program.

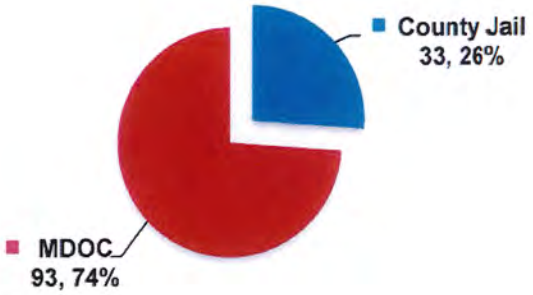
IV. STUDY POPULATION PROFILE

The study population profile was developed based on an examination of case records maintained by the MCRRC, which provided detailed information regarding the 126 male residents who successfully completed the program at the MCRRC since its opening in 2010.

DEMOGRAPHICS

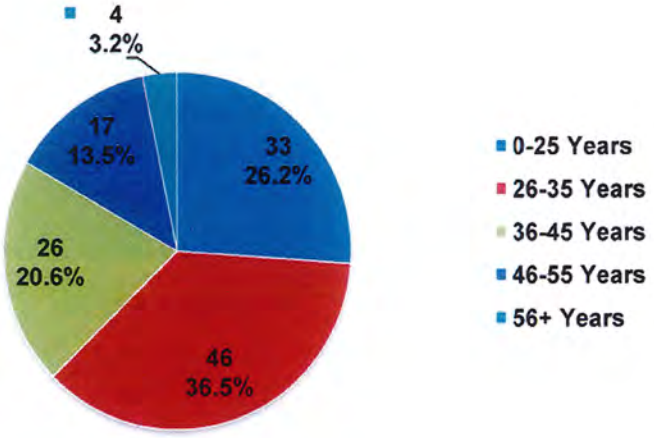
Figure IV.1 presents the study population by originating agency. Residents originating from MDOC facilities comprise 74% of the study population.

Figure IV.1: Study Population by Originating Agency



Of the 126 residents who successfully completed the program at the MCRRC, in terms of racial composition, 92.9% (117) were white and 7.1% (9) were classified as 'other.' The mean age was 33.9 years and the median (the midpoint of the data) was 31 years. Figure IV.2 presents the study population by age group.

Figure IV.2: Study Population by Age



A majority percentage (76.2%) of the study population single. Table IV.1 breaks out the study population by marital status.

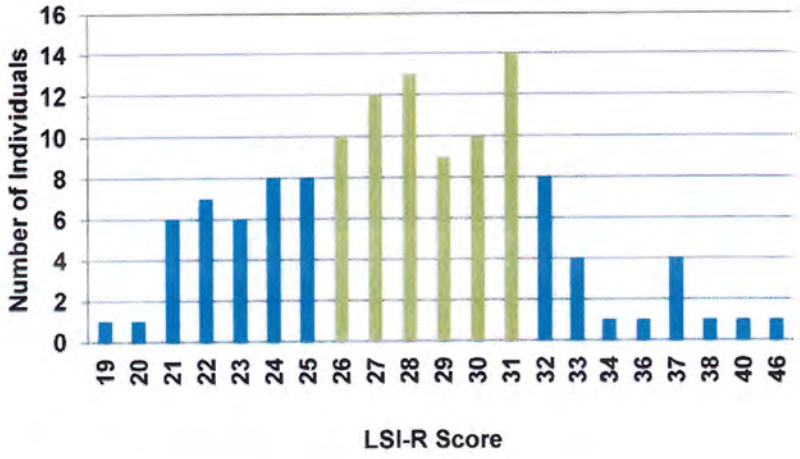
Table IV.1: Study Population by Marital Status

Marital Status	N	%
Single	96	76.2%
Divorced	14	11.1%
Widowed	1	0.8%
Married	0	0.0%
Unreported	15	11.9%
Total	**126**	**100.0%**

Level of Service Inventory – Revised

Figure IV.3 presents the LSI-R score at the time of admission to the program for each resident in the study population. At the time of admission to the program, 54% (68) of the study population had an LSI-R score that ranged from 27 – 31, which is considered to be high risk. An additional 16.7% (21) were considered to be maximum risk.

