State of Iowa Systemic Study for the State Correctional System Phase II Report

April 29, 2008

Contact Durrant:

Michael S. Lewis, AIA
Managing Principal
510 East Locust Street, suite 200
Des Moines, Iowa 50309
515.309.0945

The Durrant Group Inc. in association with:

Pulitzer/Bogard & Associates, LLC

DURRANT®

Phase Two Report

Table of Contents

Chapter I:
Introduction and Methodology

Introduction and Methodology

A. Introduction

As an extension of the State of Iowa Systemic Study for the State Correctional System Phase One evaluation completed in April 2007, Durrant in association with Pulitzer-Bogard & Associates collaborated with corrections stakeholders to implement an operations first strategic plan. During the second phase of this study, our efforts have focused on integrating opportunities for best practices into a long-range plan designed to meet the Department of Corrections institutional and community corrections goals and objectives. Together with many 'Focus Group' participants, this phase of work has moved well beyond defining the overall vision of corrections in Iowa. The framework described in this report has begun to maximize rehabilitative opportunities, will reinforce and further reduce recidivism, and sets the stage to house offenders in the appropriate environmental setting.

As with the first phase, overwhelmingly we have found highly dedicated staff throughout the correctional system. With the formation of the twelve 'Focus Groups' evaluating and mentoring treatment initiatives, services, utilization, programs, classification, and practices, we believe this study builds the foundation to deliver effective treatment programs while achieving operational objectives in each appropriate environment. In many cases, the infrastructure in Iowa's correctional system is aging or limiting. Replacement of existing facilities may be preferred however, budgetary constraints often becomes limiting. When evaluating existing buildings, long-term operational objectives when economically and functionally feasible, allow for repurposing opportunities. In order to meet the DOC Focus Group objectives the Durrant/PBA Team considered the appropriate aspects of treatment availability, policy requirements, accessibility, capacity requirements, custody and classification, cost effectiveness, and operational efficiency when making recommendations.

Regarding Master Plan recommendations during this phase of the study, a baseline consideration is the improvement of life-safety concerns within the existing facilities. At the same time, recommendations support programs and services offerings, improve staff efficiency and enhance security. Further, master plan recommendations outlined in this report are designed to support reentry and community based plans, so offenders can be placed in the appropriate environment.

This document should be viewed as a living roadmap, the first implementation step from the systemic recommendations contained in the phase one report. While the Master Plan Facility recommendations predominately focus on the Iowa Correctional Institution for Women and gender specific responses, the Policy Standards, Reentry, Classification, and Treatment Recommendations have broader implications on community corrections and institutional direction.

B. Methodology

1. Treatment Availability, Accessibility and Capacity

The Phase II Master Plan Durrant/PBA team treatment related scope included the following initial tasks:

- Further development of institutional mental health services identified in the Phase I Master Plan Report;
- A needs assessment of community-based corrections offenders with mental illnesses and co-occurring disorders; this included an assessment of the availability of community-based mental health and co-occurring treatment services, diversion and reentry opportunities, and other supportive services;
- Developing a more defined and targeted approach to reentry release planning including programs and opportunities for special needs populations and women;
- A review of community support, involvement and participation in reentry planning;
- Expanding opportunities for substance abuse treatment services related to co-occurring disorders treatment and gender-responsive treatment in the institutions and community-based corrections;
- Expanding opportunities for sex offender treatment services related to special needs offenders and women;
- Evaluating the current utilization of community-based corrections beds;
- Evaluating the impact of new Classification instruments upon staffing, programs and services, and treatment; and
- Providing guidance in furthering gender-responsive programs and services within ICIW and in community-based corrections.

2. DOC Focus Groups

Prior to the Durrant/PBA team initiating their Phase II work, the Iowa Department of Corrections established twelve focus groups address recommendations from the Phase I report and to work with the Durrant/PBA team during the second phase of work. The DOC Director was clear that there was no expectation for the Durrant/PBA team to work with all of the focus groups, only those that were most closely associated with the Durrant/PBA Phase II scope of work.

The focus groups have been a tremendous resource to the Durrant/PBA team, and their creation resulted in a shift in the Durrant work activities and work product to ensure that the focus groups continued to take a lead role in implementing the short and long term recommendations made by the team in April, 2007.

While there was no a formal modification of the Durrant/PBA scope of work, initial tasks were somewhat modified as a result of our involvement and facilitation work with the twelve focus groups. In many cases the Durrant team role changed to that of a consultant to the focus groups providing resource information and guiding the groups rather than the alternative role of leading the work and being supported by department staff.

It is anticipated that the focus groups will continue to work on these recommendations for years to come and will continue to evolve into a permanent policy and senior management "think tank" for the Department.

The twelve focus groups included:

- Building Security Basics
- CBC Bed Utilization
- Classification
- Education
- Expanded Evidence Based Practices and Programs
- Mental Health Services in Community Based Corrections
- Mental Health Services in Institutions
- Quality Assurance
- Reentry
- Sex Offender Treatment
- Substance Abuse Treatment
- Gender-Responsive Corrections for Women Offenders.

A full list of the current Focus Group Membership is available in Appendix A. Each focus group is comprised of leadership personnel who have volunteered to be involved in this major initiative. They are drawn from the institutions, community-based corrections, and central office. Each focus group has designated champions and mentors to facilitate the work of the focus group.

The synergy that developed through this Durrant Team-Focus Group process resulted in system-wide discussions, problem identification, proposed solutions, and implementation plans that are much more detailed and developed than would otherwise have been possible had the Durrant/PBA team worked without the benefit of the focus group input. There was tremendous energy and effort put forth by all group members, enthusiastic buy-in across the board, and as a key byproduct of the process leadership development from within the Focus Groups.

3. Phase II Activities

Durrant/PBA activities included site visits throughout the state to increase our understanding about the interrelationships between the operations of institutions, CBC residential facilities, and related community services. Numerous meetings were held with various groups of people including:

- Focus Groups to ensure integration between focus group and Durrant/PBA team work;

- A Policy Standards Committee that included wardens, the Director, and other key IDOC staff to development system-wide policy standards;

- ICIW staff to develop gender-specific policy standards and a macro architectural and operational program to document and address expansion needs of the institution.

- Parole Board to understand the Board's expectations for release planning and coordination.

- DHS personnel who work with community-based mental health services to better understand the funding mechanisms for services at the county level.

- On-site meetings with numerous Judicial District staff.

In addition, supplemental work with selected focus groups included:

- Providing consultation, support, facilitation, and research related to evidence based practices corresponding to the specific focus of the group.

- Attending numerous focus group meetings on-site or via conference calls.

- Developing the methodology, collecting, and analyzing data related to availability/accessibility of mental health and related services for offenders supervised by community corrections.

- Assisting with the development of EBP corrective action plans.

- Facilitating the development of institutional mental health policy standards.

4. Facilities and Infrastructure

The Durrant/PBA team's scope includes significant tasks related to the physical environment of the institutions. This includes the development of Policy Standards; a series of physical, operational, staffing and treatment criteria that describe how offenders should be housed and managed based on their custody classification level, treatment programming and special needs. These standards will also provide a framework and help guide the subsequent design, master planning and budgetary decisions for the Department's facilities.

The scope also included developing an appropriate physical plant at ICIW that will address the use of the new gender specific classification instrument as well as the Policy Standards to change the mix, type and services required by the population housed at ICIW. A long-range master plan was a key work product of this effort including relocating female offenders from IMCC and Mt. Pleasant and consolidating all female offender services (e.g., medical care, mental health care, special needs, etc.) while accommodating future growth and expansion needs.

Based on both classification determinations and treatment needs, the Durrant/PBA team determined what changes would need to occur related to security operational practices

at ICIW. Also, based on both classification determinations and treatment needs of a very diverse population, the team determined if changes to the physical plant would enhance gender responsive program delivery. The team also developed macro Operating Principles and Architectural Program for ICIW to guide both the master plan and capital budget process for the institution.

Chapter II:
Progress on the Phase I Master Plan Short Term Recommendations

Progress on the Phase I Master Plan Short Term Recommendations

A. Introduction

Significant progress has been made on implementing the short-term recommendations in the Phase I Master Plan Report provided to the Department of Corrections in April, 2007. The short-term recommendations were those activities that were recommended to be completed by the end of Fiscal Year 2008.

During the Phase II Master Plan Durrant/PBA work (July 2007-March 2008), two parallel efforts were undertaken. The twelve Department of Correction's Focus Groups described in Chapter 1 of this report adopted certain aspects of those short-term recommendations to be addressed, discussed and implementation plans developed by the focus group. In addition, to their work with the Focus Groups, the Durrant/PBA team worked on additional tasks related to the Phase I recommendations.

The role that the Durrant/PBA team adopted in their working with the focus groups varied and was dependent upon the particular activities of each group. The team worked closest with those focus groups that were specifically addressing tasks that related to our scope of work. With those focus groups, our role was one of leadership and facilitating certain work tasks and analyses. However, with many of the focus group activities, our primary role was consultative serving as a resource, as a sounding board for new concepts and ideas and in a supportive role for researching and coordinating information.

B. Description of the Progress Matrix

The following matrix is a brief synopsis of progress made both by the Durrant/PBA team and the Department of Corrections, including the Focus Groups that relate to the Phase I Master Plan short-term recommendations. Those recommendations were included in Chapter 6 of the Phase I report and are also included in Appendix B of this report. The page reference numbers that appear in the matrix reference the page numbers in Chapter 6 of the Phase I Report.

The Durrant/PBA column defines their team's role and briefly describes the activities completed for each short-term recommendation. A more complete discussion of those activities follows in the subsequent chapters of this report.

The IDOC column lists the activities completed by the Department of Corrections focus groups as well as other department initiatives related to the recommendations.

IDOC TREATMENT CAPACITY STUDY
PROGRESS ON MASTER PLAN, PHASE ONE DURRANT REPORT SHORT TERM RECOMMENDATIONS

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
Treatment Recommendations			
A. *Substance Abuse Treatment (SA)*	198		
1. SA Treatment Assessment: Fill Assessment Positions	198	*Role:* Consultative *Activity:* Priority recommendation to fill SA Assessment positions	To be contracted to an outside agency/organization. RFP in January; contract anticipated by April 08. Substance Abuse Focus Group has recommended that all offenders be screened with TCU drug use instrument upon reception. Offenders should be assessed for readiness while at reception and level of treatment need.
2. SA Treatment Continuum: Recovery Model Co-occurring Disorder Approach	198	*Role:* Consultative *Activity:* Encouraged the MH-Institution Focus group to explore the efficacy of using many of the EBP SAMHSA Recovery modules, including co-occurring treatment for special needs offenders.	CCU staff developing a co-occurring program that may incorporate this model. ICIW exploring gender-responsive model for special needs women.
3. SA Treatment Capacity	198		
a. Determine efficacy/impact of additional short term and relapse prevention programs		*Role:* Consultative *Activity:* Supported ICIW Treatment Director's exploration of alterative, effective, EBP SA treatment for those offenders who do not meet the criteria for the STAR program.	Rafferty group initiative to explore funding and expand STAR to include a condensed SA treatment program to meet the needs of the short-term female offender.
b. Study efficacy of providing short term treatment in CBC		*Role:* Consultative	Rafferty group initiative exploring efficacy of female inmates completing treatment in

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
		Activity: Encouraged IDOC to explore whether more SA treatment needs can be met in the community instead of in an institution.	community. DOC released, "Community Based Corrections Substance Abuse Treatment For the Higher Risk Offender." 9/07 that reviewed CBC treatment.
c. Complete staffing analysis to determine appropriate levels of staffing		*Role:* Consultative *Activity:* Deferred	
d. Plan to expand EBP programs across continuum		*Role:* Consultative *Activity:* Continued encouragement for expansion of EBP programs across treatment continuum with special emphasis on special needs offenders (offenders with co-occurring, brain-injuries, and developmental disorders).	In September 2007 DOC released, "Community Based Corrections Substance Abuse Treatment For the Higher Risk Offender." This report encouraged use of rigorous outcome evaluations to further define EBP SA programs. The Substance Abuse Focus Group adopted development of EBP SA programs as their mission. Both the Expanding EBP and the Quality Assurance Focus Groups are working on expanding EBP across treatment and programs in DOC. All institutions and CBC districts are presenting EBP Quality Improvement plans to the EBP Steering Committee and representatives from the EBP and Quality Assurance Focus Groups by the first part of May 2008 Significant statewide issues are being identified as a product of these presentations for continued prioritized attention at the DOC level.
e. Determine institution/CBC		*Role:* Consultative	S/A Focus Group discussed need to improve the

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
offenders access to and involvement in SA treatment in community		*Activity:* Provided support to the MH-CBC group's exploration of previous treatment and current treatment needs of offenders with mental health issues. *Role*: Lead *Activity:* Collected data about offender access to co-occurring disorders treatment in each county.	communication between institutions and CBC for offenders. DOC released, "Community Based Corrections Substance Abuse Treatment For the Higher Risk Offender." 9/07 indicated that a number of high risk offenders do not received substance abuse treatment. Department working with the Department of Education and the Department of Transportation to resolve outstanding reentry issue: Offenders completing treatment & returning to the community have an outstanding need to complete a 12 hour education course approved through the Department of Education in order to obtain their driver's license.
f. Efficacy of changing faith-based SA programs to EBP that serves up to 150 additional offenders		*Role:* Consultative *Activity:* Recommended that this program be evaluated to determine success. It was also recommended that alternative programs be explored that would increase additional treatment slots	S/A Focus Group suggested analysis of the offender population may suggest the need for some other evidence-based modality, such as a co-occurring program.
B. Mental Health Treatment (MH)	199		
1. Culture re: Mental Illness	199		
a. Annual training of clinical and nonclinical staff re: contemporary approaches and theories		*Role:* Consultative *Activity:* Served as resource for various training programs available for clinical staff re: contemporary correctional mental health practices.	MH-Institutions Focus Group has selected the McKesson InterQual system for consistent approach to diagnosis and appropriate placement on the MH treatment continuum of care. The first training program for clinical staff was held in January 2008.

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
b. Implement new MH training for security staff		*Role:* Consultative *Activity:* Numerous discussions with MH Director and both the MH-Institution and CBC Focus Groups about the need to expand training to include field officers, to increase the number of training hours, and to employ more opportunities for skill building and less didactic lecture.	The Mental Health Director has been working with a staff team to develop contemporary training for corrections staff. The MH-CBC focus group reviewed the current curriculum and recommend that it be expanded to include community supervision as well as institution issues; would encourage development of scenario training, skill building and opportunities for practice.
2. Mental Health Assessment	199		
a. Continue psychiatrist recruitment		*Role:* Consultative *Activity:* Discussion with Focus Groups and Mental Health Director about the challenges in recruiting and retaining psychiatrists. Discussed same issue with DHS MH staff.	IDOC has been actively recruiting psychiatrists. IDOC discussions with DHS re: collaboration vs. competition is recruitment of psychiatrists.
3. Mental Health Continuum	199		
a. Increase acute beds for male and female offenders		*Role:* Consultative *Activity:* Encouraged the development of a plan for additional subacute and partial/transition care beds for males at IMCC including clear criteria for placement in these beds. *Role:* Lead *Activity:* Developed a draft macro operational and architectural program for the expansion of ICIW that recommended an increase of acute care beds for	Key ICIW administrative, clinical and security staff and the IDOC Mental Health Director involved in the discussions and review of the macro operational and architectural program.

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
		women offenders to be located in a gender-responsive setting at ICIW.	
b. Develop SOPs and training re: involuntary medication		*Role:* Consultative *Activity:* Served as resource to staff and Mental Health Director re: involuntary medication SOPs that have been implemented in other states.	MH-Institution Focus Group developed an SOP for involuntary medication. Mental health staff received training about this SOP in a quarterly MH meeting.
c. Determine appropriate use of MH beds across system.		*Role:* Consultative *Activity:* Ongoing discussion with Mental Health Director about developing a continuum of care that uses consistent criteria across the IDOC institutional system. *Role*: Lead *Activity:* Developed a policy standards grid to frame the development of a continuum of care.	Mental Health-Institutions Focus Group is developing a consistent approach to assessment and treatment using the McKesson InterQual approach across the continuum of care. MH-Institutions Focus Group reviewed and edited policy standards to meet future needs of mental health care at IDOC. Focus group is reviewing criteria and all policies related to institutional placement for offenders with mental illnesses to ensure that offenders are placed into the appropriate level of care and environment to meet their treatment.
4. MH Treatment Capacity	200		
a. Complete staffing analysis		*Role:* Lead *Activity:* A Healthcare Staffing Study will be completed that analyzes NAWH, Leave Use, Task/Time, and Discipline/Task Analysis.	IDOC has developed a Healthcare Staffing Study Advisory Group that includes key members of IDOC management and healthcare staff and AFSCME collective bargaining representatives.
b. Develop plan to increase staff to meet level of care required.		*Role:* Consultative *Activity:* Staffing plan will be developed based on	IDOC has included all mental health staff in the Healthcare Staffing Study.

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
		outcome of Healthcare Staffing Study.	
5. MH Treatment Continuity in Community	200		
a. Study of CBC offenders in need of/receiving MH treatment		*Role:* Consultative *Activity:* Worked with MH-CBC Focus Group; attended meetings; served as resource to group's work. *Role*: Lead *Activity:* Developed, collected, and analyzed data from counties re: mental health and co-occurring treatment resources. Developed, collected and analyzed data from Judicial Districts re: creative strategies used to meet offender treatment needs and staff training needs	Paper review of all CBC residential records by IDOC staff; random paper review of CBC (in community) offenders; analysis of data completed by IDOC Research Director. Completion of District and County surveys by IDOC-District CBC Staff CBC-Beds Focus Group is defining the ideal residential facility for persons requiring MH treatment CBC-Beds Focus group is developing a continuum or flow of persons requiring MH treatment.
b. Determine how many MI offenders expire their sentences due to unavailable beds/resources		*Role:* Consultative *Activity:* There is anecdotal information available that indicates that placement of MI offenders into the community is difficult due to lack of resources. Worked with Mental Health-CBC Focus Group to determine the level of resources that are available by county. *Role*: Lead	IDOC data indicated that 67% of CCU offenders and 17% of MWU offenders expired sentences. Data is not available re: reasons.

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
		Activity: Met with Parole Board and discussed the difficulty locating appropriate residential and treatment resources in the community.	
c. Determine how many MI offenders do not have access to reentry/support in community		*Role:* Consultative *Activity:* Worked with both the MH-Institution and CBC Focus Groups to identify the reasons that MI offenders have difficulty with release placements in the community. *Role*: Lead *Activity:* Met with the Parole Board in Nov 2007. One issue discussed was the difficulty finding safe, supportive community placements and treatment. Met with DHS Mental Health Executive Staff to discuss use of state hospital beds, funding issues including the county CPC system, and the limitations of DHS oversight over community providers and expenditure of mental health monies.	A number of IDOC Focus Groups are working on this issue to include: MH-Institutions; MH-CBC; CBC-Beds; Reentry; Women Offenders Mental Health-CBC group working collaboratively with DHS Acute Care Focus Group re: access to care in the community.
d. Determine if additional nursing/social work positions would impact psychologist workload		*Role*: Lead *Activity:* Anticipate that the data collected in the healthcare staffing study will give insight into this issue.	IDOC has included all nursing, mental health, medical, dental, pharmacy staff in the Healthcare Staffing Study.
6. MH Management Capacity	200		
a. Develop plan to meet systemic MH management demands		*Role:* Consultative *Activity:* Discussions with MH Director re: changes in mh management structure. Available as resource	Institution MH professionals are administratively supervised by Treatment Directors; they receive clinical supervision and consultation from MH Director.