Figure IV.3: Study Population by LSI-R Score at Admission



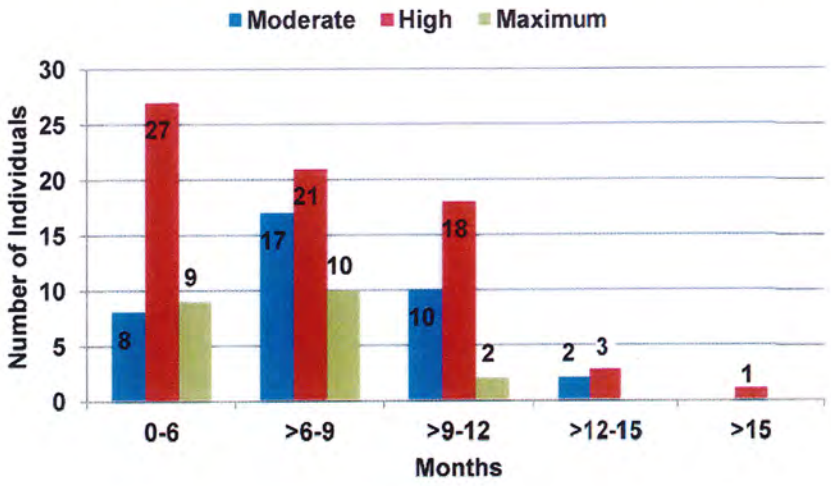
Program Duration

The number of days a resident spent in the MCRRC's program ranged from a low of 92 days to a high of 524 days. The mean was 216 days (7.2 months) in the program, and the median was 205 days (6.8 months). Seventy-three percent of the study population spent nine months or less in the program. Table IV.2 breaks out the study population by number of months spent in the program (program duration). Figure IV.4 breaks out the study population by program duration and risk level.

Table IV.2: Study Population by Program Duration

Program Duration	Total	%
0-6 Months	44	34.9%
>6-9 Months	48	38.1%
>9-12 Months	30	23.8%
>12-15 Months	3	2.4%
>15 Months	1	0.8%
Total	**126**	**100.0%**

Figure IV.4: Study Population by Program Duration and Risk Level



V. MCRRC PROGRAM ANALYSIS

The MCRRC program analysis focused on two areas often considered critical when measuring the effectiveness of correctional programs, namely, recidivism and risk reduction.

It is important to note that mentoring, though considered a fundamental program component, is not considered forensically in this analysis. At this time, the data does not lend itself to isolating mentoring's specific impact on recidivism and risk reduction.

RECIDIVISM

This study defines recidivism as an occurrence in which an individual engages in criminal conduct **and** is incarcerated for that conduct either pretrial or post-conviction.[9] It does not establish a time parameter for when such conduct must occur in order to be meet the definition of recidivism.

Figure V.1 presents the overall recidivism rate for the study population. Of the 126 residents, 31% (39) met the definition of recidivism.

Figure V.1: Overall Recidivism Rate

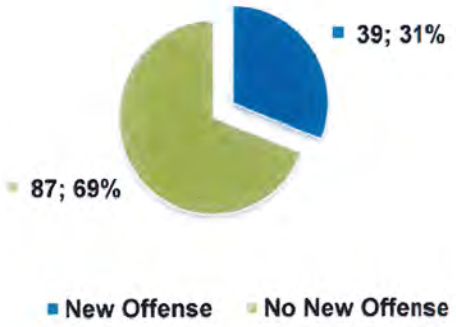
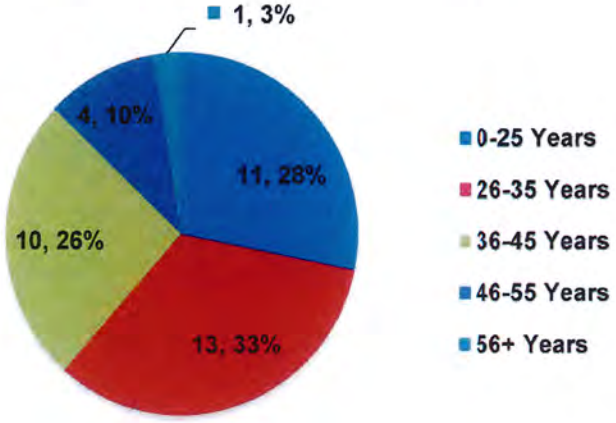


Figure V.2 outlines the ages of the residents who reoffended. At 61%, the majority of residents who reoffend are 35 years of age or younger.

[9] This definition is intended to eliminate the inclusion of civil infractions or minor misdemeanor offenses that do not generally result in incarceration. Two individuals who are part of the study met the minor misdemeanor offense threshold – one individual was arrested pretrial, convicted, and a fine imposed and paid; the second individual was issued a summons convicted, and a fine imposed and paid. For purposes of this study, one individual met the definition of recidivism and one individual did not.

Figure V.2: Recidivism Rate by Age



When a new offense occurs following release will be helpful in determining where to target post-program resources in order to maximize positive outcomes. Of the 39 residents who committed new offenses, 66.7% of new offenses occurred within the first year following release. Figure V.3 outlines when the new offenses occurred based on length of time since release. While the data are limited due to the small number of residents who have been released longer than three years, the numbers do suggest that the risk for reoffending decreases over time – which is consistent with the U.S. Department of Justice's Bureau of Justice Statistics (BJS) reporting of recidivism rates for prisoners released in 30 states in 2005.[10,11]

[10] Durose M. R., Cooper A. D., & Snyder, H. N. (2014). *Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010.* Washington, DC: U.S. Department of Justice (NCJ 244205).
[11] The BJS report cites a 67.8% recidivism rate for state prisoners who were arrested within three years of release. It should be noted that the report does not identify the risk levels of the prisoners and it is presumed that all risk levels are included in the BJS analysis.

Figure V.3: Recidivism by Length of Time Since Release

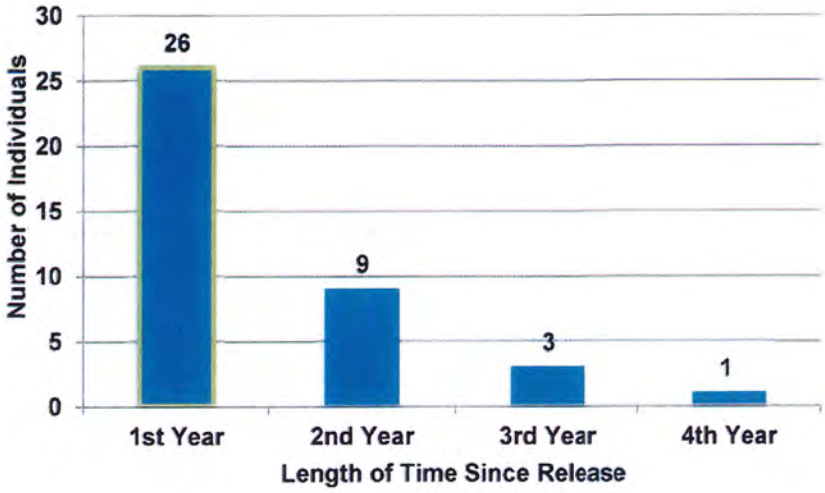


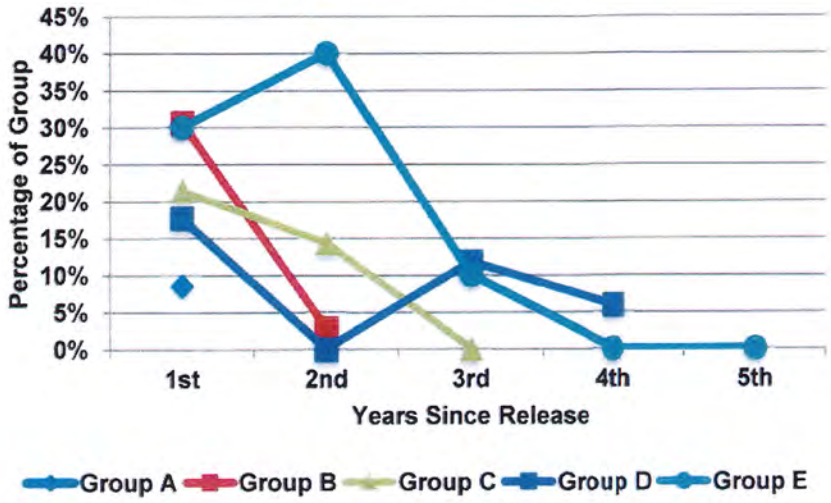
Table V.1 presents the study population in groups determined by the length of time since release (LoTSR) from the program. LoTSR was calculated using the point-in-time of 11/25/2014. For example, as of 11/25/2014, residents in Group E have been on post-program status for four or more years.

Table V.1: Study Population by Group and LoTSR

Group	N	LoTSR	Release Date
Group A	35	≤1 Year	11/26/2013 – 11/25/2014
Group B	36	≥1–2 Year	11/26/2012 – 11/25/2013
Group C	28	≥2–3 Year	11/26/2011 – 11/25/2012
Group D	17	≥3–4 Year	11/26/2010 – 11/25/2011
Group E	10	≥4 Year	05/01/2010 – 11/25/2010

Figure V.4 outlines the recidivism rate for each study population group by LoTSR. Again, while the data are limited, it does support that, regardless of the LoTSR, the greatest risk for recidivism occurs within the first year of release and decreases over time.

Figure V.4: Recidivism by Study Population Group and LoTSR



Of the 39 residents who reoffended, 41% were in the program for six months or less. Table V.2 presents the recidivism rate based on time spent in the program.