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
		for information and to answer questions.	
C. Sex Offender Treatment (SO)	200		
1. SO Treatment Assessment	200		
a. Determine if there is a more effective assessment instrument for identifying the level of treatment required for sex offenders.		*Role:* Consultative *Activity:* Available as resource to research information and obtain information.	Sex Offender Focus Group is exploring the feasibility of placing offenders into a SOT program based on assessment of treatment need.
2. SO Treatment Capacity	201		
a. Monitor outcome evaluations of 12 month intensive SO programs		*Role:* Consultative *Activity:* Provided consultation re: need to monitor programs that are using this model; IDOC is encouraged to not change to this model until outcome evaluations are available.	Sex Offender Focus Group to monitor outcome of shorter term intensive SOT
b. Determine how many sex offenders expire their sentence because unable to obtain SOT; esp., for offenders with special needs (e.g., MI, MR, women)		*Role:* Consultative *Activity:* Obtained data re: number of special needs offenders on waiting list for sex offender treatment.	Sex Offender Focus Group identified reasons for SOs expiring sentences, and is exploring possible responses.
c. Complete staffing analysis to determine levels of staff required		*Role:* Consultative *Activity:* Deferred.	
d. Develop plan to increase staff to meet current/projected demand for SOT		*Role:* Consultative *Activity:* Deferred until program/treatment staffing analysis is undertaken and completed by DOC.	
D. Medical Treatment for Aging Population	201		
1. Medical Treatment/ Nursing Care Capacity	201		

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
a. Fill Nurse Admin position		*Role:* Consultative *Activity:* Recommended filling position a priority.	Position has been filled
b. Fill vacant nursing positions to meet minimum staffing requirements		*Role*: Lead *Activity:* Healthcare Staffing Study should define the minimum nursing staffing requirements for each institution.	Plan to fill positions to be developed by IDOC based on outcome of healthcare staffing study
c. Perform healthcare staffing analysis to determine staffing for facilities		*Role*: Lead *Activity:* To complete a Healthcare Staffing Study that will include all healthcare positions. Anticipated date for completion is June 2008.	Appointed a Healthcare Staffing Advisory Committee to work with Durrant Team.
d. Plan and implement system-wide strategy to recruit nurses		*Role:* Consultative *Activity:* Available to discuss strategies.	Nursing management and AFSCME representatives are developing strategies for recruitment and retention of nursing staff.
e. Hire/train staff required to open new IMCC facility		*Role:* Consultative *Activity:* Recommended stressing the importance of procedural review and training for all new personnel During transition phase to new facility.	In progress
f. Study impact of expanding Self Administered Medication (SAMS) meds		*Role:* Consultative *Activity:* Further exploration of SAMS found that the practice is more widespread than previously reported. Supported the targeted expansion of SAMS at ICIW and for offenders with special needs prior to release.	MH-Institution Focus Group is discussing how to expand SAMS to offenders with MI prior to release to the community. Interdisciplinary input (Security, Medical, and Mental Health) will be required to develop a DOC policy.
2. Centralized Pharmacy	201		

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
a. Complete study of efficacy of centralized pharmacy services.		*Role:* Consultative *Activity:* Available as resource and to answer questions.	DOC Centralized Pharmacy Committee continues to study this issue.
E. Gender Responsive Programs and Services	201		
1. Seek Technical Assistance (TA) to plan, develop, and strengthen EBP gender responsive programs.		*Role:* Consultative *Activity:* Identification of gender responsive issues that meet treatment needs of women. Provide supportive documentation on behalf of IDOC to obtain contract or NIC technical assistance to provide gender responsive EBP components for substance abuse program. Support continued evaluation of programs to determine if they meet or can be improved to meet EBP Reviewed ICIW proposed EBP corrective action plan In collaboration with the Women's Focus Group and ICIW staff, identified a number of EBP gender responsive educational and life skills program needs that should be included in various treatment programs.	Rafferty group initiative to expand STAR to include a condensed program for short term offender needs IDOC developing EBP corrective action plans ICIW to develop survey to obtain input from offender population regarding their needs and programs they feel are most helpful
2. Increase communication with legislature/others about benefit of gender responsive treatments, programs and other services.		*Role:* Consultative *Activity:* Developed strategies how to increase community support and connections.	Conducted very comprehensive tour of facility to include benefits of gender responsive treatments, programs and other services.

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
		Prepared information included in the handout and participated in tour and discussion with legislators and special interest groups during visit to ICIW in November 2007. Participated in a walk-through of the ICIW operations and institution with key citizen groups, legislators and key staff. *Role*: Lead *Activity:* Conducted initial meeting with the Parole Board as critical partner in the reentry and release process	EBP initiative: ICIW will upon completion of course descriptions Gender Responsive Programs/Services above, share with Parole Board to assist during release hearings
F. Reentry	202		
1. Conduct resource needs assessment for providing EBP reentry programs		*Role:* Consultative *Activity:* Served as a resource to Reentry Focus Group's work; attended meetings via on-site and conference calls. Conducted on-site visits of residential treatment facilities and several alternatives to incarceration programs (e.g., drug court); served as resource to group's work. Compiled a breakdown of CBC funding by percentage from sources such as fees, appropriated, and grants.	New initiatives are being pursued to improve access to resources by offenders. These initiatives are being explored by a number of Focus Groups: Women Offenders, Substance Abuse, Sex Offenders, MH-Institutions and CBC, CBC-Beds, Expanded EBP, and Quality Assurance.
2. Build institution/CBC collaboration for release planning		*Role:* Consultative	Significant effort has been put into increasing collaboration between the institutions and the

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
		Activity: Met at six of eight CBC offices/residential treatment facilities to clarify needs and improve collaboration. Most of these tours were conducted with the Re-entry Coordinator. *Role*: Lead *Activity:* Currently developing a one page visual graphic that summarizes or visually describes the flow of an offender through the reentry process. A draft was submitted to the Reentry Focus Group and the suggested changes are currently being incorporated into a final draft for review by key staff.	CBCs. The Reentry Coordinator meets with the CBCs on a regular basis and the CBC staff members convey their commitment to ensuring collaboration for release planning. Several barriers to sharing information have been reported including the roles of the institutional and CBC-based reentry coordinators. Iowa has been selected by BJA and Center for Effective Public Policy to participate in national level reentry training & planning with 2 other state jurisdictions.
G. IPI and Vocational Programs	202		
1. Determine staff required to increase IPI and vocational program opportunities.		*Role:* Consultative *Activity:* Deferred	ICIW/Des Moines Center for Work Force implementing a Work Readiness and Registered Apprentice Core Training program Education Focus Group exploring ways to expand career center services in institutions.
H. Training and Development	204		
1. Provide specialized training needs identified		*Role:* Consultative *Activity:* Proposed staff training for working with female offenders; provided subsequent input at the Women's Focus Group meetings and with ICIW program staff to move forward on staff training Provided resources for Security Basics Focus Group to begin exploring and developing e-learning for core competency skill development and remediation for security officers.	Women's Focus Group working with Training Administrators to enhance staff training for managing female offenders Build Security Basics Focus Group subgroup received executive support to begin e-learning development

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
		Served as resource for correctional mental health training programs available from national resources. Explored opportunities to better describe the reentry process and staffs role in supporting reentry efforts.	Both MH-Institution and MH-CBC Focus Groups have reviewed current mental health training and support increasing both its focus and audience
I. ICON and Performance Measures	204		
1. Fund ICON reconfigurations, modifications and beta testing.		*Role:* Consultative *Activity:* Identifying difficulties with information sharing, using ICON to find information, and limitations of Medical ICON for mental health professional use.	Numerous upgrades to the ICON system are under development by DOC.
2. Fund validation and reliability studies for new classification instruments		*Role*: Lead *Activity:* Initial development of gender responsive classification instruments are in progress.	Classification and Women Offender Focus Groups have worked closely with Durrant Team to develop appropriate instruments. Input has also been given by MH Director related to classification of offenders with mental illnesses.
3. Develop additional key performance indicators to evaluate quality at institutions.		*Role*: Lead *Activity:* Developed draft policy standards by which the institutions can measure their conformance and recommend improvements where appropriate. The draft policy standards were reviewed with institutional representatives, revised, reviewed and are now in final draft form.	A Policy Standards Committee including key staff from institutions and central office were appointed.
J. CBC Residential Treatment	213		
1. Determine the 'right' mix of residents (overall).		*Role:* Consultative *Activity:* Support the CBC-Beds Focus group in defining the ideal residential facility to include the	CBC-Beds Focus Group is defining the ideal residential facility for offenders with a mix of treatment and supervision needs.

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
		appropriate location for these facilities.	
2. Increase support for mental health/medical services in the community to support the continuum of care.		*Role:* Consultative *Activity:* Supporting the work of the MH-CBC Group to determine the unmet need for MH Treatment for offenders in the community.	MH-CBC Focus Group is collecting data re: the mental treatment need.
3. Share best practices between the Judicial Districts and between community and institutional corrections.		*Role*: Lead *Activity:* Serve as key resource contacts working with a number of Focus Groups comprised of a mix of personnel from Judicial Districts and institutions; encouraging the cross-group communication of ideas and best practices between the institutions and community corrections.	Numerous IDOC Focus Groups are discussing mutual problems, working toward resolutions and sharing approaches to meeting the needs of offenders.
4. Maintain awareness and use of Evidence Based Practices (EBP) through training.		*Role:* Consultative *Activity:* Encouraging the focus on EBP programs and identifying training needs of all personnel to understand the importance and impact of developing EBP treatment and programs.	Quality Assurance Focus Group is identifying critical areas that need support; developing a template for elements of a good quality assurance process; and reviewing organizational structure to insure proper quality assurance monitoring.
5. Involve the Faith Community and Volunteers.		*Role:* Consultative *Activity:* Available as resource to answer questions.	
6. Evaluate the number of sex offenders in the CBC residential facilities.		*Role:* Consultative *Activity:* Available as resource to answer questions.	CBC-Beds Focus Group is defining the ideal residential facility for offenders with a mix of treatment and supervision needs.

PHASE I RECOMMENDATION	Pg Ref.	DURRANT PHASE II ROLE and ACTIVITY	IDOC
Facilities			
A. Institutions			
1. ICIW Replacement and Expansion Conducive to Gender Responsive Treatment and Supervision	204	*Role*: Lead *Activity:* Developed macro operational and architectural space program for the expansion of ICIW. Developed Master Site Plan and phased development plan as well as estimated construction costs and overall project costs.	
2. Replace older housing units	205	*Role*: Lead *Activity:* Master Plan indicated the demolition of Housing Units 1, 2, 3, 4 and 5 and the construction of a new housing building to replace the lost beds.	
3. Relocate women housed at Mount Pleasant Women's Unit to ICIW	205	*Role*: Lead *Activity:* Offenders from MPWU were accounted for in the Program and Master Plan.	
4. Relocate Reception and Classification for women to ICIW	205	*Role:* Lead *Activity:* Master Plan indicated a new Reception/Classification Center.	
5. Provide Housing for overcrowding and future needs	205	*Role:* Lead *Activity:* Master Plan indicates a new Housing and locations of future housing.	
6. Increase size of Food Service and Laundry	205	*Role:* Lead *Activity:* Master Plan indicates an addition to the current Food Service Building and a new Laundry Facility.	

Chapter III: Reentry

Reentry

A. Introduction

This chapter addresses the Durrant/PBA Phase II Master Plan work effort as it relates to working with IDOC in expanding and enhancing their reentry initiatives. The reentry initiatives previously addressed in the Durrant Phase I Master Plan report identified two short term and four long term recommendations. While the Phase I Master Plan Report provided a cursory review of reentry, the Phase II Master Plan Report seeks to expand on the status of IDOC's progress to date and update and provide additional new recommendations based on evidence based practices and the current national literature pertaining to reentry. Specialized reentry initiatives that are gender specific and address special populations (primarily the mentally ill) will be documented in this chapter and are referenced as well in Chapters 4: Treatment, and Chapter 5: Women Offenders and Gender Responsive Treatment.

Describing the various reentry initiatives are particularly important given that, to many people, "offender reentry" may appear to be simply a new name for something that has been occurring since the first offenders were incarcerated in this country. Indeed, roughly 95 percent of people incarcerated in our nation's jails and prisons are eventually released.[1] Yet offender reentry today presents new and greater challenges for a number of reasons. The sheer magnitude of released offenders has a direct impact on public safety when one considers the odds of their reoffending: statistically two-thirds of released offenders will be rearrested and half of them will likely return to prison within three years of their release.[2] Offenders are also less prepared for reentry than in previous years, with a smaller share of offenders taking part in educational and substance abuse treatment programs.[3] This limited program participation is particularly problematic given that most released offenders return home with limited skills and resources and significant challenges, including those illustrated below.

As communities begin to realize that successful offender reentry is the community's problem as much as it is a prison problem, nationwide efforts are being made to establish systems and processes to support that realization. Correctional authorities are having trouble keeping up with the needs of offenders, and simply do not have the capacity to serve them. Reentry is one of the most promising initiatives being implemented nationally to positively focus the direction of correctional services in the future. Following the landmark 2005 report by the Reentry Policy Council, a growing number of state and local governments are focusing on the growing body of evidence that systemic reforms around the practice of offender reentry could help to alleviate the

[1] Hughes, Timothy, and Doris J. Wilson. 2005. "Reentry Trends in the United States." U.S. Department of Justice, Bureau of Justice Statistics. http://www.ojp.usdoj.gov/bjs/reentry/reentry.htm.
[2] Langan, Patrick A., and David Levin. 2002. *Recidivism of Prisoners Released in 1994*. Bureau of Justice Statistics Special Report. Washington, DC: U.S. Department of Justice, Office of Justice Programs.
[3] Lynch, James P., and William J. Sabol. 2001. "Prisoner Reentry in Perspective." Washington, DC: The Urban Institute Press. http://www.urban.org/url.cfm?ID=410213.

costly cycle of incarceration, release, and recidivism.[4] The report provided comprehensive consensus-based recommendations for policy-makers and practitioners to improve the likelihood that adults released from confinement will avoid crime and become productive members of their communities. Since that report, agencies nationwide have begun to focus their funding and programming initiatives toward implementing reentry programs in their institutions and community based programs.

The traditional realm of reentry programming generally includes life skills programming, preparing for the basics (access to public services and programs, valid identification, etc.), education, and treatment prior to release from an institution. Looking past the reentry programming itself is the awareness of the stigma of an offender's involvement in the criminal justice system, particularly when an offender is directly released from an institution. Beyond institutions it is appropriate to consider the other alternatives to incarceration programs as integral components of the reentry initiative since the stigma of involvement in the criminal justice system similarly applies to offenders who are not incarcerated.

The current literature and national trends typically focus on reentry beginning at the institutional level. Indeed, reentry initiatives – those that strive to ensure a safe and successful offender transition from the criminal justice system to the community apply to all components of the criminal justice system from the institutions to community based residential programs to community supervision including probation and parole. This divergence from the literature and the national trends is important when fostering a comprehensive view of the role of reentry in the criminal justice system. All offenders in the criminal justice system must be managed with successful reentry as the primary goal.

The National Governors Association (NGA) Center for Best Practices Prisoner Reentry Policy Academy has now focused on ten states, of which Iowa has not yet been included, in an effort to help governors and other state policymakers develop and implement statewide offender reentry strategies that reduce recidivism rates by improving access to key services and support. The work of the NGA has been instrumental in identifying reentry issues and working toward evidence based practices for the ten states that have participated in the Academy, but also other states as this information is shared. Several themes have emerged among the states participating in the second round of the academy. These themes include:[5]

- **Performance Measurement**: Beyond just recidivism, states are interested in measures such as job placement and retention, job quality, housing stability, drug treatment completion, and community involvement. These interim measures should give a more complete picture of what is working and what needs improvement.

[4] Council of State Governments. *Report of the Reentry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community*. Reentry Policy Council. New York: Council of State Governments. January 2005

[5] National Governors Association Center for Best Practices. *Backgrounder: Prisoner Reentry Policy Academy Round Two.* Retrieved February 20, 2008. http://www.nga.org/portal/site/nga/menuitem.9123e83a1f6786440ddcbeeb501010a0/?vgnextoid=c223303cb0b32010VgnVCM1000001a01010aRCRD

- **Executive Orders**: Many of the participating states already have MOUs among several agencies involved in the reentry process. They believe that an executive order would add further structure and better emphasize the Governors' commitment to improving reentry.

- **Building on the Role of Families**: In recognizing that the release of an individual from prison will directly affect family members, states are looking to integrate families into release planning. Some states have release coordinators meet with family members prior to release in order to not only explain their role and what to expect, but also to address fears or concerns of those family members.

- **Adoption of Evidence-Based Practices:** States are looking to better integrate evidence-based practices into their reentry programming. They are eager to learn what works best and to direct their limited resources towards those programs that are most likely to improve outcomes. The participating states are especially interested in learning how participation in multiple programs may impact recidivism.

- **Targeting Modest Outcomes**: Research has indicated that even in successful programs, reductions in recidivism are not as big as we would like, nor last for as long as we would like. Most successful programs, in fact, reduce recidivism by 5-15%. The academy states have recognized this and while they are encouraged by the potential reductions in recidivism, are also working to set realistic expectations among policy decision makers.

- **Special Populations**: The Academy states have all cited difficulties in dealing with specialized populations, including juveniles and sex offenders. Special populations require different approaches in order to improve outcomes while returning offenders to society and protecting the publics' safety.

- **Leveraging Faith- and Community-Based Organizations**: Several of the ten states are looking to build upon the work already being done in the community in order to provide returning offenders with a continuity of care and services. These efforts range from creating databases of organizations providing services to returning offenders to actually providing grants and other supports to those community organizations. In cases where a relationship may already exist between the state and an organization, the states are examining ways to expand or further leverage those services.

- **Challenges of Unique Rural and Tribal Issues**: Several of the ten participating states have large sparsely populated regions or tribal lands that make it difficult to provide services. In rural areas it is often difficult for a returning offender to attend drug treatment or to fulfill other conditions of their release, which may in turn lead to their relocation to a more urban area. Offering these necessary services may mean separation from family, jobs, and other positive supports.

The Second Chance Act of 2007, legislation to reauthorize the grant program for reentry of offenders into the community in the Omnibus Crime Control and Safe Streets Act of 1968, to improve reentry planning and implementation, was passed by the U.S. House of

Representatives in November 2007 and the U.S. Senate on March 11, 2008. In summary, the Second Chance Act provides for the following initiatives as they relate to reentry:

- Reauthorizes and expands provisions for state and local reentry demonstration projects to provide expanded services to offenders and their families for reentry into society.

- Sets for provisions relating to grant applications, and requires grant recipients to:

    - Develop comprehensive strategic reentry plans containing measurable annual and five-year performance outcomes;

    - Establish or empower reentry task forces to promote lower recidivism.

- Requires states receiving funds under the Residential Substance Abuse Treatment program to provide aftercare services, including case management services and other support services.

- Revises the definition of "violent offender" for the purposes of the drug court grant program to include an offender who has been convicted of an offense punishable by a prison term of more than one year.

- Authorizes grant awards for new and innovative programs to improve offender reentry services.

- Authorizes enhanced drug treatment and mentoring grant programs.

- Authorizes grant funds to:

    - Conduct research on juvenile and adult offender reentry

    - Study parole and post-supervision revocation data and community safety issues.

    - Collect data and develop best practices for coordinating the efforts of state correctional departments and child protection agencies to ensure the safety and support of children of incarcerated parents and the support of relationships between incarcerated parents and their children.

These Second Chance Act provisions will provide for the continuance and enhancement of progress toward defining evidence-based, best practices for offender reentry. If signed into law, these provisions include funding for community and faith-based organizations to deliver mentoring and transitional services, and help connect offenders released from prison and jail to mental health and substance abuse treatment, expand job training and placement services, and facilitate transitional housing and case management services.

As noted in the Durrant Phase I Master Plan Report, the Iowa Prisoner Reentry Initiative (IPRI) envisions the development of model reentry programs that begin upon entry into

the [criminal justice system] and continue throughout an offender's transition to and stabilization in the community. These programs provide for individual reentry plans that address issues confronting offenders as they return to the community. The initiative encompasses three phases and is implemented through appropriate programs:

- **Phase 1-Protect and Prepare:** Institution-Based Programs. These programs are designed to prepare offenders to reenter society. Services provided in this phase include education, mental health and substance abuse treatment, job training, mentoring, and full diagnostic and risk assessment.

- **Phase 2-Control and Restore:** Community-Based Transition Programs. These programs work with offenders prior to and immediately following their release from correctional institutions. Appropriate services provided in this phase include, education, monitoring, mentoring, life-skills training, assessment, job-skills development, mental health, and substance abuse treatment.

- **Phase 3-Sustain and Support:** Community-Based Long-Term Support Programs. These programs connect individuals who have left the supervision of the justice system with a network of social services agencies and community-based organizations to provide ongoing services and mentoring relationships.[6]

IDOC has adopted the reentry model and has made considerable progress through these phases as will be discussed throughout this chapter. Additional concepts will be introduced related to reentry particularly the concept that reentry is not necessarily a program or an initiative, but rather a process or a way of doing business. The other, related key concept is recognition that reentry must be the cornerstone or the priority for managing offenders throughout their involvement in the criminal justice system and not just from the institutions.

As criminal justice professions continue to implement the reentry model and identify many of the barriers to successful reentry, they find that there are key measures to consider for effective reentry initiatives. This chapter is organized to explore these considerations/measures within the below listed major headings:

B.1. The degree to which the reentry model is supported.

B.2 The degree to which systems are in place to support transition through the stages of the criminal justice system.

B.3. The degree to which programs can be cost effectively implemented.

The IDOC has indeed demonstrated its commitment to evidence based practice reentry as will be described throughout this chapter. The considerations or measures described above tend to represent where the IDOC may have difficulty implementing successful reentry programs despite their desire and best efforts to do so. The focus of this chapter will be the exploration of these considerations/measures, and how the IDOC is progressing toward them.

[6] Durrant et al. State of Iowa Systemic Study for the State Correctional System. April 13, 2007. pp 108-109.

B. Measures of Successful Reentry

This section addresses the three measures of successful reentry listed above. Each of the measures identified represents a subcomponent of this section of the report. The research and shared experiences of practitioners have outlined myriad barriers to successful reentry. These range from the National Governor's Association Center for Best Practices initiatives, to academia, to actual practicing program staff. The list of barriers found in the literature alone is not Iowa-specific, and is too vast to list here. Rather the three major headings listed below capture the most significant barriers faced by the IDOC.

- The degree to which the reentry model is supported.
- The degree to which systems are in place to support transition through the stages of the criminal justice system.
- The degree to which programs can be cost effectively implemented.

Throughout this section, these barriers are defined as they relate to national best practices trends and then the current IDOC initiatives related to these barriers are described. As noted previously, the IDOC continues to strive toward effective evidence-based and effective reentry programming, resulting in a very fluid process. It is for that reason that not all programs will, or should be addressed in this chapter; rather, the programs within the context of this chapter will be described. Moreover, as this report was being drafted, IDOC and the Iowa legislature continued to explore reentry initiatives including "certificates of employability" that will be discussed in further detail throughout this chapter.

B1. The degree to which the reentry model is supported

Support for the reentry model is essential to the success of its implementation. There are four primary entities that should be considered to determine if the reentry model is supported. These can be found in legislation and public support generally, local community support, staff support and offender support. This section explores best practices efforts to solicit support for reentry and the degree to which IDOC has, and is able to capitalize on this support.

Legislation and General Public Support

The public/community's response to offenders often results in legislation that has the effect of restricting access to services necessary for successful reentry. Examples include:

- Federal laws prohibit many former offenders from residing in public housing and federally funded housing programs. Instead, former offenders without family support must rely on halfway houses, housing programs, the private market (where affordability and availability may be highly restrictive), and homeless shelters.