Table V.2: Recidivism Rate by Program Duration

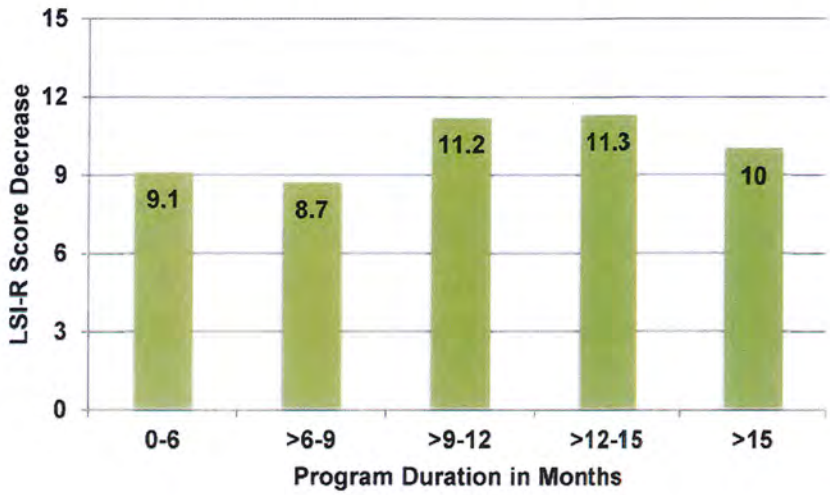
Program Duration	N	%
0-6 Months	16	41.0%
>6-9 Months	13	33.3%
>9-12 Months	9	23.1%
>12-15 Months	1	2.6%
Total	**39**	**100.0%**

Risk Reduction

While recidivism is an accepted performance measure, it is not the only measure to gauge the effectiveness of a corrections program. The MCRRC program is premised upon the concept that when a resident's dynamic risk factors are reduced there is a corresponding reduction in recidivism. As previously noted, the program uses the LSI-R to measure a resident's risk level.

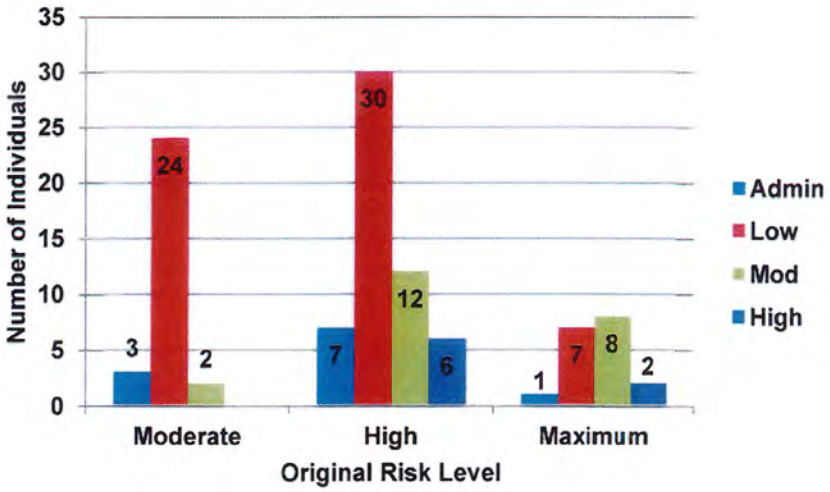
Of the 102 residents in the program who had an LSI-R completed at the time of admission to and exit from the program, 94 experienced a decrease in their LSI-R score with decreases ranging from 1 – 27 points. The LSI-R score for these residents decreased, on average, 9.6 points. Residents who were in the program for 9-12 months and 12-15 months experienced the largest average decreases in LSI-R scores (11.2 and 11.3, respectively). Figure V.5 presents the average LSI-R score decreases by program duration.

Figure V.5: LSI-R Average Score Decrease by Program Duration



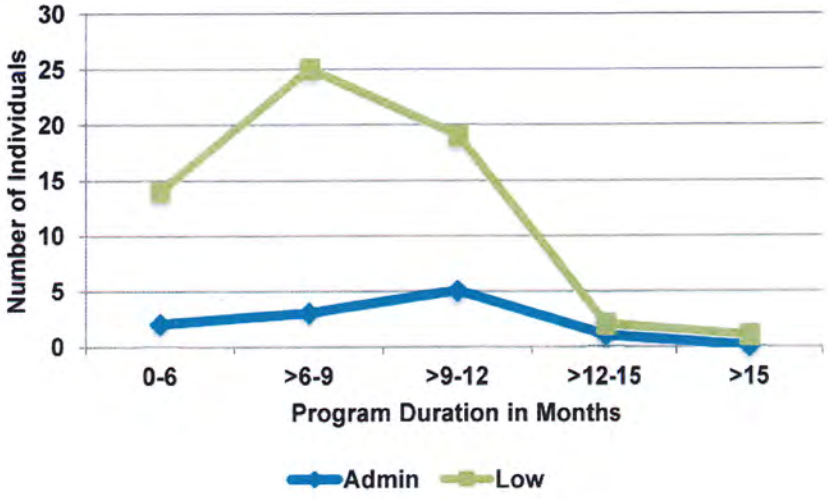
Only residents who were deemed to be moderate, high, or maximum risk as determined by the initial LSI-R were admitted to the program. Of the 102 residents for which pre- and post-program LSI-Rs were completed, 72 (70.6%) exited the program with a risk level of administrative or low. Figure V.6 presents residents' post-program risk level based on their original risk level.

Figure V.6: Post-Program Risk Level Grouped by Original Risk Level



For those residents whose risk level was reduced to administrative or low, the length of time spent in the program was examined. Data suggests that the greatest impact on reducing risk levels occurs when the program's duration is 6-12 months, with a diminishing benefit over time. Figure V.7 outlines the number of residents who saw their risk level reduced to administrative or low by length of time spent in the program.

Figure V.7: Risk Reduction to Administrative or Low by Program Duration



Recidivism and Risk Reduction

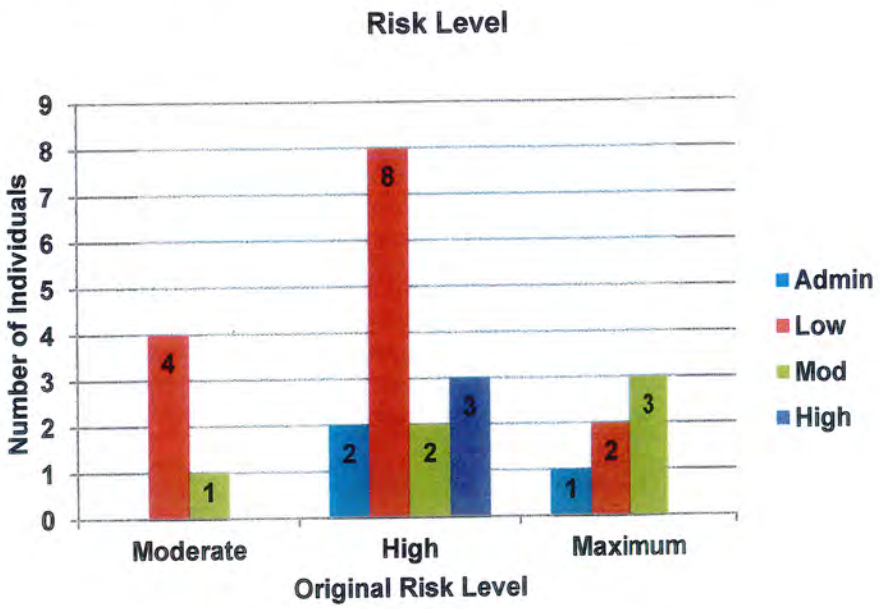
The study examined the effect the program's risk reduction efforts had on recidivism. Table V.3 presents the study population and the residents who reoffended by their original risk levels, and identifies the percentage each recidivist group comprises of the respective study population risk level group. As the risk level increases, so does the likelihood that a new offense will occur.

Table V.3: Percentage that Recidivists Comprise the Study Population by Original Risk Level

Original Risk Level	Study Population N	Recidivist N	Recidivist (Percentage of Study Population Risk Level) %
Moderate	37	7	19.0%
High	68	23	33.8%
Maximum	21	9	42.9%
Total	**126**	39	**31.0%**

Of the 39 residents who reoffended, 26 residents had both pre- and post-program LSI-Rs completed. Figure V.8 presents the post-program risk level for those residents who reoffended grouped by each resident's original risk level. Of the 26 residents with pre- and post-program LSI-Rs, 17 (65.4%) reduced their risk level to low or administrative. Of particular note, 12 of the 15 residents originally classified as maximum risk reduced their risk level to administrative, low, or moderate.

Figure V.8: Post-Program Risk Level of Residents who Reoffended, Grouped by Original



Another way to examine the reduction in risk as it relates to recidivism is to compare the number of residents who did reoffend with those residents who had the same reduced risk level and did not reoffend. Of the 102 residents with a pre- and post-program LSI-R, 94 residents experienced a reduction in risk level. In gauging a lasting reduction in risk, one would expect that with effective programming, more residents would not reoffend than the number who do reoffend. Table V.4 outlines the 94 residents with pre- and post-program LSI-Rs that experienced a reduction in risk level, and it compares, by risk level, the number of residents who did not reoffend with those that did reoffend. Of the 94 residents who experienced a reduction in risk level, 23.4% reoffended – a recidivism rate that is 7.6% less than the 31% recidivism rate experienced by the overall study population (see Figure V.1: Overall Recidivism Rate).

Table V.4: Recidivism Rate by Reduced Post-Program Risk Level

Reduced Post-Program Risk Level – N	No New Offense		New Offense	
	N	%	N	%
Administrative – 11	8	8.5%	3	3.2%
Low – 61	47	50.0%	14	14.9%
Moderate – 20	15	16.0%	5	5.3%
High – 2	2	2.1%	0	0.0%
Total – 94	**72**	**76.7%**	22	**23.4%**

VI. PROGRAM COST EFFECTIVENESS

In today's environment of shrinking financial resources, it is critical that monies be utilized in a manner that achieves optimal outcomes. In corrections, this is often related to recidivism – fewer days spent in jail or prison equate to less money spent. An accepted method for calculating this type of savings is to identify the number of 'bed days' not utilized as a result of a resident not reoffending and not being in jail or prison.