- Many offenders are released without state-issued identification or without the documentation (e.g., birth certificate, social security card) that would allow them to obtain state-issued identification. Furthermore, many state departments of motor vehicles do not accept prison documents as proof of identification.

- The Higher Education Act of 1998 makes students convicted of drug-related offenses ineligible for any grant, loan or work assistance.

- There is a lifetime ban on eligibility for food stamps and cash benefits under the Temporary Assistance for Needy Families (TANF) program for anyone convicted of a drug-related felony. The law also prohibits states from providing TANF assistance, food stamps, supplemental security income (SSI), and public housing to anyone in violation of their parole or probation. This ban is irrespective of whether or not an individual has completed their sentence, been employed and was laid off, or earned a certificate of rehabilitation/employability.[7]

- Employers in most states can deny jobs to anyone with a criminal record, regardless of individual history, circumstance, or "business necessity."

Research suggests there is an overall public attitude on criminal justice issues in the U.S. that suggest a move from support for mandatory sentencing and punishment towards alternatives to prison for non-violent offenders. Unfortunately, the research is often clouded with rhetoric from the "vocal minority," who are typically the ones heard by legislators. One clear example is a recent web-based report of the *Record Number of Americans in Prison*[8] based on the Pew Charitable Trust Report released February 2008 that discussed many of the relevant issues surrounding our growing prison population. As anticipated, the more than 3800 on-line journal entries (i.e., blog comments) received in less than 20 hours focused on "get tough" strategies rather than preparation for an offender's successful release. Many times it is the extreme view that gets the most attention.

The research on public opinion indicates that support for punitive measures or retribution involving mandatory prison sentences is a minority view among Americans. The main concern that arises from any study of opinion about criminal justice is in reducing risk to the community. The majority feels that attacking the root causes of crime offers the best opportunity for creating safer communities. And, the public believes that individual offenders can reform given adequate opportunity. They believe that the criminal justice system should focus on rehabilitation, but that it generally fails in doing so. At the same time it is not clear to what extent the public would support rehabilitation if it draws resources from other services. The majority feel that the criminal justice system needs

[7] While states can issue "certificate of rehabilitation" to lift bars to employment for certain professions in six states, not Iowa, currently do so. Iowa is currently seeking legislation to allow the Board of Parole to issue a certificate of rehabilitation based on information provided by IDOC staff.

[8] Crary, David. Associated Press. Posted February 28, 2008. Retrieved from: http://news.aol.com/story/_a/records-number-of-americans-in-prison.20080228163909990001?ncid=NWS00010000000001, on February 29, 2008

to be fair (to the victim, to the community, and to the offender), balanced, and effective *with a focus on rehabilitation*.[9]

As noted in the Durrant Phase I Master Plan Report, there are legislative initiatives that have impacted the criminal justice system in the past ten or more years including:

- The Violent Crime Initiative (Iowa Code §902.12) effective July 1, 1996, abolished parole and most of the earned time for Sexual Abuse 2nd degree (as well as several other offenses). Changes to the law have since been enacted to permit parole considerations after 70% of the maximum terms are served, but the first of these offenders will not be eligible for parole until 2015.

- A Sexually Violent Predator Law (Iowa Code Chapter 901A) was also made effective July 1, 1996, increased maximum penalties for certain repeat sex offenders and also abolished parole and award of most of the earned time for these offenders.

- Legislative changes effective July 1, 2005 created a new Class A felony, which provided for loss of earned time for refusing sex offender treatment, enhanced certain provisions related to lascivious acts with a child, and created an additional special sentence of parole.

- Districts reported that when the legislature increases staff salaries, that they often do not raise the funding to support those raises. The result is that the District must cut other spending in order to pay for increased staff salaries. These cuts usually come from the one area that is possible to cut and that is programs.

- It was also pointed out that some recently enacted legislation may have had an impact on institutional and community corrections. Some examples that have recently occurred include:

    - Operating While Intoxicated (OWI) penalty enhancements have resulted in additional prison time. Prior to this change the courts went back 6 years for prior offenses but now go back 12 years. This has resulted in a higher number of second and third offenses thus creating a "new class" of offender who are placed in prison and in CBC residential beds.
    - The addition of precursor drugs to the list of illegal drugs has resulted in additional incarcerations.

    - Barriers to housing in locations where services could be obtained primarily for sex offenders (i.e., cannot live within 2000 feet from a school).

The Iowa legislation is not unique nationwide; indeed there is considerable commonality among the states. Nonetheless, the legislation can and does have a significant impact on reentry efforts, often limiting transitional options for returning offenders. As a result,

[9] New Jersey Institute for Social Justice. Prisoner Reentry: The State of Public Opinion. Eagleton Institute of Politics Center for Public Interest Polling at Rutgers's University. Retrieved from: http:www.njisj.org/reports/eagleton_report.html. July 20, 2007

offenders return to their communities upon expiration of sentence without the benefit of services, programs, and in particular, transitional supervision. More than 20% of all IDOC releases during January 2008 were upon expiration of sentence.[10] Granted, not all of the releases would require supervision following release; however this statistic does highlight the potential significance of a failing to provide for appropriate transitional/step-down measures.

A comprehensive review of the Iowa legislation should be considered to determine which legislation actually supports public safety and which legislation may serve as barriers to successful reentry although they and do not negatively impact public safety.

The grant received by the ACLU of Iowa to create a publication about restoration of voting rights to ex-felons is a positive step in supporting reentry,[11] as is the legislation introduced that would mandate the Board of Parole to implement a certificate of employability program.

Local Community Support

Local community support includes the degree to which the community can, and chooses to support the reentry initiatives; and in particular, the programs an offender may require for successful reentry upon return to the community. Moreover, the local community support includes the access to resources, family and community ties, and appropriate peer relationships. The salient questions include:

- Will the offender return to the community he/she resided prior to incarceration?
- Is the family willing to aid in the reentry plan?
- Are there appropriate and affordable housing and services?

Many fathers are released from prison with large child support payment arrearages. Many mothers may have lost custody of their children under the conditions of the Adoptions and Safe Families Act.

Offender reentry disproportionately impacts disadvantaged communities and neighborhoods, typically central cities. Returning offenders are often concentrated in specific communities. In these neighborhoods, large percentages of individuals are either in correctional institutions are/or under some type of correctional supervision. This problem is further compounded because these neighborhoods have high unemployment rates and offer few job opportunities. This churning of large numbers of individuals between prisons and particular communities has a tremendous destabilizing impact on already disadvantaged communities. In fact, research suggests that such high concentrations of returning offenders and the movement of individuals in and out of prison actually drives crime rates up in these disadvantaged communities.[12]

[10]Source: Iowa Board of Corrections Meeting Minutes. February 14, 2008. E-1 Movements Statewide. 01/01/2008-01/31/2008.
[11] Source: Email forwarded by Rachel Scott, Division Administrator, Iowa Commission on the Status of Women.
[12] MacLellan, Thomas. Backgrounder: The challenges and Impacts of Prisoner Reentry. National Governors Association Center for Best Practices. Washington DC. Nov 4, 2004

Particularly in the rural communities, as is the case in much of Iowa, transportation is a major issue. Buses may not be available and the distances may be too far to walk and/or bike. Offenders without an operator's license and/or a vehicle must rely on their family or friends to take them to supervision/program/services appointments. For many families and friends, this requires taking time off from work since many programs and services are operated during standard business hours.

Increased employment is associated with positive public safety outcomes. Researchers have found that from 1992 to 1997, a time when the unemployment rate dropped 33 percent, slightly more than 40 percent of the decline (in overall property crime rate) can be attributed to the decline in unemployment.[13]

There is a growing body of research that shows a clear relationship between work and criminality. For example, research shows that higher rates of labor force participation correspond to lower crime rates among returning offenders. However, despite the well-documented public safety benefits of employment, most returning offenders do not have jobs before being released and do not fare well in the labor market. Despite these challenges, there are indicators that suggest that employers are more willing to hire ex-offenders if third-party intermediaries, such as social service organizations, faith-and community-based organizations, or parole, are involved. Furthermore, employers are also more likely to hire ex-offenders if they are aware of incentives, such as Federal Bonding, Work Opportunity Tax Credit, and Welfare-to-Work programs.[14]

The public/community support for reentry programs can also be seen in its local funding for treatment and services programs for persons returning to the community. Based on the current year Revised Budget FY 2008, only three counties provide funding to their local CBCs, with only 0.7% of the total CBC revenue budget from local counties statewide. Although the CBC funding is discussed in greater detail later in this report, the apparent lack of local community support through funding can be a significant concern.

Public/community support is also demonstrated through the use of Community Accountability Boards that exist in many of Iowa's CBCs. These boards include representatives of law enforcement, city housing, substance abuse and mental health programs, psychiatric nurses, mental health advocates and work force development. Theses boards assist offenders returning to, and remaining in the community by providing a network of interested community representatives and steering the offender to resources where these resources that might be difficult to secure otherwise. Although these Boards are not restricted to mental health programs, successful programs in Iowa that use the Community Accountability Boards are the First and Sixth Judicial Districts. Recent evaluations prepared in February 2007 show that ex-offenders who have a mental illness and participate in the mental health reentry programs are more likely to be successfully discharged from the program and remain in the community rather than reoffending and returning to jail or prison than those with a mental illness who work with a traditional parole officer. Only 24 percent of the participants were unsuccessfully

[13] Maseelall, Aliya; Petteruti, Amanda, Walsh, Nastassia; Ziedenberg, Jason. Employment, Wages and Public Safety. Justice Policy Institute. Washington, DC. October 1, 2007.
[14] MacLellan, Thomas. Backgrounder: The challenges and Impacts of Prisoner Reentry. National Governors Association Center for Best Practices. Washington DC. Nov 4, 2004

discharged from the program, compared with 39 percent of the comparison group who were reincarcerated. Sixty-nine percent of participants in mental health reentry programs successfully completed those programs, versus 61 percent of the comparison group members.[15]

Community commitment to the reentry process is essential for successful offender reentry. The CBCs, the Community Accountability Boards and support from the local community to work with offenders to find housing, employment and other resources are promising initiatives that are proving to be evidence-based. These initiatives, coupled with the one-stop centers described under Partnerships below, will likely be the cornerstone for offender reentry in the future.

Staff Support

The staff support addresses the degree to which the reentry initiative is understood and implemented by staff working for the IDOC and the CBCs. The systemic issues surrounding the efficient use of staff to implement reentry initiatives will be addressed in Section B.2. The staff's understanding of the reentry model and the case planning process will have a significant impact on the offender's ability to understand how he/she progresses through their reentry plan and the level of support the offender will receive in working through the plan.

Ensuring that IDOC staff support the reentry initiative includes both institutions and CBCs since each of these entities has a significant role in the transition of the offender through the system, and therefore reentry as a whole. In fact, research in New Jersey suggested that parole officers became more likely to revoke parole and to return a parolee to prison for lesser infractions than had previously been the case following the issuance of firearms to parole officers which had the effect of "changing the culture of the agency."[16]

Many criminal justice agencies are using boundary-spanners to look at the degree of "fit" between the goals and missions of organizations and the needs of offenders. They work to secure funds and partnerships through that fit, all of the while employing a thorough knowledge of the scientific rationale, theory and policy implications to guide them in their endeavors. Improper referrals, like unsympathetic parole officers, may result in a breach of supervision, sending the offender back to prison, leading to a break in the chain within the social service community.

The IDOC initiatives related to supporting reentry initiatives are varied and at different levels of efficacy. As noted in the Durrant/PBA Phase I Master Plan Report, a Reentry Services Coordinator was hired to integrate the system's reentry programs. Once the IDOC Reentry Coordinator was hired, there were three initiatives executed to educate the staff to the reentry model. These initiatives included presentations to the facilities, networking with the CBCs and providing information through the Quarterly IDOC Newsletter. The addition of newer publications such as *Data Download* provides feedback to staff regarding IDOC initiatives. These initiatives aided in getting information

[15] Source: http://www.ncjrs.gov/ccdo/in-sites/summer2007/reentry_2.html. Iowa Reaches Out to Ex-Offenders With Mental Illness. Retrieved March 18, 2008.
[16] Travis, Jeremy; Keegan, Sinead; Cadora, Eric. A Portrait of Prisoner Reentry in New Jersey. December 8, 2003; http://www.urban.org/url.cfm?ID=410899.

out to staff, but there continues to be concern that staff have not embraced the notion that reentry is a process and not merely a program that begins just prior to an offender's release.

Additional CBC and Institutional Reentry Coordinators were funded and hired to provide more direct client support. Since the IDOC currently begins the reentry planning upon entry into the institutions, the newly funded Reentry Coordinators have been assigned to each of the eight District CBCs and to the three primary facilities from which offenders are released (i.e., ICIW, Newton, and Rockwell City). These staff aid in securing appropriate resources and ensuring that the reentry plan is implemented. The assignment of the Reentry Coordinators to the facilities with the greatest number of releases is the most efficient use of these staff. However, it is important to note that from 20-30 percent of offender releases are still from other facilities without the benefit of a Reentry Coordinator. The lack of focus on a reentry plan in these cases is particularly significant because these offenders are typically those who are the most difficult to place in the community and they are more likely to reoffend.

Reentry Coordinators assigned to the CBCs are used differently in each district. The current job descriptions are general and do not require strict adherence to reentry principles. In most cases, the CBC Reentry Coordinators are used as resource coordinators who screen potential resources in the community and find the appropriate resource for offenders returning to the CBCs. This function is critical to the reentry process both transitioning from the CBC level to community supervision and transition from the institution to the CBC level. The CBCs must maintain an ongoing and current list of resources available and the criteria for their use. In many respects these Reentry Coordinators are operating as the boundary-spanners as described above.

In other cases, the Reentry Coordinators are assigned to support programming and other CBC priorities. There is no indication that the Reentry Coordinators do not serve a critical function at the CBCs regardless of their assigned responsibilities. It does raise a question as to whether the position needs to be assigned as a resource coordinator (rather than reentry coordinator) or if there needs to be a strict adherence to the reentry coordinator concepts that were originally intended.

Reentry Coordinators at the institutions also support the reentry program by supporting the correctional counselor staff, sharing resources, and monitoring milestones in the release process. The reliance on the institutional Reentry Coordinator rather than the Correctional Counselor may have the potential to fundamentally relieve institutional case management staff of their responsibility to implement the reentry plan. Correctional counselors may assume that the reentry coordinator is coordinating the reentry plan, and therefore the correctional counselor is available to work on other, seemingly equal, priorities. In this case, there indeed may be a need to monitor the transition of the offender through the reentry case plan, particularly if correctional counselors are still managing caseloads of 125 or more as noted in the Durrant Phase I Master Plan Report. Moreover, the ICON system must provide easy access to reentry information (e.g., progress through the reentry plan) as described in greater detail in this chapter.

Consistent with the premise that employers are more willing to hire ex-offenders if third-party intermediaries are involved, the support of IDOC staff can be instrumental in securing parole for many offenders. According to members of the Board of Parole, the correctional counselors who prepare offenders for their parole hearing are generally

more likely to be approved for parole.[17] Despite the lack of empirical evidence to support this notion, the Board of Parole reports that correctional counselors are conducting mock parole hearings and are actively supporting the release of many of the offenders.

Offender Support

It is generally agreed upon that most offenders strive to secure release from the criminal justice system. Offenders having a stake in their own reentry will likely be more successful than those for who are walked through the process. Many resources exist for the offender who seeks to secure opportunities for successful release. One such resource is the Employment Information Handbook for Ex-Offenders. This handbook addresses opportunities that begin with what the offender should do to prepare for release, through Department of Labor programs and other programs that may provide assistance.[18]

The Director of the National Institute of Corrections reinforced that one promising evidence-based practice for motivating offenders and fostering positive behavioral changes is motivational interviewing (MI).[19] First developed in the addiction treatment field, MI is now being applied widely and with positive results in corrections, particularly in probation and parole. The principle behind MI is that by listening to offenders and following up on the positive aspects of their speech and thinking, corrections professionals can help increase offenders' motivation to make positive changes in their lives that will reduce their likelihood of reoffending. The IDOC currently uses motivational interviewing techniques as part of their initial classification interview and in implementing case management for offenders in the institutions and CBCs.

Mechanisms to encourage offender support for reentry also include fees for service, and other motivating factors such as incorporating program completions and prosocial behaviors in the classification instrument that is currently undergoing revision.

B2. The degree to which systems are in place to support transition through the stages of the criminal justice system.

Regardless of the support an offender may have to progress through their reentry plan, a major barrier to successful reentry is ensuring there is a process in place to transition from one phase of the case plan to another. This transition must be accomplished in a seamless fashion if the reentry planning is to be uninterrupted. Only through established processes and well-developed partnerships among the key stakeholders will reentry transition occur successfully.

Historically, an offender's transition into to the community has lacked coordination between criminal justice partners. There was no mal-intent in these cases; rather, each of these criminal justice partners endeavored to fill the gaps of reentry on their own and, more importantly, based on their perception of the most pressing issue at that time. The

[17] Interview with Board of Parole representatives October 8, 2007.
[18] U.S. Department of Labor. Employment Information Handbook for Offenders. 2005 Edition.
[19] Thigpen, Morris L. A Guide for Probation and Parole: Motivating Offenders to Change. US Department of Justice, National Institute of Corrections. June 2007. NIC Accession Number 022253

result of this approach was duplication of processes, and in some cases programs, and the lack of a smooth transition/step down approach to reentry. The duplication of programs and services will be addressed in Section B.3; the lack of a smooth transition will be addressed in this section.

Key components of a reentry process that facilitates successful transition into the community include the following:

- The importance of a tiered, flexible, step-down approach for reentry. This approach requires cooperation from the institutions and the CBCs. As such, some systems approaches/procedures must be put in place so there is a common language and common objectives.

- The degree to which the criminal justice system can establish partnerships with local, state and federal, and non-profit agencies to effectively assess and address offender needs. There is considerable evidence to support the premise that a period of supervised transition from prison to the community enhances public safety and the rehabilitation of offenders.[20]

- The ease at which information can be shared between the criminal justice partners. Technology is a major resource to the field staff and administrators to share information regarding an offender's progress to the reentry case plan, and providing feedback regarding both individual progress and overall reentry successes, or failure, to tailor future resource allocation.

These three concepts will be the focus of this section of the report.

Step-down Reentry

A tiered and flexible step-down approach is essential to support offender reentry. One of the most salient concepts discussed earlier in this chapter is at what point in an offender's involvement with the criminal justice system does/should reentry begin. Most IDOC reentry initiatives begin upon an offender's reception in the prison system. These initiatives include establishing a reentry plan based on a battery of assessments administered at upon intake at the IMCC. However, some of these assessments are administered when the offender enters the criminal justice system and is assigned to CBC staff. The access to these assessments (e.g., LSI-R) suggests that reentry could, and perhaps should begin upon entry into the criminal justice system rather than just upon entry into the institution. Admittedly, it would not be cost effective to administer the entire battery of assessments as an offender is assigned to CBC staff; however, when these assessments are indicated, is essential that the reentry planning begin and continue based on the assessment findings.

A critical component of an effective reentry model is a seamless continuum of care with information about the offender's progress being transmitted through each stage of reentry. Within the reentry continuum-of-care process, transitional or "step-down"

[20] Solicitor General of Canada. (1998). Towards a Just, Peaceful and Safe Society – The Corrections and Conditional Release Act Five Years Later.

programming in a secure setting plays a critical role.[21] Outcome research indicates that the continuum of care model is not only essential to successful reentry, but has been found to reduce recidivism in a high-risk offender population. The reentry continuum of care model consists of multiple phases: the institutional phase, the "step-down" phase, the community release phase and aftercare. The first phase focuses on a comprehensive assessment of the offender's risk level and treatment needs. The "step-down" phase is designed to provide treatment in a modified therapeutic community, which rewards pro-social behavior. Residents participate in role-playing exercises designed to teach new skills and prepare them for challenges they are likely to face in the outside word. During the community release phase, the offender's risks and needs are matched with the appropriate release center services.[22] The IDOC uses this continuum of care model and seeks to seamlessly transitions offenders through this model.

There are also a number of program initiatives that allow for discretion in implementation based on the offender's responsivity to treatment and programming. Examples include provision for placements into some CBC programs for a length of time defined as "the maximum benefits." Under this provision, offenders can be released and returned to residential facilities as determined appropriate for the offender.

Several District CBCs provide for a graduated sanctions model that the CBCs use to impose timely consequences for inappropriate offender behavior to reduce the demands of community corrections on the courts' time. The District CBCs that are most successful with the graduated sanctions model report having strong relationships with the judiciary. At least one district reported anecdotally that they enjoy the judiciary agreeing with their recommendations 95% of the time.

Many of the CBC initiatives are described in subsequent chapters however it is important to note that these initiatives range from residential treatment to life skills programming at varying levels of efficacy. In some cases there are extensive waiting lists (particularly residential beds), and some programs are streamlined/modified to meet the needs of the offender population (e.g., limited transportation, conflicting work hours, etc). Residential CBC beds are a resource available to support the step-down concept. In fact, work release programming is frequently a parole release condition. Due to the lack of beds, however, some offenders often wait in the institutions for a bed to become available. One option that has been used to help prepare offenders for work release in the community is the Minimum Live Out program (MLO). This program is available at the three primary release facilities (Newton, Mitchellville and Rockwell City). The MLO program offers the offender an opportunity to live outside the secure perimeter and work in the community under criteria similar to the CBC Work Release Program. The difficulty with the MLO program however, is that the offender is often working in an area where job options are limited (e.g., Mitchellville), and more importantly, these offenders are not building support systems in the community to which they will return. The MLOs do provide a necessary step down level for offenders who require a very gradual step down to community supervision, and therefore the concept should not be discarded altogether;

[21] Fretz, Ralph. "Step down" programs: the missing link in successful inmate reentry. Corrections Today. April 1, 2005.
[22] Community Education Centers, Inc. CEC's Continuum of Care Model Prepares Offenders for Successful Reentry. Retrieved from: http://www.cecintl.com/News/DocumentSingle.aspx?DocumentID=11615, March 8, 2008.

rather MLOs should be used when appropriate in the reentry continuum, but not because there is a lack of more appropriate beds.