In addition to the bed days and associated cost savings calculations, other measures that often support a specific program's cost effectiveness focus on the collection of fines, restitution, child support, and other fees and charges that, presumably, would otherwise go uncollected, and in-kind contributions made to the larger community through a program's community service work programs.

This section of the report endeavors to quantify the MCRRC program's cost-effectiveness by examining bed days saved and the program's efforts to collect monetary obligations imposed by the courts (fines, restitution, and child support) and by the program (room and board), and in-kind contributions (community service work programs). Since the program's beginning in January 2010 through 2014, the program has generated revenue and savings ranging from $1.2M to $3.2M. Table VI.1 summarizes these revenues and savings. A more detailed discussion regarding these revenues and savings follow.

Table VI.1: MCRRC Program Revenues and Savings

Category	Revenues/Savings
Bed Day Savings	$676,200 – $2,704,800
Fines & Restitution	$60,136
Room & Board	$103,707
Child Support	$171,934
In-Kind Contributions	$172,095

BED DAY SAVINGS

The first step in calculating bed day savings is to determine the average length of time since release for those residents who reoffended and for those who did not reoffend.[12] For the 39 residents who reoffended, the LoTSR averaged 330 days, while the LoTSR for the 87 residents who did not reoffend averaged 588 days. The residents who reoffended represent a 31% recidivism rate.

The second step was to identify a comparison recidivism rate that would best represent those residents who had been incarcerated and who likely did not have access to a similar program, and who did not reoffend. For this, this study relied on the BJS report (2014), which outlines a recidivism rate of 67.8% for state prisoners released in 2005 in 30 states and who were arrested within three years of release, a number that increases to 76.6% for those arrested within five years of release. With a 67.8% recidivism rate, this means that 32.2% of the state prisoners released did not reoffend. For purposes of this analysis, it was assumed that 32.2% of the study population would not reoffend regardless of whether or not they participated in a program similar to that operated by the MCRRC.

[12] The LoTSR ranged from 12 – 1,669 days for the 126 individuals that comprised the study population

The third step was to determine the number of remaining residents who did not reoffend (MCRRC Recidivism) or would not have reoffended regardless of their incarceration environment (No New Offense Assumption). Table VI.2 outlines the calculations that identifies the number of residents (46) who did not reoffend, presumably as a direct result of being part of MCRRC's program.

Table VI.2: MCRRC Program – Non-Reoffending Population

Population Status	N
Total Study Population	126
MCRRC Recidivism (31%)	-39
No New Offense Assumption (32.2%)	-41
Non-Reoffending Population	46

To derive the total number of bed days saved, the fourth step multiplies the non-reoffending population number (46) by the average LoTSR days calculated for residents who did not reoffend (588 days). The MCRRC program calculates 27,048 bed days[13] have been saved since the program opened its doors in January 2010.

Conservatively, it is estimated that bed days saved for the study period represents $676,200 in cost savings. Table VI.2 outlines potential cost savings ranging from $676,200 to $2,704,800.

Table VI.3: Bed Days Saved (27,048) Cost Savings

Sample Per Diem[14]	Cost Savings[15]
$25	$676,200
$50	$1,352,400
$100	$2,704,800

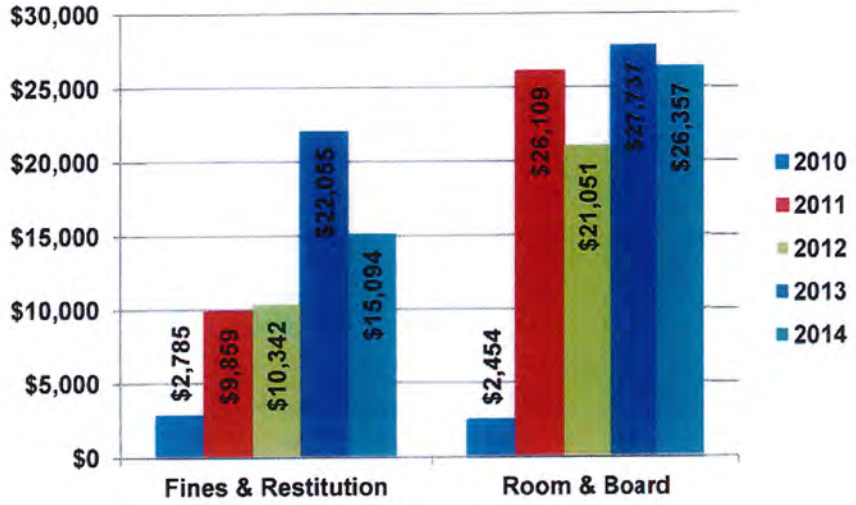
Fines, Restitution, Child Support Payments

Fines and Restitution

As the program has evolved and moved towards full implementation, it continues to promote fiscal accountability for its residents. To that end, residents who maintain employment are required to make payments toward court-ordered fines and restitution, and in support of their subsistence (room and board). For reporting years 2010 – 2014, the program has collected $60,136 in fines and restitution, and $103,707 in room and board. Figure VI.1 presents the monies collected for fines and restitution, and room and board by year.