Some jurisdictions are using their local detention facilities to support the reentry effort and address the lack of beds in the community residential facilities. At the local detention facility the offender is provided transitional education and programming and then placed on work release. In Virginia, the educational programming and work release occur for 45 days each. The intent is to acclimate the offender to his locality and family, provide easy access to those who will supervise and provide services when they are released, to make finding housing easier, establish an employment base, and have more funds (from earnings) available to the offender than would otherwise be on hand upon release.

Considerable thought has been given to ensuring that offenders transition from the institutions to the CBC residential facilities and then to community supervision. Generally, a specific push to begin the transition planning occurs between six months and 60 days prior to release eligibility. The institutional reentry coordinators initiate contact with the offender and the assigned case manager. However, recognizing that offender information is available prior to incarceration, it is natural to assume that the reentry process (i.e., to eliminate barriers to community reentry through early assessment and appropriate interventions, establishing pro-social offender behavior expectations, effectively leveraging reentry through systems linkages) needs to include offenders who are under community supervision. Under this model, offenders who only reach community supervision may also be assessed, directed to participate in relevant interventions, etc. to reduce the risk of reoffending. Indeed, many CBC probation and parole staff would argue that they have espoused these principles and concepts for many years. The recognition of the importance of reentry by the institutions merely supports many existing CBC initiatives. With this understanding in mind, the importance of developing a tiered, step-down system, the CBC is a key participant.

One barrier to seamless transition is the lack of a comprehensive process flow that would aid case managers and/or reentry coordinators to make appropriate placements. This concern is discussed in greater detail in Section 2.C. The CBC-Bed Focus Group is endeavoring to clarify the process or flow that would support transitional reentry for special populations. A continuum or flow to identify the special populations that require additional focus would also provide for better information as to the use, and need for, CBC residential beds.

Partnerships

In order for reentry to be successful, and for a smooth transition from one program/initiative to another, partnerships must be developed so that case management or reentry staff can swiftly and easily place offenders in appropriate treatment programming consistent with their reentry plan.

The importance of the boundary-spanner was addressed earlier in this chapter as it relates to developing resources and fitting these resources to the offender's need(s), but the significance of this role cannot be overstated as it relates to supporting an offender's transition through the reentry case plan. In order for the system to be seamless, particularly for the offender, there must be a period of transition between the reentry plan at each level/tier (e.g., institutions, community based residential treatment and

probation/parole). During this transition period, the offender must undergo preparation to be supervised by a different criminal justice system partner, begin to acclimate to the new set of expectations, and begin to find closure with their currently assigned case manager and other treatment staff.

Consistent with the significance of the partnerships is the degree to which there is a consistent message among the partners; in this case, the institutional staff, community-based corrections staff and Parole Board. This message must also be consistent among the line security staff and the program staff. Security and treatment cannot operate independent of each other, indeed they are interdependent. Programs cannot be effective if offenders do not feel safe within the program environment; security is not as effective if offenders do not exhibit self-control that is a learned behavior through cognitive-behavioral programming and reinforcement.

An example of an effective partnership is the agreement between the Board of Parole and IDOC to hire an additional Statistical Research Analyst to conduct Board risk assessments at the time of an offender's admission to the prison. The implementation of the front-end risk assessment enables the IDOC to establish a DOC Release Recommendation Date that will drive offender programming and release recommendations.

One successful partnership initiative occurred in North Carolina whereby legislation was passed to focus, in part, on creating strong partnerships between the state and local corrections agencies by requiring them to cooperate in developing and funding effective community corrections programs. Where each program once had submitted its own budget, the Sentencing Commission, working with the Department of Corrections, brought various local community corrections agencies together to agree on a unified budget.[23] The state continued to fund and run most large programs, such as intensive probation, while local governments continued to fund and run smaller programs that they developed or that already existed. The state appropriated annual grants to local governments to support their community corrections efforts. It was a win-win outcome for the state and local officials. The state profited because North Carolina's communities served as proving grounds for a variety of community corrections approaches, localities received not only funding from the state, but also annual lists of community corrections programs in the state, which gave judges regularly updated information to determine appropriate punishments for offenders.[24]

There are several examples that illustrate how Iowa's criminal justice system has moved in the same direction as North Carolina, but without the legislative directive. Iowa has benefited from a long history of collaboration between the institutions and community based corrections. Iowa was one of the first and only states to successfully focus on the concept of community based corrections in the early 1970s. In 1974, the General Assembly passed legislation specifying the development of community-based corrections locally administered within the eight Judicial Districts. All non-institutional

[23] Wright, Ronald F., "Counting the Cost of Sentencing in North Carolina, 1980-2000" (September 14, 2001). Available at SSRN: http://ssrn.com/abstract=287356 or DOI: 10.2139/ssrn.287356

[24] Pew Charitable Trust. Sentencing and Corrections Reform Case Study: North Carolina. February 14, 2007. Available at: http://www.pewcenteronthestates.org/report_detail.aspx?id=33048.

adult offender supervision (i.e., probation, parole, and work release) was assigned to the eight district departments with programming monitored by the Department of Corrections.[25]

The community-based structure embeds local priorities in managing probation and parole offenders. Each CBC agency is governed by a Board of Directors established by the Iowa Code with members that include: county supervisor from each county in the District, members of the judiciary, and members from project advisory committees. The Boards set policy, approve budgets and oversee the management of administrative and program operations consistent with DOC standards. The DOC works with the CBCs to develop statewide planning, program guidelines and outcome measures, and provides for capital construction and budget oversight.[26]

The CBCs provide a sound foundation for networking and developing partnerships with counties and private providers. Under the CBC concept, the state is not dictating the county's needs; rather, services are implemented to meet the needs of the communities where the greatest needs exist.

One potential area of concern is the consistency in service delivery between the CBCs and the degree to which the state, the primary funder of the CBCs, can secure resources to meet its goals and objectives. For example, if the CBC elected not to implement the Iowa Prisoner Reentry Initiative (IPRI), the state has little authority to ensure that the CBCs implement the state's initiatives. All observation suggests that the cooperation between the DOC and the CBCs has been supportive. Although there is not empirical evidence as to why the relationship continues to be productive, it could easily be the case that both the institutions and the CBCs strive to implement best practices, and therefore the systems they put in place are consistent.

On the other hand, there does need to be an expectation that the funding is used to advance the vision of the IDOC. The figure below summarizes the current year Revised Budget FY 2008 CBC revenue budget disaggregated by type.

[25] Prouty, Dennis. Community-Based Corrections. Issue Review. Iowa Legislative Fiscal Bureau. September 23, 1998

[26] Source: Iowa Department of Corrections Application for Center for Effective Public Policy's Serious and Violent Offender Reentry Initiative Training Program: Community Safety Through Successful Offender Reentry. Overview of Collaborative Relationship Between DOC and CBC. March 15, 2006.

Figure III-B2-1: DISAGGREGATION OF CBC REVENUE BY TYPE

District	Total Budget	State Appropriated Funds	Percent of Total	Participant Fees / Vending	Percent of Total	Localities Funding	Percent of Total
1	$16,176,550	$12,934,249	80.0%	$2,507,537	15.5%	$446,624	2.8%
2	$12,492,481	$10,486,325	83.9%	$1,600,000	12.8%		0.0%
3	$7,247,798	$6,103,760	84.2%	$787,694	10.9%		0.0%
4	$6,287,683	$5,711,137	90.8%	$520,000	8.3%		0.0%
5	$24,368,600	$18,736,696	76.9%	$2,003,648	8.2%	$133,250	0.5%
6	$16,724,195	$13,169,987	78.7%	$1,997,540	11.9%		0.0%
7	$8,913,753	$7,253,026	81.4%	$1,384,763	15.5%	$164,464	1.8%
8	$8,334,270	$7,298,544	87.6%	$600,000	7.2%		0.0%
TOTAL	***$100,545,330***	***$81,693,724***	***81.3%***	***$11,401,182***	***11.3%***	***$744,338***	***0.7%***

Source: Revised Budget FY2008.

The state funded revenue of the District CBC budget ranges from a low of 76.9 percent of the total budget to a high of 90.8 percent of the total budget. Most districts do not benefit from local funding support and those that do receive local funding only receive, in this case, a maximum of 2.8 percent of the total budget. The remainder of the funding is received from grants (not listed in the above table) and participant fees or revenue from vending to the offenders.

There are three areas of concern when considering the revenue sources. These concerns can be summarized as follows:

1. Does the IDOC receive services for offenders returning from the institutions commensurate with the total state funding?

2. To what degree do participant fees and vending/commissary revenue contribute to the reentry effort?

3. To what degree does local funding or the lack of local funding, indicate the support of the locality to the reentry effort?

The research we have uncovered begins to identify some of the key considerations regarding this funding. When considering the cost-benefit to the IDOC for funding the CBCs it is important to note that the legislative expectation of IDOC's funding is that the CBCs are a major component of the criminal justice system. Without the CBCs, there would likely be a decreased utilization of alternatives to incarceration programs and services, thus increasing the institutions' offender population. Therefore, the assumption is that funding for the CBCs would continue irrespective of whether these funds were requested by the IDOC through the budget process.

Institutional correctional counselors must develop relationships with case management staff at the CBCs. This collaboration is currently underway due in no small measure to the implementation of the focus groups. Specific examples of difficult to place cases are being raised during the focus group meetings. Those who attend those meetings are sharing their similar experiences and some of the resources they have been able to secure. These relationships must continue to be fostered/developed to maintain the current momentum they are experiencing.

Another promising initiative is the implementation of one-stop centers. These centers are designed to provide previously incarcerated offenders with an even broader range of transitional services to help them address the barriers many face as they strive to regain self-sufficiency and secure employment. The goal of one-stop centers is to reduce recidivism and to increase public safety by offering a comprehensive menu of support inmates at one location, under one roof.[27] While many of the services are accessible on site, other critical resources are made available through a streamlined referral process to outside criminal justice and community partners (i.e., wrap-around services). Some states have already implemented these programs that are often a collaborative agreement between the Department of Labor and the state departments of corrections or localities. Massachusetts, New Jersey, the cities of Philadelphia and Chicago, and other jurisdictions are successfully implementing these programs. The IDOC and the Governor are exploring the one-stop concept programs for Iowa. This program, along with the successful CBCs and Community Accountability Boards, offer promising results for offenders returning to communities from Iowa's prisons.

Use of Technology

Establishing processes to ensure effective transition through the case management plan, and measuring outcomes of the reentry initiatives cannot be accomplished without effective data management systems. While much data is captured about offenders while they are in the criminal justice system, particularly when they are incarcerated, the systems that store this information must be flexible and robust in terms of the utility of the data and the ability to retrieve data via management reports that support evidence based practices. Lack of compatibility among databases and information systems managed by criminal justice system partners as well as with health and social service information systems can be a significant obstacle to effecting successful offender reentry.

The ICON system is indeed a robust information management system that receives data from most of the criminal justice system partners including the CBCs and the Department of Corrections. The Board of Parole also has access to the database, although they do not provide data input. What makes the ICON data management system so unique from other States is the comprehensive nature of the data sharing. Since this system is shared among the criminal justice partners, institutional and CBC staff can benefit from the information collected by others to develop an offender focused reentry case plan. Data can be shared and updated as necessary to ensure the most current and accurate data possible. Moreover, the shared use of the system allows for improved efficiency since staff do not have to enter offender static data (name, gender, date of birth, etc.) more than once.

An example of the benefits of the shared ICON system is the ability to share information for reentry planning. Information that is entered into the system is available to both IDOC and the CBCs. This is significant since both assessment information and reentry plans are available to both the institutions and CBC staff. An example of this is included below:

[27] Source: http://www.phila.gov/reentry/History.html. History of Reentry in Philadelphia. Retrieved March 15, 2008.

- The Level of Service Inventory Revised (LSI-R) is administered on all offenders to determine their three or four primary treatment needs at the institution, and in some cases at the CBC. Additional assessments that are administered upon commitment to the institution are the Jesness, Adult Basic Education, Beta IQ and a cursory mental health screen.

- Once priority treatment needs are identified, a reentry case plan is developed that outlines the programs and services that the offender will optimally complete before release to the community. If the results of the LSI-R suggest that the risk/needs present a low risk, programs/treatment will not be recommended, consistent with the "What Works" literature. For example, IDOC offers a variety of treatment programs and services described earlier in this report. In addition to treatment, there are additional programs that address educational needs.

- The needs of the offender are matched with the program availability and a "program intervention" is initiated. Once an offender completes the program (or is removed from the program) the intervention is closed, thus providing critical information to the staff making future decisions about offender placements.

- The LSI-R is the primary driver for obtaining information about an offender's needs. Frequently the LSI-R is administered at the CBC level and the information can then be used or updated upon an offender's commitment to the institution. As stated previously, the ICON system is set up to allow the LSI-R results and the reentry case plan to be shared between these criminal justice partners.

Trained staff can retrieve management and statistical reports. There is also the flexibility of information technology staff to modify data fields and data processing to accommodate new initiatives and requirements. With their assistance, staff can access data in a variety of ways to conduct comprehensive analyses of data and trends. These reports are instrumental in making informed decisions regarding the process evaluation and outcome evaluations of programs -- thus supporting evidence based practices.

Some reports are produced on a regular and routine basis (either weekly, monthly, quarterly, etc). Other reports are produced on an ad hoc basis to meet a specific data request. The ongoing reporting has produced changes in priorities and policies including overall institutional bed needs. For example, analyses have resulted in modifications to system-wide population projections. Projections developed by the CJJP in 2006 showed the system population growing to 11,383 in 2016. Recently the revised projections indicate that the system population, and in particular the male population, is not projected to increase as rapidly as had been thought and in fact the projections have decreased by nearly 18% in one year, while the female population is projected to continue to grow at an increased rate of 5.2% as compared to last year.

Despite its very robust statistical and management reporting features, there are opportunities for the ICON system to better support reentry planning and implementation as described below.

Recognizing that successful reentry is a primary goal of the IDOC and the legislature, it is essential that the records management system provide easy access to credible

information regarding an offenders' status through the reentry case plan. In some cases, users cannot access data due to password protections. A review of access levels is currently underway to ensure the maximum appropriate access by users.

There is also a concern that the ICON system cannot illustrate an offender's status in the reentry process in a one-screen view. Currently a user may be required to view several screens to ensure they have an understanding of the treatment, service, and progress of the offender. An analogy that can be used to illustrate these concerns is the difference between a dos-based system and a windows-based system such as providing data in one screen view and the ability to use drill-down menus that provide a visual picture of the offender's status. As a result, staff suggested that it may be easier for the information technology staff to retrieve the necessary data because they have a better understanding of the underlying programming and therefore can easily retrieve information that may illustrate overall need/status.

To obtain the maximum benefit of the ICON system as it relates to reentry initiatives, the system must provide a summary of information relevant to an offender's reentry progress/status. Improvements could include providing an overview screen that would illustrate an offender's progress through their reentry plan in a flow chart style format. The field user could then activate a particular point in the plan to determine what the offender must complete to meet the next phase of the reentry plan (e.g., to show if an offender is currently accepted into a program or is on a waiting list). Using similar programming, administrators would be able to "drill down" to specific future times when offenders may be eligible for a particular program. With that type of planning capability, it will be an effective means for anticipating future costs or a reduction in programs if the needs do not warrant the same level of programming.

Mapping

The other deficit of the ICON system is the lack of a mapping system. Mapping systems are used to pull data from a data management system to provide a visual of data trends. These trends may include arrest data, conviction data, residence data and other data that is critical to the decision making process. For example, it would be important to know which jurisdictions have the highest rate of drug offenses for two reasons. First, it would help identify where prevention resources would be best utilized, and second, treatment opportunities could then be targeted in these areas. The patterns and distribution of reentry could be better understood, and a greater knowledge of them could enable local policymakers and service providers to develop more effective interventions.

The mapping trend started in the mid-1990s, when a new model for action research emerged. Organizations in several communities throughout the country began to assemble neighborhood-level data and then help community actors apply this information to motivate positive change in distressed areas and aid in program and policy development. In order to learn from each other and promote the model to other cities, these organizations joined together with the Urban Institute in 1996 to form the National Neighborhood Indicators Partnership (NNIP). Using data describing various conditions and trends at the neighborhood level to identify spatial patterns of problems and opportunities, these institutions have engaged their communities on issues ranging from welfare reform to vacant housing to public health. Applying this successful NNIP model to the topic of offender reentry, the Urban Institute in 2001 began efforts to

develop the Reentry Mapping Network, a partnership working to strengthen communities' capacities to understand and address local problems related to offender reentry.

Where appropriate, this data could be illustrated on a map that would also include major highways. Continuing with the drug use example, it would be important to know if the majority of the high intensity drug trafficking areas are located at major interstate highways. This data could suggest that drugs are being transported to these areas and then distributed from these high-risk points. Where this is the case, enhanced patrol/law enforcement measures would be appropriate.

Mapping can provide a detailed illustration of the reentry phenomenon and can help guide policy development at the local level. The utility of reentry mapping is best illustrated through the types of questions this method might help answer.

- *Where Are Offenders Returning?* Analyses of offender reentry that are limited to the county or city level may obscure important patterns and trends occurring within the community. Mapping can help identify areas that experience high concentrations of offenders returning home. For example, by mapping the last known addresses of released offenders, one can pinpoint concentrations within cities and neighborhoods, right down to the city block. This information can provide local policymakers and community organizers with the capacity to target intervention efforts and resources in the areas that most need them. And, because the use of a Geographic Information System (GIS) enables spatial analysis across a variety of variables of interest, one can map not only where offenders are returning, but may also explore what types of offenders are returning to specific neighborhoods. For example, one could map released offenders based on whether they are under post-release supervision. Those under supervision are more likely to be monitored and to have access to programs and services than their counterparts who are released unconditionally. This difference can have implications for service delivery, in that if unsupervised releasees are located in certain clusters within a city, services could be targeted to those locations. This is particularly important to returning sex offenders who often have difficulty securing housing obtaining services. The use of mapping technology could allow correctional counselors and case managers to work closely with offenders to provide the most appropriate resources; communities could provide resources in locations where there may be a significant need for those services.

- *Are Resources and Services Accessible to Those in Need?* One of the most useful applications of spatial analysis as a policy tool is the generation of maps to guide resource allocation. Mapping released offenders in conjunction with services available to them can illustrate areas containing adequate services in close proximity to where the majority of offenders return. Such mapping can also detect a "service delivery mismatch," in which services exist but are not easily accessible. Another example that illustrates how reentry mapping might guide resource allocation is the need for safe and affordable housing for returning offenders. Some offenders have no housing available to them after their release and have no remaining ties to family and friends on the outside. These housing challenges are exacerbated when offenders return to their old neighborhoods only to find that there are no shelters or affordable housing options for them.

Mapping the locations of shelters, halfway houses, and other affordable housing in relation to where offenders return can illustrate the extent of this problem and provide guidance in choosing an appropriate site for new housing options for releasees. Identifying areas with high concentrations of returning offenders may also help guide service delivery for the families of returning offenders in these neighborhoods. In addition, mapping may help focus law enforcement and parole officer efforts to mitigate the public safety risks associated with high concentrations of released offenders. For example, mapping gang activity within the community and gang affiliation among released offenders may help in pinpointing those who are at greatest risk of committing violent crimes after release, suggesting a different type of reentry intervention for that subgroup than for the general population of releasees.

- *What Are the Characteristics of Areas with High Concentrations of Releasees?* Identifying and responding to the challenges of offender reentry require an understanding of the nature of the communities to which offenders return. Thus, examining neighborhood indicators of both basic demographics and community well-being (e.g., housing tenure, percentage of female-headed households, vacant housing, voter status, educational attainment, marital status, fertility, infant mortality, place of birth, language, and ancestry) can aid in developing a measure of community resources, which will help determine the extent to which communities are equipped to address reentry challenges. Research examining the geographic distribution of released offenders in Baltimore, for example, found that the six communities that were home to the greatest number of returning offenders also had rates of unemployment, female-headed households, poverty, and crime that were much higher than the citywide average.

- *How Can Mapping Help Measure the Success of a Reentry Intervention?* Mapping can also serve as a tool for assessing the effectiveness of intervention efforts. For example, if an intervention involves attracting new businesses to a community with high concentrations of returning offenders, mapping the change in employment rates over time can provide evidence that the business is having a positive impact on employment compared with other areas in the city.

Currently, this data must now be synthesized by hand by providing a listing of the jurisdictions and then mapping the results by hand. This is a cumbersome process and there is not sufficient staff to conduct this type of analysis, particularly on an ongoing basis.

A comprehensive review of the data management system should be considered to determine the degree to which the ICON system advances the reentry initiative, and to explore enhancements to the system such as mapping.

B3. The degree to which programs can be implemented cost effectively.

The reentry initiative is being implemented at a very fast pace considering the progress made since the time that the initiative was first prioritized in 2006. The number of CBC and institutional initiatives/activities are too numerous to detail in this report; however initiatives/programs that have made the most significant impact will be noted. This

should not diminish the understanding of the full range of programming, services and initiatives implemented by the IDOC, particularly over the past several years.