[13] 27,048 days = 46 individuals x 588 days (average LoTSR)
[14] Per diem is the cost to house a single resident for one day
[15] Cost savings = number of bed days saved x per diem

Figure VI.1: Fines & Restitution and Room & Board by Year



Child Support Payments

Data regarding child support payments by the program's residents were provided by the Maine Department of Health and Human Services.[16] Of the 126 residents who comprise the study population, 80 residents are required to make child support payments. Since 2010, 57 (71.3%) residents have made payments totaling $171,934.

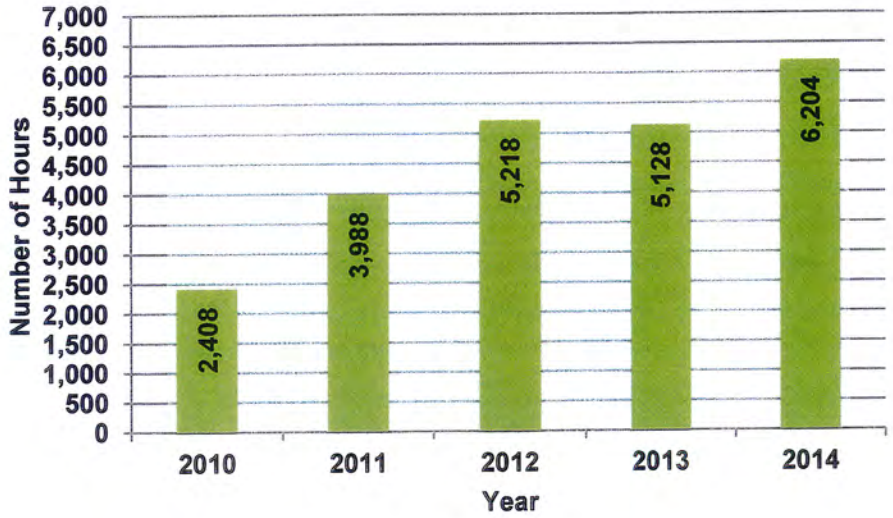
IN-KIND CONTRIBUTIONS

The program has built strong relationships with over 35 community partners that participate in the program's community service work program. For those residents who have not yet secured employment and for those with a desire to contribute to their community, the program, in collaboration with its community partners, engages residents in productive work projects. As an example of an MCRRC community service work project, the MCRRC Garden produced and supplied 26,000 pounds of fresh produce in 2014, which was then distributed to those in need, including local food pantries, soup kitchens, churches, and nonprofit organizations, and the MCRRC itself.

Since 2010, residents have provided over 22,000 hours of community service; calculated at Maine's minimum wage of $7.50/hour, these hours are valued at $172,095. The number of community service hours has improved each year – community service hours in 2014 (6,204 hours) represent a 157.6% increase when compared with 2010 (2,408 hours). Figure VI.2 presents the number of community service hours provided by residents by year.

[16] Jennifer Snow, DHHS Intensive Case Manager

Figure VI.2: Residents' Community Service Hours by Year



VII. FINDINGS AND CONCLUSIONS

This study provided an opportunity to examine the recidivism rates and risk levels for residents who successfully completed the program through the lens of prevailing research and to establish benchmarks for ongoing program development and continuing improvement efforts. Of particular note, because this study focused on recidivism rates and risk reduction, it does not address the integral elements that comprise the actual program – fidelity of interventions, reflection of evidence-based practices, delivery strategies, staff qualifications, etc.

In addition to previously noted research, the study draws on the research of Dr. Edward J. Latessa – a national expert on evidence-based practices in the criminal justice arena, in evaluating the study's results – specifically, two presentations entitled 'What Works and What Doesn't in Reducing Recidivism: The Principles of Effective Intervention,'[17] and 'Re-thinking Reentry: Dr. Ed. Latessa on Evidence-Based Practices.'[18]

FINDING ONE: RISK AND NEED ASSESSMENT

Actuarial risks and needs assessment tools target the right clients for the right interventions, and aid in knowing what is working to reduce recidivism. "What tool you use matters less than how well you use it." These tools aid in identifying both static and dynamic risk factors. Most important, it identifies those dynamic risk factors that can be changed through effective interventions – some that change quickly, like employment, while others take longer to change, like criminal thinking. (Walter, 2014)

Consistent with the research, the program utilizes the Level of Service Inventory – Revised, a validated assessment tool, to identify risk factors and to target associated criminogenic needs. An individualized reentry plan is developed and implemented for each resident that targets multiple risk factors. The LSI-R is administered pre- and post-program to identify reductions in risk levels.