The two short–term recommendations identified in the Durrant Phase I Master Plan Report were to conduct a needs assessment to determine additional resources necessary to enhance capacity of applicable institutions to provide evidence-based reentry programs; and, to build further collaboration between institutions and the CBCs around Reentry Release Planning for incarcerated offenders. Arguably, one of the most effective initiatives to accomplish the collaboration is the implementation of the twelve (12) focus groups during the Spring of 2007. The Director's vision to provide forum for the criminal justice partners to coordinate and "cross pollinate" addresses the critical issues that are current and significant to the IDOC.

An inventory of available services is underway and is being conducted in large measure by the CBC Reentry Coordinators. Resources are also being catalogued at the institutional level since there are a number of reentry programs to prepare offenders for transition to the community. As noted in the Durrant Phase I Master Plan Report, institutions are attempting to move toward evidence-based practices in their provision of programs and delivery of services; however, in most cases the infrastructure has not been fully developed and these programs are under-resourced. The most significant deficit is in the area of outcome studies, which is the cornerstone of evidence-based programs that have been proven to be effective.[28] [29] [30]

According to Gendreau, who is one of the foremost researchers in criminal justice and correctional programming, there are principles for effective and ineffective programs. These principles are based on a combination of meta-analysis, narrative reviews, selected experimental studies and clinical knowledge. In summary, these principles are as follows:

1. Services – Services should be intensive and behavioral in nature. Intensive services occupy 40% to 70% of the offenders' time while in a program and are of three to nine months in duration. Behavioral programs are based on the concepts of using prosocial reinforcements that are contingent on the behavior being enacted. Token economies, modeling and cognitive behavioral programs are prevalent in the offender behavioral treatment literature. A well-designed program will employ at least two of these reinforcements.

2. Behavioral Programs – The behavioral programs should target the criminogenic needs (the dynamic risk factors) of high-risk offenders. It is critical that behavioral programs employ risk assessment measure that measure a wide range of criminogenic need factors.

[28] FY 2008 Budget Request
[29] Aos, S; Miller, M & Drake, E. (January 2006). Evidence-Based Adult Corrections Programs: What Works and What Does Not, Washington State Institute for Public Policy
[30] Aos, S,; Miller, M & Drake, E. (October 2006). Evidence-Based Public Policy Options To Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates. Washington State Institute for Public Policy,

3. Characteristics of offenders, therapist, and programs should be matched which supports the principle of responsivity. This principle is based on matching treatment x offender type x therapist's style with the following three components:

    - Matching the treatment approach with the learning style and personality of the offender.
    - Matching the characteristic of the offender with those of the therapists.
    - Matching the skills of the therapist with the type of program.

4. Program contingencies and behavioral strategies should be enforced in a firm but fair manner.

5. Therapists should relate to offenders in interpersonally sensitive and constructive ways and should be trained and supervised appropriately.

6. Program structure and activities should be designed to disrupt the delinquency network by placing offenders in situations (people and places) where prosocial activities predominate.

7. Relapse prevention strategies should be provided in the community to the highest extent possible.

8. A high level of advocacy and brokerage should be attempted as long as community agencies offer appropriate services.

There are also principles of ineffective intervention that should be avoided. Some of these ineffective interventions are:

1. Traditional "Freudian" psychodynamic nondirective or client-centered therapies ("talking" cures, ventilating anger, externalizing blame, etc).

2. "Medical model" approaches, such as changes in diet, pharmacological (i.e., testosterone suppressants).

3. Subcultural and labeling approaches that base their response on emphasizing respect for the offender's culture and "doing good for the disadvantaged."

4. Programs, including behavioral, that target low-risk offenders since the low-risk offenders would likely not reoffend regardless of their participation in programs.

5. Programs, including behavioral, that target offender need factors that are weak predictors of criminal behavior (e.g., anxiety and depression).

6. Punishing smarter strategies – often more commonly known as intensive supervision programs (home confinement, frequent drug testing, restitution, shock incarceration, boot camps).

Gendreau points out that the punishing smarter strategies are popular in the United States but are not popular in other comparable Western societies such as Canada. In one preliminary meta-analysis of the punishing smarter literature, the authors found that these programs produce, on average, a slight increase of recidivism of 2%. Similar studies have found the same results. Of the studies that reported reductions in recidivism of more than 20% were ones where each attempted to provide as much treatment services as possible.[31]

Evidence-based practice in community corrections is also recognizing the importance of Gendreau's principles of effective intervention by translating the research findings and developing eight Evidence-based Principles for Effective Interventions[32] as follows:

1. Assess Actuarial Risk/Needs – the ability to identify needs and ensure the assessment is transportable to other criminal justice partners.

2. Enhance Intrinsic Motivation

3. Target Interventions.

    a. Risk Principle: Prioritize supervision and treatment resources for higher risk offenders.

    b. Need Principle: Target interventions to criminogenic needs.

    c. Responsivity Principle: Be responsive to temperament, learning style, motivation, culture and gender when assigning programs.

    d. Dosage: Structure 40-70% of high risk offenders' time for 3-9 months.

    e. Treatment: Integrate treatment into the full sentence/sanction requirements.

4. Skill Training with Directed Practice (use Cognitive Behavioral treatment methods).

5. Increase Positive Reinforcement

6. Engage Ongoing Support in Natural Communities.

7. Measure Relevant Processes/Practices

[31] Gendreau, Paul. The Principles of Effective Intervention With Offenders. Choosing Correctional Options That Work. Alan T. Harland, Editor. Sage Publication. Thousand Oaks. 1996.
[32] Faust, Dot. Implementing Evidence-Based Practice in Community Corrections: The Principles of Effective Intervention. National Institute of Corrections and Crime & Justice Institute. Washington DC. April 30, 2004.

8. Provide Measurement Feedback.

Cost effective program implementation requires a combination of ensuring offender's needs are identified, the appropriate evidence-based resources are available, and the offender is responsive to treatment. The availability of appropriate community resources is partially a result of the ability of a community to fund community based programming both for its community-based and returning offender population, and others for whom there is a higher risk of becoming involved in the criminal justice system (e.g., substance abusers, etc). Rural counties are not able to provide many services primarily because it would not be cost effective to do so. One illustrative example was reported by a probation officer who directed a client to undergo substance abuse assessment because a substance abuse treatment provider was not available in this particular area, and the offender has limited means of transportation. The offender, in this case, was meeting all other terms of probation, and this particular service just was not available in a client centered fashion. IDOC and the CBCs report using similar creative means to secure services or treatment programs for offenders in need.

Successful program *participation* is contingent in large measure on the offender's willingness to participate in evidence-based programming or other resources availed them. Punitive measures such as loss of driving privileges and exclusion from professions are cited as being significant for recently released offenders as particular barriers to obtaining stable jobs.[33] The exclusion from some professions is exemplified in a newspaper report in one Florida jurisdiction that listed the jobs that needed to be filled by major employers in the area as computer skills, health care, and senior home care. Most of these positions would not welcome employing someone with a criminal history.[34]

As noted earlier in this chapter, housing continues to be a significant issue for the offender population. Most offenders will not be released to the streets without having appropriate housing, yet felons or persons with bad credit histories can be disqualified by potential landlords.

Transportation continues to be a significant barrier to securing employment and receiving services. This barrier may be related to either the lack of a valid operators' license or the lack of a vehicle. In either case, the offender must often rely on family and friends (with whom they likely already have a strained relationship), to provide transportation. As noted earlier, this barrier is most prevalent in rural jurisdictions where distances are far too great for offenders to walk/bike to employment/services/programs.

Measures to address the effectiveness and appropriate utilization of these programs are a priority for IDOC staff. Several of these program initiatives include:

- A survey was conducted in July 2007, of the programs available at both the institutions and District CBCs. The results of the study indicated that of their total number of programs, more than half were ranked as "Needs Improvement." Of the 12 areas ranked, both the institutions and the CBCs noted that "Documentation of an

[33] Eagleton Institute of Politics Center for Public Interest Polling, Rutgers the State University of New Jersey, "United Way of Central Jersey Compass Needs Assessment," focus group with recently released prisoners in New Brunswick, March 2001 – June 2002 (Patrick Murray).
[34] Source: *Miami Herald* , Sunday, January 27, 2008.

External Evaluation" and "Examples of how community support and connections that last are established" were two of the top three deficits. This survey suggests the need for continued emphasis on evidence-based practices, but the survey itself is clearly evidence that IDOC seeks to provide evidence programs and services.

- There are other initiatives that suggest a commitment to evidence-based practices. The IDOC partnered with the Department of Management to evaluate IDOC institutional substance abuse treatment interventions' effectiveness, and found that IDOC is administering a number of promising substance abuse treatment programs. An in-house analysis of the violator program found it to be promising *if* participants receive comprehensive aftercare services. For those who do, the recidivism rate for violation program participants is comparable to those who had served longer terms of confinement. And the Division of Criminal and Juvenile Justice Planning is currently evaluating all drug courts, which includes a comparison of judge-directed courts with community panel-led courts.[35]

- The institutions are also re-evaluating their programs with the goal of realizing maximum benefit of resources. Staff at the Newton Correctional Facility (NCF) acknowledged that the existing computer lab is underutilized. The NCF is currently working with DMACC to bring additional programs like keyboarding and basic computer skills. Creative alternatives are being considered such as using canteen funds to pay for instructors while DMACC updates the computers. Similarly NCF has identified 35 potential employers in Des Moines, Ames, Story City, West Des Moines and Boone where there is a substantial shortage of trained welders. These employers will interview candidates returning to their community and determine potential employability.

- Another promising program that is a collaborative effort between the IDOC, the Iowa Workforce Development Centers, the Second District Correctional Services, and the Division of Criminal and Juvenile Justice Planning (the systems analyst partner) is the Rural Service Delivery Model to help offenders safely and successfully reenter rural Iowa communities. This project will replicate aspects of the current Urban Reentry Model provided by FY 2002 Serious and Violent Offender funds in Polk County. This particular program focuses on the Second Judicial District which has seen a significant increase in the number of offenders under supervision and current resources are inadequate to provide the necessary services. The program proposes to test and establish a sustainable Rural Reentry Model that can be replicated in other rural areas, both within and outside of Iowa.[36] The Iowa Risk Assessment/Reassessment system instrument will be administered every six months for assigning levels of supervision and must score 39 or less on the LSI-R to participate in the program. This program identifies impact/outcome, evaluation and sustainment measures with the goals to:

[35] Source: Letti Prell. Data Download, Iowa Department of Corrections. Volume 1, Issue 1. March 2008.
[36] Maynard, Gary, Director. Project Narrative: Iowa Prisoner Reentry Initiative (IPRI_ Rural Service Delivery Model: A Collaborative Effort to Help Offenders Safely and Successfully Reenter Rural Iowa Communities in the Second Judicial District. January 2007.

1. Design and develop a Rural Reentry Service Model that provides pre-release services, successful transition planning and aftercare services for offenders released from state institutions to rural communities.

2. Implement assessment, intervention, transition planning, and coordinate services with the Department of Correctional Services (CBCs).

3. Develop a reentry model that will effectively provide needed services to offenders across a widespread, rural area.

4. Produce positive outcomes related to program completion, post release supervision, reduction in recidivism and, and increased collaborative partnerships.

- The Division of Criminal and Juvenile Justice Planning will be conducting a comprehensive study of drug courts for adults and juveniles including costs analysis and will be available in the fall of 2008. The report will also report on which type of drug court is more successful – community panel or judicial model.[37] This initiative along with other initiatives/programs listed herein are significant indicators of the IDOC's direction to implement programs that are evidence-based (i.e., establishing a data collection and analysis component with programming that fit the criteria for "promising" programs), and incorporate relevant partners to maximize the program's potential success.

Response to Special Populations

The ability to adequately address offender reentry is based in large measure on the ability of the programming to response to the individual needs of the offenders. Responsivity to treatment is a result, in part, of the treatment being geared toward specific needs. For example, a female offender may have difficulty relating her substance abuse to sexual abuse if the program is coeducation. The same considerations apply to other special populations as well. Programs and reentry initiatives must be designed for and responsive to the needs of these special populations.

Female Offenders

Although all offenders must confront the problems of reentry into the community, many of the obstacles and barriers faced by women offenders are specifically related to their status as women. Beyond the stigma attached to a criminal conviction and to a history of substance abuse, women carry additional burdens. These extra burdens are due to such individual-level characteristics as single motherhood and decreased economic potential as well as to system-level characteristics, such as the lack of services and programs targeted for women, responsibilities to multiple agencies, and lack of community support for women in general.

Often, women in the larger community and who are not offenders confront many of the same harsh realities. There is a need for wraparound services—that is, a holistic and

[37] Source: Report of Lettie Prell. Iowa Board of Corrections Meeting Minutes. November 2, 2007. Ft. Dodge Correctional Facility.

culturally sensitive plan for each woman that draws on a coordinated continuum of services within the community. Working with women in the criminal justice system requires ways of working more effectively with the many other human service systems that are involved in their lives."[38] Integrated and holistic approaches, such as wraparound models, can be very effective because they address multiple goals and needs in a coordinated way and facilitate access to services[39].

Wraparound models stem from the idea of "wrapping necessary resources into an individualized support plan."[40] Both client-level and system-level linkages are stressed in the wraparound model. The need for wraparound services is highest for clients with multiple and complex needs that cannot be addressed by limited services from a few locations in the community.

For women leaving custodial environments, the program focus should be on planning for successful community reentry. Many types of reentry services for female offenders would also benefit women in the larger community.

The development of more effective and comprehensive services for women generally and women offenders specifically could enhance community services and also could help to prevent crime.

Offenders with Mental Illness and Co-Occurring Disorders

Significant percentages of offenders in Iowa have mental illnesses and co-occurring disorders (mental illness and substance abuse). Once embedded in the criminal justice system, these multi-challenged offenders have numerous social service needs including housing[41] and other basic requirements; medical, substance abuse and mental health care treatment needs (including psychiatric medication); and require specialized correctional supervision. In short, they have multiple service needs from many agencies of both the human services and criminal justice systems. Therefore, it is vital that this criminal justice subpopulation have reentry planning that begins upon entry into the criminal justice system rather than upon entry into the institutions. While diversion may not traditionally be considered within the framework of reentry, it is an important consideration for offenders who have mental illnesses. For the offender with mental illness, early diversion from the criminal justice system must be a key consideration because the effective evidence based programs have primarily intervened prior to incarceration in a prison. When diversion from the criminal justice system is not possible, efforts should focus upon preventing further penetration into the criminal justice system.

That said, some offender crimes and risk to public safety will prohibit this from occurring and will result in incarceration in prison. Reentry from prison to the community for

[38] Jacobs, A. (2001). Give 'em a fighting chance: Women offenders reenter society. Criminal Justice Magazine, 16(1), p. 47.
[39] Reed, B., & Leavitt, M. (2000). Modified wraparound and women offenders in community corrections: Strategies, opportunities and tensions. In M. McMahon (Ed.), Assessment to assistance: Programs for women in community corrections (pp. 1-106). Lanham, MD: American Correctional Association.
[40] Malysiak, R. (1997). Exploring the theory and paradigm base for wraparound fidelity. Journal of Child and Family Studies, 6(4), p. 400.
[41] Roman, C.G. (2006). *Moving Toward Evidence-Based Housing Programs for Persons with Mental Illness in Contact with the Criminal Justice System*. Gains Center.

offenders with mental illness is difficult due to the complexity of these release needs. Too often these offenders serve the full term of their sentences in prison and are released directly into the communities without necessary supports in place.

The offenders with serious mental illnesses who are not connected to the services that will assist in reintegration into communities are more likely to be reincarcerated. Inadequate reentry planning puts these incarcerated offenders, who enter the criminal justice system's jails and prisons in a state of crisis, back on the streets in the middle of another crisis without housing, benefits, medication, treatment and other supports in place. The outcomes of inadequate reentry planning include compromising public safety, increasing psychiatric symptoms, hospitalizations, new criminal offenses, and rearrest[42].

Reentry planning for offenders with mental illnesses and co-occurring disorders requires bi-directional responsibilities (in-reach into the jails and prisons and outreach into the community) and collaboration among providers. The results of these efforts will only be as good as the correctional-mental health partnerships in the community. Reentry planning can only work if justice, mental health, and substance abuse systems have a capacity and a commitment to work together.

There are a number of programs that have been identified as either promising or evidence-based practices that are effective with the criminal justice involved offender with mental illness. They include the Sequential Intercept Model[43], APIC Model[44], Assertive Community Treatment (ACT) Teams[45], Mental Health Courts[46], Probation/Parole with Specialized Officers and Reduced Caseloads[47], integrated treatment and correctional supervision, and community-based correctional residential facilities with treatment and programming for offenders with mental illnesses. These programs will be discussed in more detail in Chapter 4 of this report.

As stated before, underlying the success of reentry is the collaboration of agencies across two different service systems: human services and criminal justice services. Not only does this require commitment from the agencies and service systems, but it also requires that the essential services to support and treat these offenders be available and accessible in the community.

Available programs and services are often dependent upon local, state and federal funding. As will be discussed later in this report, there is wide variation in the availability of services across Iowa and a significant shortage of funding for treatment resources in many counties. Despite this, through creative collaboration and program development,

---

[42] Osher, F. (2007). *Short-term Strategies to Improve Reentry of Jail Populations: Expanding and Implementing the APIC Model*, American Jails, Jan-Feb 2007, p. 9-19.
[43] Munetz, M. and Griffin, P. (2006). *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*. Psychiatric Services: 57:4, pp. 544-549.
[44] Osher, F.; Steadman, H.; and Barr, H. (2002) *A Best Practice Approach to Community Reentry from Jails for Inmates with Co-Occurring Disorders: The APIC Model*. National GAINS Center.
[45] Morrissey, J. and Meyer, P. (2005). Evidence-Based Practice for Justice Involved Individuals. A Discussion Paper. GAINS Center and SAMHSA.
[46] *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court (2007).* Justice Center: The County for State Governments,
[47] Skeem, J. and Louden, J. (2006). *Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment.* Psychiatric Services: 57:3, pp 333-342.

some judicial districts in Iowa have been able to maximize those limited resources to provide diversion and reentry opportunities for offenders with mental illnesses.

CBC Bed Utilization

Another important consideration with respect to program availability is the utilization of the CBC residential treatment and work release beds. The current use of the CBC beds can be summarized by reporting that both the CBCs and the institutions clearly strive to use these resources in the most effective and efficient way possible. All staff interviewed, and the Durrant Phase I Master Plan Report acknowledges that there are not sufficient resident beds in the community to meet the need of the current population. Offenders remain in the institutions longer than required because their Parole Release plan generally has a requirement for residential treatment, and an appropriate bed is not available. The Des Moines Women's Residential Correctional Center reported a waiting list of 27 as of October 2006. The priorities for these beds are for parole violators, women with children and federal offenders. The nine offenders waiting for a work release bed (one-third of the waiting list) were not on the priority list. As a result, creativity must be employed at the institutions to attempt to meet the treatment needs with existing resources.

One of the concerns reported by both CBC and institutional staff is that offenders released from the prison system may be assigned to a residential treatment facility outside of their legal residence jurisdiction because the appropriate treatment programs do not exist in that jurisdiction. The data management system should, and is believed to currently be capable of prioritizing offender placements based on resources. For example, if substance abuse treatment is a component of the reentry case plan, an institutional bed may be prioritized for an offender whose home residence is located in a district that does not have a residential substance abuse treatment facility.

- This approach will require collaboration with the Board of Parole so that there is an understanding of why some offenders should be permitted to use community-based resources rather then completing programming in the institution prior to release from the institution. In these cases, offenders will still be required to that complete the program; it is a matter of where the program is provided.

- Prioritization of placement would have to consider more information than merely residence and availability of resources. The treatment need, risk, classification, responsivity and other factors should also be a consideration in the prioritization. And, above all, the system programmed prioritization must include a provision for overrides by specified staff.

The lack of consistency among the institutional and community-based programs creates another barrier to ensure that core criteria are met within each program. This is not to suggest that each program should be operated as a mirror image of the other programs; different resources exist in the districts and the districts must meet the need of the communities within that district. Rather, it is to suggest that minimum core requirements or program objectives with measurable outcomes must be included in each like program. This consistency among programs is important to ensure that as release planning occurs, each program option can be assumed to meet the basic needs of the eligible candidates. For example, a parole officer must know that an offender returning to a district following community based residential treatment has met specific objectives.

Duplication of services/programs can also occur between the within the institutions between the program staff and the industries staff whereby some effective life skills programs may be duplicated.

The CBC-Bed Focus Group recognizes the importance of providing for this consistency and is currently in the process of developing standard criteria, flow, etc., for each type of program. One of the benefits of these standards (for lack of a better term) is that the Department of Corrections can provide the quality assurance for meeting the standards and fund only those programs that meet the standards. If programs exist within a jurisdiction that does not meet the standards, the program may no longer be funded through the Department of Corrections.

Another equally disconcerting issue related to the use of residential beds is the disparity between the District CBC funding received through the IDOC budget request and the number of CBC beds that are available to IDOC offenders transitioning through their reentry plan. The assumption would be that the resources would be in place when needed for IDOC offenders being released from the institutions. This is not always the case as waiting lists are extensive and IDOC offenders do not always take priority over other offenders such as probationers and Federal prisoners. The table below is based on data obtained in 2006, but it illustrates how the CBC beds are utilized.