FINDING TWO: HIGH-RISK OFFENDERS

Risk refers to the potential of reoffending and not the seriousness of the offense. Over 70% of residents had an assessed risk level of high or maximum. The program targets only those individuals who are assessed as moderate, high, or maximum risk, and is diligent in screening out those individuals who are considered low-risk. This practice is consistent with the research that notes in order to reduce recidivism, the focus needs to be on the people most likely to 'reactivate,' and also programs that work for high-risk offenders produce the opposite effects for low-risk offenders (Walter, 2014).

FINDING THREE: LENGTH OF TIME SINCE RELEASE

While the data are limited, it does support that, regardless of the LoTSR, the greatest risk for recidivism occurs within the first year of release and decreases over time, which is consistent with the research (Cooper and Snyder, 2014). Accordingly, the mentoring component of the

[17] Latessa, Edward J. (2011). *What Works and What Doesn't in Reducing Recidivism: The Principles of Effective Intervention.* (2015 February 4). Retrieved from http://sccounty01.co.santa-cruz.ca.us/prb/Latessa_EBP.pdf

[18] Walter, Christopher. (2014). *Dr. Ed. Latessa on Evidence-Based Practices.* Re-thinking Reentry. (2015, February 4). Retrieved from http://rethinkingreentry.blogspot.com/2014/04/dr-ed-latessa-on-evidence-based.html

program provides ongoing support to residents for up to 90 days post-release.

Further analysis is required to determine when the majority of new offenses occur and whether providing 90 days post-release support is adequate or whether this period should be extended or adjusted. In addition, critical examination of the mentoring component itself should be undertaken to determine whether the support being provided is relevant and useful, and targets demonstrated needs.

Finding Four: Treatment Dosage

Studies show that the longer in treatment the greater the effects, yet positive effects diminish if treatment goes too long. Higher risk offenders require a much higher dosage of treatment (Walter, 2014). As a general rule, 100 hours of intensive treatment for moderate risk and 200+ hours for higher risk offenders should be provided. One hundred hours of intensive treatment will have little, if any, effect for higher risk offenders. These hours do not include work, school and other activities that are not directly addressing criminogenic risk factors (Latessa, 2011).

Detailed data is not available regarding the actual number of treatment hours provided to individual residents. The data based on program duration would indicate that further analysis is warranted as it appears, generally, that some moderate-risk residents may be receiving too many treatment hours, while some high- and maximum-risk residents many not be receiving enough treatment.

Finding Five: Recidivism

Research notes that when targeting high-risk offenders, even with evidence-based practices and even if recidivism rates are reduced, there will still be a high percentage of failures. It further notes that if there are 100 high-risk offenders, about 60% will fail. However, if you put them in a well-designed evidence-based program for sufficient duration, the failure rate is likely closer to 40% (Latessa, 2011). The BJS study of prisoners from 30 states revealed that 67.8% of released prisoners were arrested for a new crime within three years, and 76.6% were arrested within five years. Of those arrested, 56.7% were arrested within the first year post-release (Cooper and Snyder, 2014).

The overall recidivism rate for residents who successfully completed the program is 31%. Of those residents who reoffended, 66.7% did so within the first year following release. While the data are limited due to the small number of residents who have been released longer than three years and not statistically significant, the data supports that the risk of reoffending is highest during the first year following release and that risk does decrease over time.

As noted earlier (see Finding Four: Treatment Dosage), program duration can be a contributing factor to recidivism. Of the 39 residents who reoffended, 41% were in the program for six months or less.

Finding Six: Risk Reduction

Through assessing and targeting criminogenic needs for change, the probability of recidivism can be reduced (Latessa, 2011).

Of the 102 residents who had an LSI-R completed at the time of admission to and exit from the program, 94 experienced a decrease in their risk level – 72 exited the program with a risk level of administrative or low. Residents who were in the program for 9-12 months experienced the

greatest average decreases in LSI-R scores.

Finding Seven: Recidivism and Risk Reduction

At first review, the study results substantiated the assumption that as risk level increases so does the risk for reoffending. For the entire study population, for each progressively higher risk level, the percentage of those residents who reoffended increased.[19]

When a comparison of the reduced risk level and number of residents who did reoffend with those residents who had the same reduced risk level and who did not reoffend was made, the assumption did not hold. Those with a reduced risk level of low had the highest rate of recidivism. However, at the same time, this group also comprised the largest group when categorized by reduced post-program level. Further review is warranted to determine that the LSI-R is being properly administered to assure proper scoring of its 10 domains, in both pre- and post-program assessments.

Conclusions

While the study sample size is small and consequently limited the depth of the analysis, the study results demonstrate promising program outcomes that serve to reduce recidivism through risk reduction. It is important to look more forensically at the individual components of the overall program, including, but not limited to, assessment tool utilization, dosage, mentoring and specific program effectiveness. Doing so will require accepted study methodology for each component, which was beyond the scope of this study. The MCRRC reentry program is encouraged to continue to build upon this study, strengthening the program and creating a model for other jurisdictions.

[19] Based on residents' original risk level