Figure III-B3-2: CBC Bed Utilization

Offender Type	Beds Occupied	Offenders on Waiting List
Federal Holds	130	27
Operating While Intoxicated (OWI)	232	49
Probation	615	246
Parole	17	22
Work Release	470	267
Other	14	9
Total	**1478**	**620**

Source: Combined data of two reports dated October 4, 2006: Statewide Facility Beds Occupied, and Statewide Facility Waiting List

A review of bed utilization as illustrated in this table appears to suggest that despite the IDOC providing more than 75 percent of the total funding for CBCs, the work release (i.e., reentry transition beds) only represent approximately 32 percent of the total bed utilization. The data is not intended to recommend that all of the CBC beds, or even 75 percent or more, should be dedicated to IDOC work releases. There are legitimate reasons to continue providing beds for other purposes as indicated below:

- Federal holds are those that while they do generate revenue for the CBCs, there would be fewer opportunities for federal offenders to undergo a step down reentry program, and therefore an increased likelihood of reoffending. Additionally, these offenders enter the CBCs with a detailed reentry plan in place.

- The OWI program has promising outcome measures, and without probation beds, offenders may well be placed in a local jail or prison.

An additional 72 CBC beds are under construction to include Davenport, Fort Dodge and Cedar Rapids. Moreover, an additional 260-280 beds are also being proposed in several jurisdictions to bring the total CBC beds up to a maximum of 1,792. This figure is still short of the 2,098 beds identified as being needed in the 2006 Statewide Facility Count Reports. The future demand for beds would likely be affected by the outcome of the IDOC and Governor's Reentry and Community Treatment Resource Center initiative – an innovative approach to engaging offenders, families and neighborhoods in successful offender reintegration.

An additional consideration is the fees for service that are charged to offenders. The fees can range from program per diem fees, medication, bus passes and supervision fees. It is indeed important for offenders to take ownership in their reentry, including paying for services/programs that are provided. The difficulty becomes when there is a potential that the offender may violate his probation or parole conditions by prioritizing other financial obligations over the payment of participant fees. Generally, however, the offender's probation/parole is not violated as long as the offender continues to make reasonable payments. Offenders are eligible for early release if they can pay their fees. A more comprehensive review of the role of fees should be conducted to determine the degree to which the collection of fees should determine program eligibility.

Based on our findings, many of which are included in this report, the IDOC is committed to implementing programming that is specific to individual offender needs in a cost effective manner. In some cases the IDOC will need to continue to cultivate collaboration with the CBCs; however, it is essential that the CBC resources are sufficiently available to offenders returning to the community more commensurate with the state funding that is approved as part of the IDOC budget process.

C. Recommendations

Reentry Program Short Term Recommendations

The short–term recommendations to be implemented by end of Fiscal Year 2009 include:

1. Programs and Services

a. Fast track the CBC Bed Focus Group initiative to develop of a continuum of care or flow for each of the identified specialized populations. Plot programs/services on a continuum that outlines for all staff where the program fits on the continuum.

b. Complete the inventory for programs and services available in the institutions, the district level and the local communities. Once the comprehensive inventory is completed, the programs/initiatives should be plotted on a continuum of services that represents a step-down approach for each of the major treatment interventions. This initiative has started but should continue on a fast-track.

c. Develop standards, or at a minimum key objectives and performance measures for all programs. Share this information among the CBCs and institutions.

d. Continue implementing programs that are consistent with evidence-based practices, and sharing findings information with field staff.

e. Continue to seek grant funding for evidence-based programs to support the reentry effort.

f. Implement one-stop centers throughout the state with the goal of streamlining access to services/resources and providing access in areas where these services are most needed.

g. Evaluate the efficacy of the Minimum Live Out centers in comparison to expanded CBC beds and/or using detention facility program options to transition offenders back to the community.

2. Reentry Planning

a. Ensure that CBC staff are involved in developing the institutional reentry plan whether through conferencing or at the intake facility.

b. Reevaluate the role of the Reentry Coordinators at the institutional level to ensure they do no supplant the current case manager role.

c. Reevaluate the role of the Reentry Coordinators at the District CBCs to better clarify their role (e.g., resource coordinator, boundary-spanner, etc.)

d. Conduct a comprehensive review of the Iowa legislation to determine which legislation actually supports public safety and which legislation may serve as barriers to successful reentry and do not impact public safety.

e. Engage all staff, particularly in the facilities, to understand and manage offenders in a manner that supports the reentry process. The degree to which they are directly involved in reentry planning as a performance measure can greatly improve staff commitment to the reentry initiatives.

3. CBC Bed Utilization

a. Review how CBC beds are assigned and identify action steps to increase the number of beds available to IDOC offenders eligible for work release.

b. Partner with the Board of Parole to develop a plan for improved release planning recommendations to include that correctional counselors better prepare offenders for their Parole Hearing.

Reentry Program Long-Term Recommendations:

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

1. Information Technology

a. Purchase mapping software if this program software is not currently available in the system. If appropriate, team up with local experts (e.g., universities or nonprofit data centers) to obtain mapping assistance. Software vendors such as ESRI and MapInfo offer training workshops throughout the country for a fee (see www.esri.com and www.mapinfo.com). Beginning mappers can also take advantage of the workshops offered through NIJ's Crime Mapping Research Conference or the NIJ-funded Crime Mapping and Analysis Program in Denver, CO.[48]

b. Evaluate opportunities to improve user access to the ICON system to obtain quick and accurate information regarding an offender's status in the reentry case plan.

2. Transitional programs at local detention facilities.

Consider creating transitional programs at local detention facilities to support the reentry program. Offenders could be returned to the jail in the community to which they will return. The intent is to acclimate the offender to his locality and family, provide easy access to those who will supervise and provide services when they are released, to make finding housing easier, establish an employment base, and have more funds (from earnings) available to the offender than would otherwise be on hand upon release.

[48] For a comprehensive list of mapping training and tutorial options, see www.ojp.usdoj.gov/nij/maps/training.html.

Chapter 4: Treatment

Treatment

A. Introduction

The Durrant/PBA team's involvement in furthering the Phase 1 Master Plan Report recommendations pertaining to treatment was more focused and targeted in this second phase work effort. Specifically, the Durrant/PBA team served in both a consultative and lead role with key mental health personnel associated with the IDOC's institutions as well as the IDOC Mental Health-Institution Focus. Our role was the same working with the mental health staff at the CBC level as well as the Mental Health-CBC focus group. We also facilitated discussions with the Department of Human Services, Mental Health Disability Services to better understand the relationship between community-based offenders' treatment needs, reentry planning, and local and state funding mechanisms.

The team served a more limited consultative role in addressing substance abuse and sex offender treatment needs working with the IDOC focus groups on the specific treatment needs of offenders with mental illnesses, co-occurring substance abuse disorders, and gender responsive treatment needs of women. Information related to gender responsive treatment needs are included in both this chapter and in Chapter 5: Women Offenders and Gender Responsive Treatment.

B. Offenders with Substance Abuse

The Durrant/PBA team focused on co-occurring disorders treatment for both male and female offenders. In addition, our work focused on all female offenders who require treatment for either co-occurring disorders or substance abuse with the goal of developing treatment solutions that are evidence-based and responsive to the particular needs of women offenders.

1. Co-Occurring Disorder Treatment

Offenders who have co-occurring disorders are those who have a mental illness as well as substance abuse treatment needs. All offenders who have been diagnosed with co-occurring treatment needs should be provided with services. The definition of co-occurring disorders varies both across and within mental health and substance abuse service systems. One of the more useful ways to define co-occurring disorders is the National Consensus Four Quadrant Model[49] for categorizing co-occurring disorders. In this model, the severity of mental illness and substance abuse disorder are divided into high and low severity for each disorder. While treatment is integrated in all four quadrants of the model, the locus of care/treatment and the required service coordination levels change according to the levels of severity of each disorder. Integrated co-occurring disorder treatment[50] is most effective when provided by dually trained (mental health and substance abuse) clinicians.

---

[49] Minkoff, K. and Cline, C. (2004). *Changing the World*: *The Design and Implementation of Comprehensive Continuous Integrated Systems of Care for Individuals with Co-Occurring Disorders*. Psychiatric Clinics of North America, 27(4): 727-43.

[50] Source: SAMHSA http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/IDDTUsersguideAJ1_04.pdf. Retrieved March 14, 2008.

For example, as seen in Figure IV-A-1, Quadrant II, individuals who have high severity mental illness (usually severe, persistent mental illnesses) and low severity of substance abuse will be best treated in a mental health setting. While a person who has both high severity mental illness and substance abuse (as seen in Quadrant IV), may be best treated in psychiatric hospitals and correctional facilities. This model was developed for the community and has been extended into the institutional setting as well. The use of this model allows for the development of a range of programs to address the variations in mixed acuity found in offenders who have both mental illnesses and substance abuse disorders.

Figure IV-A-1: National Consensus Four Quadrant Model For Categorizing Co-Occurring Disorders

QUADRANT III – Low MH/High SA **Low Severity of Psychiatric Symptoms High Severity of Substance Issues/Disorders** **Locus of Care**: Substance Abuse Treatment System **Level of Service Coordination**: Collaboration between systems; formal relationships developed among providers that ensure both MH and SA problems are addressed in treatment.	**QUADRANT IV – High MH/High SA** **High Severity of Psychiatric Symptoms and High Severity of Substance Issues/Disorders** **Locus of Care**: Psychiatric hospitals, correctional facilities, hospital emergency rooms **Level of Service Coordination**: Integrated services; relationships between MH and SA providers developed in which the contributions of professionals in both fields are merged into a single treatment setting and regimen.
QUADRANT I – Low MH/Low SA **Low Severity of Psychiatric Symptoms and Low Severity of Substance Issues/Disorders** **Locus of Care**: Primary Care Settings **Level of Service Coordination**: Consultation between systems; informal relationships among providers developed to ensure that both MH and SA problems are addressed.	**QUADRANT II – High MH/Low SA** **High Severity of Psychiatric Symptoms and Low Severity of Substance Issues/Disorders** **Locus of Care**: Mental Health Treatment System **Level of Service Coordination**: Collaboration between systems; formal relationships developed among providers that ensure both MH and SA problems are addressed in treatment.

SAMHSA's Recovery Model[51] is a promising program that demonstrates effective treatment outcomes for individuals with serious mental illness. The Recovery Model's co-occurring treatment modules use an integrated approach to providing services. Recovery, in this context does not mean that cessation of symptoms is required for recovery—it is much more about the empowerment of people with mental illnesses to be able to learn to manage their illness with the appropriate supports in place. Each offender with mental illness and substance abuse develops their own definition of recovery, which many view as a process rather than a destination. Recovery for persons with mental illness incorporates principles of hope, personal responsibility, education, self-advocacy and support.[52] This approach to treating co-occurring disorders is consistent with the underlying philosophy of Reentry.

There has been progress on the Phase I Master Plan Report recommendation, "co-occurring disorders treatment programs be developed for all offenders housed in special needs units in the institutions." The report further recommended that the program be piloted at the Clinical Care Unit (CCU) at Ft. Madison. A curriculum has been developed and progress is underway; it is currently under review by the treatment team at CCU. The SAMHSA Recovery Model is being evaluated for incorporation into this co-occurring disorders treatment curriculum. Once tested, this treatment curriculum should be used at all mental health special needs units to treat offenders who have co-occurring disorders.

It is vital that programs for offenders who have co-occurring disorders continue to be developed across the continuum of correctional supervision. As noted in the Substance Abuse Treatment Performance Audit Report[53], "this population is challenging because of the multiple issues they face". As such, it was expected that offenders with mental health diagnoses would be more likely to recidivate. The performance report found that generally, offenders with both substance abuse treatment needs and a mental health diagnosis had higher recidivism rates over those who had substance abuse treatment needs alone.

If a range of co-occurring disorders treatment programs are not developed across the continuum of correctional supervision, it is likely that recidivism of these offenders will dramatically increase over time and in fact there will be an increase in the numbers of offenders with co-occurring disorders who are ultimately incarcerated in state correctional institutions.

2. Gender Responsive Substance Abuse Treatment

a. Co-Occurring Disorders Treatment

The ICIW Treatment Director acknowledges that further program development is needed to provide a gender-responsive program to treat women who have co-occurring disorders. This will become magnified when the Mt. Pleasant Women's Unit population is

[51] Source: SAMHSA EBP Recovery Model: http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/about.asp, Retrieved, March 16, 2008.
[52] Ibid.
[53] Iowa Department of Management Performance Audit Program, Does Prison Substance Abuse Treatment Reduce Recidivism? Performance Audit Report: Iowa Department of Corrections' Licensed Substance Abuse Programs, May 25, 2007.

moved to ICIW. When that occurs there will be a significantly greater demand for gender-responsive co-occurring disorders treatment; therefore current co-occurring treatment programs for the female offenders need to be revised and expanded.

The concept of integrated treatment for women with co-occurring disorders (CODs), as articulated by Minkoff[54], emphasizes the need for correspondence between the treatment models for mental illness and addiction. The model stresses the importance of well coordinated treatment for both disorders. Co-occurring recovery treatment goals are emphasized, as well as the need to employ effective treatment strategies from both the mental health and the substance abuse treatment fields. The co-occurring disorders literature suggests that, integrated treatment recognizes the need for a unified treatment approach to meet the needs of a client with multiple disorders. The range of women with co-occurring disorders is consistent with the Four Quadrant Model previously discussed. When developing programs for women who have co-occurring disorders, this model suggests that a range of programs would best meet the treatment needs of incarcerated women with co-occurring disorders.

Consistent with gender responsive treatment, SAMHSA's Recovery Model treatment modules are based on a person's competencies and strengths while promoting self-reliance.[55] While outcome evaluations have not been completed on the use of the Recovery Model with women-only groups, there is no evidence to suggest that women with co-occurring disorders would benefit any less than men-alone or mixed gender groups. It is vital that the treatment principles of gender-responsive treatment be incorporated into any treatment program for co-occurring disorders.

b. Substance Abuse Treatment

The ICIW Star program was evaluated[56] by Iowa's Department of Management and found to be effective in both reducing new convictions and total recidivism rates for incarcerated female offenders in Iowa. The WINGS and the Violators Programs, both shorter term programs than STAR, did not reduce either measure.

Unfortunately, the numbers of women who can access and be treated in the STAR (Sisters Together Achieving Recovery) program are very limited due to the nine month length of the program which oftentimes exceeds the length of stay of a sentenced female offender at ICIW. The Substance Abuse and Women's Focus groups have developed two strategies for expanding substance abuse treatment opportunities. First, expand the STAR program's bed capacity to 90 (from the current 45). Second, develop a new program called "STAR-Light" that will use an intense, but shorter version of the STAR program, with mandatory 12-18 month community-based follow-up substance abuse treatment. Together these strategies will significantly expand the substance abuse treatment capacity of ICIW.

---

[54] Minkoff, K. and Cline, C. (2004). *Changing the World: The Design and Implementation of Comprehensive Continuous Integrated Systems of Care for Individuals with Co-Occurring Disorders*. Psychiatric Clinics of North America, 27(4): 727-43.
[55] Covington, S. and Bloom, B. (2006). *Gender Responsive Treatment and Services in Correctional Settings.* Inside and Out: Women, Therapy and Prisons.
[56] Iowa Department of Management Performance Audit Program, Does Prison Substance Abuse Treatment Reduce Recidivism? Performance Audit Report: Iowa Department of Corrections' Licensed Substance Abuse Programs, May 25, 2007.

The numbers of female offenders with substance abuse treatment needs are substantial. Without adequate treatment interventions at every point in the correctional continuum, the rate of incarceration and recidivism for female offenders will continue to increase significantly.

C. Offenders with Mental Illnesses

There are offenders with mental illnesses who require correctional supervision, depending where they are in the correctional continuum of institutions, community based correctional residential facilities, or community based field supervision. During this phase of the Durrant/PBA work effort, further analysis was undertaken to determine the numbers of offenders in all three settings who required mental health treatment, the resources available to provide necessary treatment, and access to mental health resources across the continuum of correctional supervision.

1. Offenders with Mental Illnesses in the Institutions

a. Data Update

While the number of incarcerated offenders who had mental illnesses requiring treatment was documented in the Phase I Durrant/PBA Master Plan, it is important to continue to track these numbers due to the continued growth of these populations and thus the need for expanded treatment. Figure IV-B-1 demonstrates that a one-day snap shot analysis found that the percentage of seriously, persistently mentally ill offenders (those who have major mental illnesses that will require life-long treatment) incarcerated in the IDOC institutions was 30.4% of the total population in 2007.

Figure IV-B-1: Serious Persistently Mentally Ill Offenders Prison Population December 31, 2007

Serious, Persistent Mentally Ill Offenders in Prison			
Facility	**Total Offenders**	**Female**	**Male**
Anamosa State Penitentiary	317		317
ASP - Luster Heights	1		1
Clarinda Correctional Facility	344		344
Clarinda Lodge	41		41
Fort Dodge Correctional Facility	233		233
Iowa Correctional Institution for Women	321	321	0
Iowa Medical & Classification Center	232	19	213
IMCC - Psychiatric Hospital	14		14
Iowa State Penitentiary	164		164
ISP - Clinical Care Unit	177		177
ISP - John Bennett Unit	40		40
ISP - Farm 1	10		10
ISP - Farm 3	13		13
Mount Pleasant Correctional Facility	281		281
Mount Pleasant Women's Unit	66	66	0
Newton Correctional Facility	206		206
Newton - Correctional Release Center	77		77
North Central Correctional Facility	103		103
Statewide	**2,640**	**406**	**2,234**
% of Prison Population	***30.4%***	***56.8%***	***28.0%***

Source: DOC: Prell, ICON Data

In addition, there were another 942 or 11% of offenders who have less severe mental illnesses who also require mental health treatment. Of particular note, is the high percentage of female offenders (56.8%) who have serious mental illnesses – nearly double the rate for male offenders.

Figures IV-B-2 and IV-B-3 compare the total offender population diagnosed with any mental illness (major mental illness plus additional offenders who have mental health diagnoses that require treatment) on 12/31/06 and 12/31/07. While the total offender population decreased from 8836 to 8693 between 2006 and 2007, the offenders who have mental illnesses increased from 3535 to 3581. While this represents only a 1.2% increase in one year, if it continues to increase at this rate annually there could be significantly more incarcerated offenders with mental illnesses.

Figure IV-B-2: Offenders with Any Mental Illness in Prison by Gender December 31, 2006

Mentally Ill in Prison by Gender 12/31/2006				
Gender	Total	%	Total Offender Population	% of Population That is MI
Female	530	15.0%	789	**67.2%**
Male	3,005	85.0%	8,049	**37.3%**
Total Mentally Ill	**3535**	100.00	**8,836**	**40.0%**

Source: DOC: Prell, ICON Data

Figure IV-B-3: Offenders with Any Mental Illness in Prison by Gender 12/31/2007

Mentally Ill in Prison by Gender 12/31/2007				
Gender	Total	%	Total Offender Population	% of Population That is MI
Female	476	13.3%	715	**66.6%**
Male	3,105	86.7%	7,978	**38.9%**
Total Mentally Ill	**3,581**	100.0%	**8,693**	**41.2%**

Source: DOC: Prell, ICON Data

The numbers of incarcerated offenders with mental illnesses continue to increase. Related issues addressed by this Phase of the Durrant/PBA Master Plan sought to determine:

- What is the rate of offenders who have mental illnesses who serve their entire sentence without benefit of parole or work release?
- What are the issues underlying these sentence expirations: lack of treatment in the institutions or lack of treatment and other resources in the community?
- What is the recidivism rate of those who expire their sentences?
- What can be done by the institutions and community-based corrections in reentry planning to improve the likelihood that incarcerated offenders who have mental illnesses can receive supervised transition to the community, thus decreasing the likelihood of new offenses and recidivism and improve the likelihood of community stability?

The Durrant/PBA team met with Parole Board in October 2007 to discuss their criteria for early release of offenders. Included among the many inquiries were the release criteria for offenders with mental illnesses and co-occurring disorders.

The primary focus of the Board is public safety. Release criteria require that the offender has met treatment requirements in the institution and has a well developed community release plan that offers a supervised, stable living environment in the community.

Of particular concern were the numbers of offenders who were housed in the institutional special needs units who expire their sentences and are released into the community without parole supervision and often without sufficient community supports in place.

To determine the expiration rates, the releases from these units for 2004 yields the best data. As seen in Figure IV-B-4, nearly sixty seven percent (67%) of the offenders exiting the Clinical Care Unit (male unit) and over seventeen percent (17%) of offenders exiting the Mt. Pleasant Women's Special Needs Unit did so by expiring their sentence.

Figure IV-B-4: Special Needs Units Expiration of Sentences

For Expiration of Sentence Only:					
Facility	**Total Released**	**Expiration of Sentences**	**Expiration Rate**	**N Returned**	**Recidivism Rate**
Clinical Care Unit (CCU)	33	22	66.6%	8	36.4%
Mt. Pleasant Women (MWU)	52	9	17.3%	2	22.2%
Statewide		**1,068**	**313**	**313**	**29.3%**

Source: DOC: Prell, ICON Data

Offenders released from the Clinical Care Unit recidivate at a rate of 36.4%; female offenders released from the Mt. Pleasant Unit recidivate at a rate of 22.2%.

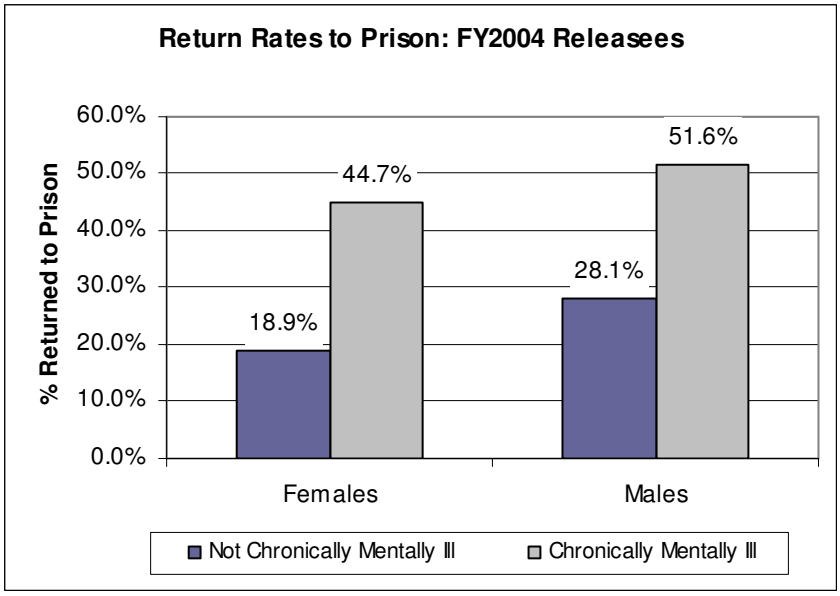
As seen in Figures IV-B-5 and IV-B-6, when comparing the recidivism rates of offenders who have mental illnesses with those who do not have mental illnesses there are significant differences. If a female offender has any chronic mental illness, the recidivism rate increases from 18.9% to 44.7%. A male offender who has any mental illness recidivates at a rate of 51.6%; a male offender with no mental illness recidivates at a rate of 28.1%.

Figure IV-B-5: Recidivism Rate by Gender and Mental Illness

Return Rates to Prison, FY2004 Prison Exits By Gender and Chronic Mental Illness				
Sex	**Chronic MI Diagnoses**	**Total Released**	**Total Returned**	**Recidivism Rate**
Females	None	196	37	18.9%
	Any	257	115	44.7%
Males	None	2,192	617	28.1%
	Any	888	458	51.6%
Follow-up tracking period was 3 years for each offender.				

Source: DOC: Prell, ICON Data

Figure IV-B-6: Recidivism Rates for Releasees FY 2004



Source: DOC: Prell, ICON Data

Figure IV-B-7 shows the expiration of sentence for those offenders housed in special needs units by offense type. While the numbers are too small to draw any meaningful conclusions, the recidivism rates of those who have committed violent crimes are high.

Figure IV-B-7: Special Needs Unit Expiration of Sentences by Type of Offense

Expiration of Sentence -- Recidivism by Offense Type:			
Offense Type	Total Released	N Returned	Return Rate
CCU:			
Drug	1	0	0.0%
Property	10	3	30.0%
Public Order	3	0	0.0%
Violent	8	5	62.5%
MWU:			
Drug	3	1	33.3%
Other	1	0	0.0%
Property	3	1	33.3%
Public Order	1	0	0.0%
Violent	1	0	0.0%

Source: DOC: Prell; ICON Data

Figure IV-B-8, an analysis of offenders with mental illnesses by most serious type of charge who were released in 2004, shows that when controlling for both offenses and mental illness, offenders with chronic mental illness have higher recidivism rates than offenders who do not have mental illnesses. This is an important analysis when

considering the importance of careful reentry planning for offenders with mental illnesses. Recidivism rates range from 31.7% to 55.6% for these offenders.

Figure IV-B-8: Comparative Recidivism Rates of Offenders Who Have Chronic Mental Illness by Offense Type

Return Rates to Prison, FY2004 Prison Exits By Offense Type and Chronic Mental Illness						
	Not Chronic MI			Chronic MI		
Offense Type	Total Released	Total Returned	Recidivism Rate	Total Released	Total Returned	Recidivism Rate
Drug	796	243	30.5%	334	183	54.8%
Property	711	220	30.9%	421	234	55.6%
Public Order/Other	399	110	27.6%	188	92	48.9%
Violent	482	81	16.8%	202	64	31.7%

Source: DOC: Prell, ICON Data

Figure IV-B-9, a snapshot of offenders with mental illnesses by gender by most serious type of charge on December 31, 2007, shows that forty one percent (41%) of the offenders with mental illness committed a violent offense as their most serious charge leading to incarceration. Serious mental illness plus a history of a violent offense decreases the likelihood that an offender will receive an early release. Reentry planning will be more time consuming, more complex and significantly more difficult than for offenders without mental illnesses. Whether or not they serve their entire sentences and/or are directly released from a special needs unit, offenders with serious mental illnesses are less likely to return to prison if solid reentry plans with sufficient community supervision and resources are in place.

Figure IV-B-9: Mentally Ill Offenders by Gender by Most Serious Charge Type

Mentally Ill Offenders on 12/31/07 by Most Serious Charge Type & Gender					
Crime Type	Gender	Serious MI	Other MI	Total	Serious MI Total %
Violent	F	128	24	152	4.8%
Violent	M	955	376	1331	36.2%
Property	F	119	18	137	4.5%
Property	M	505	193	698	19.1%
Drug	F	103	19	122	3.9%
Drug	M	422	187	609	16.0%
Public Order	F	21	5	26	0.8%
Public Order	M	160	48	208	6.1%
Other	F	30	4	34	1.1%
Other	M	156	53	209	5.9%
Unknown	F	5	0	5	0.2%
Unknown	M	36	14	50	1.4%
MI Totals		**2640**	**941**	**3581**	**100.0%**

Source: DOC: Prell, ICON Data

Figure IV-B-10 demonstrates that when an offender has more than one mental health diagnosis, each additional diagnosis increases the recidivism rate. If an offender released in 2004 had four or more chronic mental illnesses, the recidivism rate was 84.6%.

Figure IV-B-10: Recidivism Rates by Number of Chronic Mental Illness Diagnoses

Return Rates to Prison, FY2004 Prison Exits By Number of Chronic Mental Illness Diagnoses			
Chronic MI Diagnoses	**Total Released**	**Total Returned**	**Recidivism Rate**
None	2,388	654	27.4%
1	583	184	31.6%
2	285	170	59.6%
3	160	120	75.0%
4 or More	117	99	84.6%

Sentence expiration and recidivism rates are of serious concern. Vulnerable offenders who have serious mental illnesses, mental retardation, and brain injuries coupled with substance abuse issues are unlikely to reenter and stabilize in the community without treatment, housing, special correctional supervision and other supports in place. It is likely that these special needs offenders if released without community treatment and supports in place, will destabilize, present risk to public safety of the community, and return to prison.

Therefore, it is clear that successful reentry to the community for offenders with serious and persistent mental illness is dependent upon the accessibility and availability of treatment, housing and other necessary supports in the community. The accessibility and availability of treatment in Iowa's communities is discussed later in this chapter.

b. Continuity of Mental Health Services Across the Institutional Continuum of Care

A critical finding of the Phase I Master Plan was that there was no consistent approach to mental health treatment across the nine institutions. A major undertaking during the Phase II work was to develop policy standards that systematize the approach to mental health treatment across the institutions. This includes criteria for placement into levels of care (acute, partial/step-down, special needs units, and outpatient care). In developing these standards, Durrant/PBA worked closely with the Mental Health Institution Focus Group who reviewed current policies, updated some, and determined the need to develop additional system-wide policies for mental health treatment. Since these policies require central office DOC approval and adoption, the Mental Health Policy Standards should be considered a draft working document at this time.

Each of the mental health policy standards address requirements for mental health treatment provided in reception, acute care, transition/step-down, special needs units, and general population, with gender specific considerations for female offenders. The policy standards that were considered are briefly discussed below and listed in Figure IV-B-11. The relevance of each of the policy standards are briefly discussed briefly in the following bullets.

- *Criteria for Admission or Transfer into Level of Care:* Consistent with community mental health treatment, acuity of symptoms should be the primary consideration for placement into the appropriate level of mental health care. Key to appropriate placement is the application of consistent criteria to determine the level of acuity and therefore the level of mental health care required to provide appropriate treatment. The Department of Correction's Mental Health Services division has adopted the McKesson InterQual clinical decision support criteria tool to provide consistency in determining the acuity and level of treatment required for incarcerated offenders. Training in the use of this instrument was provided to the clinical staff in January 2008. This tool is currently being tested at IMCC and the Clinical Care Unit (CCU) at Ft. Madison.

  Based on the Department of Corrections' Calendar Year 2006 Facility-to-Facility Transfer Analysis, clear criteria for transfer is especially important to avoid unnecessary transfers or "transfer of offenders with mental illnesses who are problems" from institution to institution. This report found that transfers of mentally ill/developmentally disabled offenders occur at a disproportionate rate, compared to their representation within the total offender population and make up the majority of offenders transferred four or more times in one year. The InterQual assessment tool will be utilized, in part, to determine whether an offender meets the criteria for transfer to either a more intensive or less intense treatment environment. The use of this objective tool can prevent transfers into an inappropriate treatment or non-treatment correctional unit. It is expected to be implemented system-wide in 2008 and will provide a consistent method of determining the appropriate placement of offenders with mental illnesses.

- *Assessment:* Criteria for mental health assessment were also developed for each level of care. Initial assessments will include: Intake appraisal, Standard DOC Mental Health Services Appraisal, Modified MINI; TCU; Health Services Intake; and Psychiatric Screening (if needed). Based on the outcome of the assessment that will include the InterQual assessment tool, mental health professionals will work with offender services to determine the appropriate mental health placement within the system. In addition, minimal requirements for mental health clinical review of offender placement within each level of care were developed.

- *Classification:* A new classification instrument has been developed for both male and female offenders. Mental health input into the custody classification process and transfers into mental health settings will be a critical component of the new custody classification system once it is fully implemented.

- *Medical Restraints:* Current policy HSP-609 was reviewed and incorporated into the Mental Health Policy Standards. A consistent approach to using and documenting medical restraints is required for safe, effective management of offenders with mental illnesses.

- *Suicide Precautions and Mental Health Observation:* Based on earlier Durrant/PBA work, the DOC Suicide and Self Injurious Prevention (SSIP) and Mental Health Observation (MHO) policies were reviewed and updated. They are currently being field tested at IMCC. The new approach provides for more individualized, therapeutic interventions to manage offenders who require a

higher level of observation due to being suicidal, self-destructive or acutely psychotic.

- *Disciplinary Detention:* Use of disciplinary detention for offenders with mental illnesses is remarkably inconsistent from institution to institution. This policy is currently under review by the Mental Health Institution Focus Group in coordination with the Director of Offender Services. The goal is to develop a different approach for offenders with mental illnesses that are more treatment focused.

- *Administrative Segregation and Protective Custody:* Apparently there are options available under policy IO-SM-02 for more individualized approaches for offenders who have mental illnesses. These will be further explored in an effort to prevent offenders with mental illnesses and those who have not been identified as having mental health treatment needs from becoming identified as "intractable." This policy is also currently under review by the Mental Health Institution Focus Group in coordination with the Director of Offender Services. The goal is to develop a different approach for offenders with mental illnesses that are more treatment focused.

- *Offender Observers and Mentors:* Offender observers are currently used in some institutions to assist with the observation of offenders who are suicidal. Mental health mentors are also used with women offenders. The focus group discussed how to expand the use of mentors, including peer mentors, throughout the system. Key to the expansion is a well developed training plan for both offender observers as well as mentors, careful selection of these offender workers, and supervision of their work.

- *Individual Mental Health Treatment:* The type of individual mental health treatment that will be provided at each level of care was outlined by the Mental Health-Institution Focus Group. Treatment provided will be consistently appropriate to the level of acuity of the offenders.

- *Mental Health Group Treatment:* The type of group mental health treatment that will be provided at each level of care was outlined by the Mental Health-Institution Focus Group. The use of group treatment should increase as offender's symptoms become less acute. Group treatment is the basis for many of the Recovery Models modules for offenders with serious mental illness.

- *Mental Health Documentation:* The use of the InterQual Clinical Decision Support Criteria Tool is dependent upon detailed clinical SOAP (Subjective, Objective, Assessment, and Plan) notes. This was implemented as a policy standard for documentation of all mental health services encounters. Discussions were also held regarding some of the barriers in the current Medical ICON system to accessing and sharing information that is required for the management, treatment planning, and reentry planning for offenders who have mental illnesses.

- *Reentry Planning:* A significant barrier to release for offenders with mental illnesses is access to treatment services, benefits, and supported housing in the

community. Therefore, reentry planning must begin early in the incarceration. At the same time it must be acknowledged that community reentry plans will be complex and must be solidly in place before the offender is to be released.

- *Self-Administered (SAMS) Medication:* If reentry into the community is to be successful, offenders who have mental illnesses should be given the opportunity to manage their own medication prior to release. Decisions to implement SAMS must be individualized and coordinated between medical, mental health, and security personnel. (Currently, psychiatric medications are not self-administered; yet offenders with mental illnesses are given other medications--some potentially harmful if used to overdose-- to self-administer.) As part of the release planning efforts, offenders must learn how to self-medicate to simulate their real world experiences in preparation for returning to their respective communities.

Figure IV-B-11: Mental Health Policy Standards						
Intervention	**Reception IMCC (ICIW, Newton for federal offenders)**	**Acute IMCC**	**Stepdown /Transition IMCC, ICIW**	**Special Needs Units CCU, CCF, ICIW, MWU**	**General Population (Outpatient)**	**Gender Specific Considerations**
Admission/ Transfer	InterQual Screening; Screening for mental health problems, Initial treatment planning, Crisis Intervention. Prepare for transfer to other institutions, Decisions made by Offender Services	InterQual Screening; Crisis Intervention and Stabilization; Preparation for Transfer; Civil Commitment; Treatment Planning including long-term and short term limited goals; Coordination with MH Services, Placement in inpatient setting if needed, Decisions made by Offender Services	InterQual Screening; Result of Treatment Plan; Treatment Planning including long-term and short term limited goals; Meets transfer criteria; Decisions made by Offender Services	InterQual Screening; Transfer from IMCC or other Institution if acuity increases; Meets InterQual criteria; Treatment Planning including long-term and short term goals Request of treatment team to MH Director; Transfer decision made by Offender Services	InterQual Screening if mental status changes; Stable Population With No MH Need; or stable on medication; Periodic Monitoring By MH; Collaboration between mh staff at receiving and sending facilities; Transfer decisions made by Offender.	InterQual Screening; Same across the continuum with special emphasis on women's needs (e.g. hx of trauma, etc.)
Assessment	Intake appraisal; MH appraisal; Modified MINI; TCU by Counselors; Health Services Intake; Psychiatric screening; Notification of Offender Services to assist in transfer	Daily Interdisciplinary Team Meeting including MH, Security, Medical, Programs/Treatment and others; Mental Health Team Meeting weekly; UR weekly	Daily Interdisciplinary Team Meeting including MH, Security, Medical, Programs/Treatment and others; ; UR weekly	Daily Interdisciplinary Team Meeting including MH, Security, Medical, Programs/Treatment and others; ; 90-day review by Psychologist, 90-day review By Psychiatrist, Crisis Intervention	Initial Assessment; MINI/TCU; As needed; Daily Rounds;	Daily Interdisciplinary Team Meeting including MH, Security, Medical, Programs/Treatment and others; Discussion should include individualized approaches to problems with consideration for gender specific needs.
Classification/ Transfers	Classification Initial Classification	Classification for increased	Psychologist / Mental Health	Psychologist / Mental Health	Psychologist / Mental Health	Psychologist/ Mental Health Professional

Figure IV-B-11: Mental Health Policy Standards						
Intervention	**Reception IMCC (ICIW, Newton for federal offenders)**	**Acute IMCC**	**Stepdown /Transition IMCC, ICIW**	**Special Needs Units CCU, CCF, ICIW, MWU**	**General Population (Outpatient)**	**Gender Specific Considerations**
	to include level of acuity / InterQual; GAF level; Written MH Tx Plan; Gender Specific Issues; Acuity Reassessment for transfer within the next 30 days; Transfers-facility assignment by acuity/ InterQual; MD orders for admission to acute. Transition, SNU; Medication; Review for pending appts. Prior to transfer	acuity done More often than q. 90 days; psychologist input into classification	Professional input into classification	Professional input into classification	Professional input into classification	input into classification Process adjusted to reflect gender-responsiveness
Medical Restraints	Policy already In Place (HSP-609), Decisions made by anyone; nurse should review; Placement done ASAP; MD orders required following placement; Must be reviewed and/ or renewed q. 4 hours	Policy already In Place (HSP-609), Decisions made by anyone; nurse should review; Placement done ASAP; MD orders required following placement; Must be reviewed and/ or renewed q. 4 hours	Policy already In Place (HSP-609), Decisions made by anyone; nurse should review; Placement done ASAP; MD orders required following placement; Must be reviewed and/ or renewed q. 4 hours	Policy already In Place (HSP-609), Decisions made by anyone; nurse should review; Placement done ASAP; MD orders required following placement; Must be reviewed and/ or renewed q. 4 hours ; Review for possible transfer to higher level of acuity	Policy already In Place (HSP-609), Decisions made by anyone; nurse should review; Placement done ASAP; MD orders required following placement; Must be reviewed and/ or renewed q. 4 hours ; Review for possible transfer to higher level of acuity	Policy already In Place (HSP-609), Decisions made by anyone; nurse should review; Placement done ASAP; MD orders required following placement; Must be reviewed and/ or renewed q. 4 hours ; Review for possible transfer to higher level of acuity;

Figure IV-B-11: Mental Health Policy Standards						
Intervention	**Reception IMCC (ICIW, Newton for federal offenders)**	**Acute IMCC**	**Stepdown /Transition IMCC, ICIW**	**Special Needs Units CCU, CCF, ICIW, MWU**	**General Population (Outpatient)**	**Gender Specific Considerations**
Suicide Precautions and Mental Health Observations	Policy/procedure (HSP-626) being tested at IMCC	Policy/procedure (HSP-626) being tested at IMCC	Policy/procedure (HSP-626) being tested at IMCC	Policy/procedure (HSP-626) being tested at IMCC; After designated period of time, review for possible transfer to higher level of acuity.	Policy/procedure (HSP-626) being tested at IMCC; After designated period of time, review for possible transfer to higher level of acuity	Policy/procedure (HSP-626) being tested at IMCC; After designated period of time, review for possible transfer to higher level of acuity
Disciplinary Detention	MH Policy needs to be developed that is treatment focused; yet consistent with DOC DD policies	Under development by MH-Institutions Focus Group; will require training and change in culture re: mental illness	Under development by MH-Institutions Focus Group; will require training and change in culture re: mental illness	Under development by MH-Institutions Focus Group; will require training and change in culture re: mental illness	Under development by MH-Institutions Focus Group; will require training and change in culture re: mental illness	Under development by MH-Institutions Focus Group; will require training and change in culture re: mental illness
Administrative Segregation/ Protective Custody	MH Policy needs to be developed that is treatment focused; yet consistent with DOC AS/PC policies	Under development by MH-Institutions Focus Group; will require training and change in culture re: mental illness	Under development by MH-Institutions Focus Group; will require training and change in culture re: mental illness	Under development by MH-Institutions Focus Group; will require training and change in culture re: mental illness	Under development by MH-Institutions Focus Group; will require training and change in culture re: mental illness	Under development by MH-Institutions Focus Group; will require training and change in culture re: mental illness
Inmate Observers and Mentors Including Peer Support	Develop consistent approach and training to use inmate worker observers and mentors. Will require initial and ongoing training, careful selection, ongoing supervision,	Developed by MH-Institutions Focus Group; final reviews required	Developed by MH-Institutions Focus Group; final reviews required	Developed by MH-Institutions Focus Group; final reviews required	Developed by MH-Institutions Focus Group; final reviews required	Developed by MH-Institutions Focus Group; final reviews required

Figure IV-B-11: Mental Health Policy Standards						
Intervention	**Reception IMCC (ICIW, Newton for federal offenders)**	**Acute IMCC**	**Stepdown /Transition IMCC, ICIW**	**Special Needs Units CCU, CCF, ICIW, MWU**	**General Population (Outpatient)**	**Gender Specific Considerations**
	debriefing and support to be effective.					
Individual MH Treatment	Initial assessment; Crisis intervention; Medication management; Focus on individual treatment plan (ITP) and Goals; Civil commitment patients need Tx Plan.	Crisis intervention; Medication management; Focus on ITP and goals	Crisis intervention; Medication management; Focus on ITP and goals	Crisis intervention; Medication management, Focus on ITP and goals	Crisis intervention; Medication management, Focus on ITP and goals	Crisis intervention, Medication management, Focus on ITP goals with particular emphasis on gender specific treatment needs.
Mental Health Group Counseling	N/A	Medication management; crisis stabilization	Medication management; crisis stabilization; Life Skills; Psychoeducation	Anger Management, Life Skills, Medication Management, Co-occurring Treatment; Psychoeducation, Community Reentry	Anger Management, Life Skills, Medication Management, Programs available to general population;	Women's Issues, Sexuality, Women's Health, Borderline Personality Disorder, Trauma, Children and Parenting, Relationships, Communication
Mental Health Documentation	Detailed SOAP notes that support InterQual criteria + ACA Standards	Detailed SOAP notes that support InterQual criteria + ACA Standards	Detailed SOAP notes that support InterQual criteria + ACA Standards	Detailed SOAP notes that support InterQual criteria + ACA Standards	Detailed SOAP notes that support InterQual criteria + ACA Standards	Detailed SOAP notes that support InterQual criteria + ACA Standards
Reentry Planning	Begins at admission; Assess for Required SSI/SSDI upon	Ongoing treatment planning with long and short term goals; Psychologist	Ongoing treatment planning with long and short term goals; Psychologist	Ongoing treatment planning with long and short term goals; Formalized discharge meeting	Ongoing treatment planning with long and short term goals; Formalized discharge meeting	Ongoing treatment planning with long and short term goals; Formalized discharge meeting

Figure IV-B-11: Mental Health Policy Standards						
Intervention	**Reception IMCC (ICIW, Newton for federal offenders)**	**Acute IMCC**	**Stepdown /Transition IMCC, ICIW**	**Special Needs Units CCU, CCF, ICIW, MWU**	**General Population (Outpatient)**	**Gender Specific Considerations**
	release; housing needs; Psychologist and/or Social Worker involved	and/or Social Worker involved	and/or Social Worker involved	for offender; Psychologist and/or Social Worker involved Avg. 6-9 months prior to discharge – Mental Health staff need to be included in reviewing reentry planning/treatment and placement	for offender; Psychologist and/or Social Worker involved Avg. 6-9 months prior to discharge – Mental Health staff need to be included in reviewing reentry planning/treatment and placement	for offender; Psychologist and/or Social Worker involved; Avg. 6-9 months prior to discharge – Mental Health staff need to be included in reviewing reentry planning/treatment and placement
Self Administered Medications (SAMS) Medication	MH Policy Needs to be Developed Needs to be a Multi-Discipline process (including Security and Medical) Psychiatry needs to be involved when any types of SAMS are given to mentally ill offenders. Goal to control Pharmacy lines; Need to be safer medications	Under development by MH-Institutions Focus Group	Under development by MH-Institutions Focus Group	Under development by MH-Institutions Focus Group	Under development by MH-Institutions Focus Group	Under development by MH-Institutions Focus Group

c. Continuum of Mental Health Services in the Institutions

A continuum of mental health treatment and care is under development to meet the treatment needs of incarcerated offenders with mental illnesses. The continuum includes acute care, partial/transition care, special needs units (SNU), and outpatient care (general population). It is clear that all institutions cannot provide a full continuum of treatment for mental illness. Acute care and partial/transition care will be provided at IMCC and in the future at ICIW. Male special needs units are currently located at Clarinda, IMCC and Ft. Madison. Female special needs units are located at ICIW and Mt. Pleasant.

Decisions have been made to place male offenders with developmental disabilities and brain injuries in a special needs unit at the Clarinda Correctional Facility instead of scattered across all of the special needs units. Centralizing these offenders in one place will allow focused programming that will meet the treatment needs of these offenders. This unit will develop specialized programs for these individuals.

A significant number of male offenders who have been housed in the special needs units at the Clinical Care Unit (CCU) have brittle levels of acuity resulting in labile moods and behavior with little stability. These offenders fluctuate in their acuity levels and thus require frequent changes in their treatment including their medications. Decisions have been made to assess the offenders currently housed in the CCU and to move those who are most acute to facilities (e.g. IMCC) that can provide close monitoring and more intensive mental health treatment.

Further discussions are in progress regarding the offenders with serious mental illnesses and best treatment environments within the Department's facilities.

Figure IV-B-12: Distribution of Designated Mental Health Beds

Distribution of DOC Designated Mental Health Beds				
Institution	**Acute**	**Transition / Step-Down**	**Special Needs Units (SNU)**	**Total Designated MH Beds**
Anamosa State Prison (ASP)	0	0	0	0
Clarinda Correctional Facility (CCF)	0	0	120	120
Ft. Dodge Correctional Facility (FDCF)	0	0	0	0
Iowa Correctional Institute for Women (ICIW)	0	8	60	68
Iowa Medical and Classification Center (IMCC)	23**	20	48	91
Licensed Hospital	23*	0	0	23
Iowa State Penitentiary (ISP)	0	0	0	0
Clinical Care Unit (CCU)[57]	0	0	196	196
Mt. Pleasant Correctional Facility (MPCF)	0	0	0	0
Mt. Pleasant Women's Unit (MPU)	0	0	96	96
Newton Correctional Facility (NCF)	0	0	0	0
North Central Correctional Facility (NCCF)	0	0	0	0
All Institutions	46	28	520	594
Male Beds	23*	20	364	407
Female Beds	23**	8	156	187
* Forensic for NGRI, evaluations, jail transfers, civil commitment transfers; no DOC offenders **Used for forensic females same above				

As seen in Figure IV-B-12, the new facility at IMCC includes 20 observation beds for subacute care of offenders and 48 transition beds being used for offenders who have mental illnesses. Currently, these are used for both male and female offenders because there is no acute care available at ICIW; there are only two secure observation cells with camera monitoring and 8 transition beds for those who require subacute care. Once ICIW's initial construction is completed, all females will be treated in that gender-responsive environment, thus further increasing capacity for male offenders at Mt. Pleasant and IMCC. Further information about the ICIW expansion plans is available in both Chapters Five and Seven of this report.

IMCC's East and West Wing units (total 46 beds) are only used for civilian patients who are undergoing forensic evaluation, who have been found Not Guilty by Reason of Insanity (NGRI), or who are unable to be managed in either the DHS hospitals or in the county jails. These licensed psychiatric hospital beds are very limited and are the only forensic beds currently in use in the state. It should once again be noted that placing

[57] Assessment and Movement Process in Progress. Those least stable and most acute are being moved to IMCC.

civilian patients inside a prison, although allowed under Iowa statute, is most unusual. As recommended in the Phase I report, the Department should consider changing practices and use the full intent of the legislation that "permits" but does not mandate the transfers of civilian and other patients into the IMCC licensed psychiatric hospital.[58]

d. Mental Health Training Programs

A new training program has been developed by a multi-disciplinary staff group. This training includes more scenario discussions and expanded opportunities for security officers to practice basic assessment and interventions skills. The mental health training also includes how to identify symptoms of possible mental illness and effective management strategies to intervene with offenders who have acute and subacute symptoms of mental illnesses. This program has not yet been implemented due to institutional budgetary constraints.

2. Offenders with Mental Illnesses under Community Based Correctional Supervision

One of the key initiatives in Phase II Master Planning was to determine the number of offenders with mental illnesses who are under community supervision who also have mental illnesses and co-occurring disorders that require treatment. An unanswered question was, "Of those offenders, what percentage have access to (or are currently in) the CBC residential programs?" And further, what number of offenders under community-based correctional field supervision, also have mental health and co-occurring (substance abuse and mental health) treatment needs?

To answer those questions, a series of three surveys were completed:

1. *Survey of CBC Records of Offenders to determine how many had diagnoses of mental illness and co-occurring substance abuse disorders.* The Mental Health – CBC Focus Group, in coordination with the DOC Research Director, and in consultation with Durrant/PBA, surveyed records of offenders under community corrections supervision. Personnel were advised to only count those offenders who were diagnosed with a mental illness of a co-occurring disorder by a mental health professional. Field supervision estimates excluded self-supervised offenders, and those on diversion caseloads. A copy of the Survey instrument is available in Appendix C. This survey looked at the following two populations:

    a. One-day snapshot survey of *all* community corrections offenders in residential facilities on October 15, 2007 offenders.
    b. One-day snapshot survey of randomly selected offenders under field supervision on October 15, 2007.

2. *Survey of County Level Mental Health and Co-occurring Disorders Treatment Availability for offenders.* A survey of the availability of mental health and co-occurring disorders treatment in the community was developed by the Durrant/PBA team, facilitated by the Mental Health-CBC Focus Group, and completed by CBC personnel. Data was collected from December 26, 2007

[58] Iowa Code Section 904.201 http://www.legis.state.ia.us/IACODE/2003/904/201.html

through January 25, 2008. A copy of the survey instrument is available in Appendix C.

3. *Survey of Judicial Districts* to determine strategies used to access treatment, management of offenders who have mental illness and co-occurring disorders, and probation/parole officer and case manager training needs to be able to better manage this population. A survey of the Judicial Districts ability to manage the offenders in community-based corrections who have mental illnesses and co-occurring disorders was developed by the Durrant/PBA team, facilitated by the Mental Health-CBC Focus Group, and completed by CBC personnel. A copy of the survey instrument is available in Appendix C.

The highlights from these survey findings are presented below.

a. Prevalence of Mental Illnesses and Co-Occurring Disorders in CBC Residences

As shown in Figure IV-B-13, 454 (28%) offenders in CBC residential facilities have diagnosed mental illnesses; an additional 228 (14%) additional offenders have diagnosed co-occurring disorders (substance abuse disorder plus at least one other mental illness diagnosis).

Figure IV-B-13: Prevalence Estimates: Mentally Ill Offenders in CBC Residential Facilities

	Group Population Estimates				
District	Substance Use Disorders[59]	Co-Occurring Disorders	Other Mentally Ill	No MI Diagnosis	Confidence Interval
1JD	57	48	130	162	3.78
2JD	10	10	62	95	3.56
3JD	15	21	30	27	4.12
4JD	8	9	26	46	2.24
5JD	96	59	69	121	4.37
6JD	22	31	69	98	2.62
7JD	39	33	34	65	2.06
8JD	22	17	34	35	5.12
Statewide	269	228	454	649	1.42

Source: CBC Mental Health Focus Group Offender Survey, October 15, 2007

In Figure IV-B-14, the survey of CBC Residential Facilities found that 276 (60.9%) offenders who have mental illness and 144 (63.2%) offenders who have co-occurring disorders are receiving treatment. The survey also found that 178 (39.2%) offenders who have mental illness and 84 (36.8%) offenders who have co-occurring disorders are not receiving treatment.

[59] While substance abuse disorders that have no relational mental health disorder are included in this table they are not significant to the purpose of this report which is to identify the number of offenders who have treatment needs for mental illnesses and co-occurring disorders.

Figure IV-B-14: Mentally Ill Offenders in Residential Facilities Currently Receiving Treatment

Mentally Ill Offenders in Residential Facilities: Percent Currently Receiving Mental Health Care or Treatment						
	% of Offenders Receiving Treatment		Estimates: Number Receiving Treatment		Estimates: Number Not Currently in Treatment	
District	Co-Occurring Disorders	Other Mentally Ill	Co-Occurring Disorders	Other Mentally Ill	Co-Occurring Disorders	Other Mentally Ill
1JD	76.7%	65.9%	37	86	11	44
2JD	37.5%	76.0%	4	47	6	15
3JD	72.2%	46.2%	15	14	6	16
4JD	100.0%	76.0%	9	20	0	6
5JD	48.6%	65.9%	29	45	30	24
6JD	59.3%	53.3%	18	37	13	32
7JD	74.2%	46.9%	24	16	9	18
8JD	46.2%	34.6%	8	12	9	22
Statewide	63.2%	60.9%	144	276	84	178

Source: CBC Mental Health Focus Group Offender Survey, October 15, 2007

b. Prevalence of Mental Illnesses and Co-Occurring Disorders under CBC Field Supervision

As shown in Figure IV-B-15, an estimated 4,189 (18%) offenders under CBC field supervision have mental health diagnoses; an additional 1,969 (9%) offenders under CBC field supervision have diagnosed co-occurring disorders (substance abuse disorder plus at least one other mental illness diagnosis)

Figure IV-B-15: Offenders Who Have Mental Illnesses and Under CBC Field Supervision

Prevalence Estimates: Mentally Ill Offenders Under CBC Field Supervision					
	Group Population Estimates				
District	Substance Use Disorders[60]	Co-Occurring Disorders	Other Mentally Ill	No MI Diagnosis	Confidence Interval
1JD	486	284	972	2,336	5.43
2JD	589	331	506	1,684	5.37
3JD	566	238	279	1,223	5.48
4JD	307	52	82	602	5.02
5JD	873	499	1,018	4,240	5.34
6JD	404	345	419	1,051	5.24
7JD	201	138	408	905	5.00
8JD	95	82	505	1,136	5.30
Statewide	3,521	1,969	4,189	13,177	1.90

Source: CBC Mental Health Focus Group Offender Survey, October 15, 2007

[60] While substance abuse disorders that have no relational mental health disorder are included in this table they are not significant to the purpose of this report which is to identify the number of offenders who have treatment needs for mental illnesses and co-occurring disorders.

Figure IV-B-16 indicates that of those offenders who are under CBC Field Supervision who have mental illnesses, 56.5% are receiving treatment. Of those offenders who have co-occurring disorders, 64.4% are receiving treatment. Of significance is that 1821 (43.4%) offenders who have mental illness and 701 (35.6%) offenders who have co-occurring disorders are not receiving treatment.

Figure IV-B-16: Offenders Under CBC Field Supervision Currently Receiving Treatment

Mentally Ill Offenders Under CBC Field Supervision: Percent Currently Receiving Mental Health Care or Treatment

District	% of Offenders Receiving Treatment		Estimates: Number Receiving Treatment		Estimates: Number Not Currently in Treatment	
	Co-Occurring Disorders	Other Mentally Ill	Co-Occurring Disorders	Other Mentally Ill	Co-Occurring Disorders	Other Mentally Ill
1JD	71.4%	61.1%	203	594	81	378
2JD	53.1%	49.0%	176	248	155	258
3JD	58.6%	67.6%	140	189	98	90
4JD	92.9%	31.8%	48	26	4	56
5JD	62.5%	55.1%	312	561	187	457
6JD	70.2%	54.4%	242	228	103	191
7JD	65.4%	58.4%	90	238	48	170
8JD	69.2%	56.3%	57	284	25	221
Statewide	64.4%	56.5%	1,268	2,368	701	1,821

Source: CBC Mental Health Focus Group Offender Survey, October 15, 2007

In spite of the significant numbers of offenders who are under CBC supervision and receiving treatment, one wonders why the numbers of diagnosed individuals who are not receiving treatment exist. Is it a matter of not currently needing treatment or is it difficult for offenders to receive treatment? Therefore, further study was undertaken to assess the availability of mental health and co-occurring treatment for offenders in Iowa's communities.

c. Availability of Mental Health and Co-occurring Disorder Treatment in the Community

A survey was completed for 98 of 99 Iowa counties to assess the availability of and access to community-based mental health and co-occurring disorders treatment for offenders. The surveys were completed by a CBC probation/parole officer. A copy of the survey is available in Appendix C.

The initial survey question asked if the county central point of coordination (CPC[61]) would use county funding to provide treatment services for offenders under CBC

[61] Central Point of Coordination. Each county (or group of counties) has a designated CPC. Central Point of Coordination (CPC) is the term adopted by the State County Management Committee to define the "Single Point of Entry" required by Chapter 331 of the Iowa Code. CPC

Supervision. Figure IV-B-17 indicates that there is wide variation in CPC decisions to use county funding for treatment services for CBC offenders who have diagnosed mental illnesses or co-occurring disorders.

Figure IV-B-17: County Funding for Treatment Services for Offenders under CBC Supervision

		Type of CBC Offenders			
	# of Counties	Probationers	Parolees	Work Release	Residential
JD 1	11	100%	100%	73%	73%
JD 2	22	100%	100%	45%	95%
JD 3	16	88%	88%	19%	19%
JD 4	9	100%	100%	100%	100%
JD 5	16	94%	94%	00%	13%
JD 6	6	100%	100%	33%	50%
JD 7	5	100%	100%	100%	100%
JD 8	15	100%	33%	00%	47%
Statewide	99	96.96%	88%	33%	55%

Source: Durrant Study County Survey, December 26, 2007-January 25, 2008

The percentage of counties that will fund mental health treatment for offenders under CBC supervision vary; while nearly 97% of the counties will pay for probationer treatment and 88% will pay for parolee treatment; only 33% will pay for work release offenders and only 55% will pay for offenders in residential facilities. When the counties do pay for treatment services, the offender must qualify for a legal settlement determination[62] in order to access that assistance. Some counties hold the position that offenders who are in residential facilities are under the control of the Department of Corrections and therefore DOC should pay for their treatment services.

Eighty nine counties have at least a satellite mental health office; ten do not. Where there is no satellite office available, the offenders must travel to a neighboring county to receive mental health services. This presents a transportation issue for many of the offenders; the lack of transportation may prohibit access to treatment for some.

Consistent with these findings, an uninsured offender finds it difficult to access outpatient treatment and hospitalization services. Without insurance, medication services are also difficult to access, even if available. In Figure IV-B-18, seventy three (73) counties have a mental health professional who can prescribe medications; twenty five (25) did not. It is notable that while some counties have a satellite mental health office there is no available mental health professional with prescriptive privileges (e.g. Psychiatrist, Psychiatric Nurse Practitioner) to prescribe psychiatric medications. In many of these

---

is an administrative function and is a component of the managed system required by Chapter 331 of the Iowa Code (also referred to as SF 69). The development of a CPC function was in response to the problems in the past of access for individuals to services within the MH/DD service delivery system. The purpose of the management plan is to provide a clear defined process and management of the MH/DD funding system within the county.

[62] *"Legal settlement"* means a person's status as defined in Iowa Code sections 252.16 and 252.17. A person continuously residing in a county in this state for a period of one year acquires a settlement in that county except as provided in subsection 7 or 8 of Iowa Code Section 252.16.

counties, primary care and family physicians are the only resource for psychiatric medication prescriptions.

Of the seventy six surveys with response to a question about how long it takes to have a medication appointment, the average wait was six (6) weeks. As noted in Figure IV-B-18, the average range of time on a waiting list is 4-10 weeks. In at least one county, the wait for a medication assessment/appointment could be as long as 20 weeks.

Figure IV-B-18: Available Psychiatric Medication Prescriber and Wait Time for Available Medication Appointment

	Prescriber			
	Total # Counties	**Yes**	**No**	**Avg. Wait for Appointment**
JD 1	11	6/54.5%	5/ 45.4%	6 weeks
JD 2	22	8/36.4%	13/59%	7.5 weeks
JD 3	16	15/93.8%	0	4 weeks
JD 4	9	9/100%	0	7 weeks
JD 5	16	10/62.5%	6/37.5%	10 weeks
JD 6	6	6/100%	0	7 weeks
JD 7	5	4/80%	1/20%	4 weeks
JD8	14	10/71.4%	4/28.6%	6 weeks
Statewide	**99**	**68**	**29**	**6 weeks**
%	**100%**	**68.7%**	**29.3%**	
3 missing				

Source: Durrant Study County Survey, December 26, 2007-January 25, 2008

The availability of co-occurring disorders treatment for offenders who have a mental illness and substance abuse is even more limited. The provision of co-occurring disorders treatment can vary. It may be provided by mental health services, substance abuse services, or in some rare cases by correctional services. In some counties, a parallel approach to providing co-occurring disorders treatment is used. This means that mental health and substance abuse services are coordinated but provided by separate specialists in each field. Other counties use the more contemporary integrated treatment approach for co-occurring disorders. The integrated treatment approach is provided in tandem by a team of mental health and substance abuse professionals or even more ideally, the treatment is provided by professionals who are dually trained in both mental health and substance abuse.

Figure IV-B-19 shows the availability of co-occurring disorders treatment and the approaches used in each judicial district. There is some duplication in who provides services because some counties have more than one provider of co-occurring disorders treatment.

Figure IV-B-19: Availability of Co-Occurring Disorders Treatment by Judicial District

Co-Occurring Disorders Treatment										
		Treatment		Provider of Co-Occurring Treatment				Type of Treatment	
JD/# Counties		Total	%	MH	SA	MH+SA	Corrections	Integrated	Parallel
JD 1	11	5	45.5%	1	2	1	1	2	1
JD 2	22	4	18.2%	0	2	2	0	4	8
JD 3	16	16	100%	3	1	12	0	1	14
JD 4	9	5	55.6%	5	5	4	0	3	5
JD 5	16	15	93.8%	11	4	6	0	2	6
JD 6	6	2	33.3%	2	2	1	1	2	6
JD 7	5	5	100%	0	1	4	0	1	4
JD 8	14	1	7%	0	0	1	0	1	0
Statewide 3 missing		53	53.5%	22	17	31	2	16	44

Source: Durrant Study County Survey, December 26, 2007-January 25, 2008

Figure IV-B-20 depicts the respondents' perceived ease in accessing psychiatric hospitalization for offenders. It is notable that the majority of the responses were polarized. 35.3% of respondents believed that psychiatric hospitalization was not available for offenders especially in the 5th and 8th Judicial Districts. On the other hand, 34% of respondents believed that psychiatric hospitalization was always available for offenders especially in the 1st and 4th Judicial Districts. In addition, at least 9 of the 16 counties in the 3rd Judicial District perceived access to hospitalization as always available. The rest of the respondents varied in their opinion about how easy it is to access psychiatric hospitalization for offenders.

Figure IV-B-20: Perceived Ease to Access to Psychiatric Hospitalization for Offenders

Judicial District	# of Counties	Perceived Access to Psychiatric Hospitalization for Offenders*					
		0*	1*	2*	3*	4*	5*
JD 1	11	0	0	0	0	0	11
JD 2	22	6	13	0	0	0	2
JD 3	16	2	1	1	0	2	9
JD 4	9	0	0	0	0	0	9
JD 5	16	11	1	2	0	1	0
JD 6	6	0	0	0	1	3	0
JD 7	5	2	0	0	1	1	1
JD 8	14	12	0	0	2	0	0
Statewide	99	33	15	3	4	7	32
Percentage	100%	35.1%	16%	3%	4%	7.5%	34%
Missing	5						

Source: Durrant Study County Survey, December 26, 2007-January 25, 2008

*Legend:
0 = Not Available
1 = Theoretically, but nearly impossible to access
2 = Difficult, but able to access
3 = Available but long waiting lists for services

4 = Available most of the time
5 = Always available

The survey also asked whether the county had a contract with a provider for psychiatric hospitalization. Only 33 respondents stated that there was a contract in place; 47 respondents stated that there was no contract in place; the remaining 18 respondents did not answer the question.

In addition to accessing mental health or co-occurring disorders treatment, the survey inquired about access or availability to special community-based mental health services. These services may prevent incarceration in jail or prison or may assist with re-entry into the community. These services, which are discussed in more detail under the Reentry section of this chapter, include such services as:

- Jail Diversion Programs
- Jail Mental Health Programs
- Mental Health Courts
- Mobile Crisis Units
- Assertive Community Treatment Teams (ACT)

Figure IV-B-21 shows the availability of special services to offenders in the judicial districts.

Figure IV-B-21: Access to Special Community-Based Mental Health Services

Access to Special Services										
	Jail Diversion		Jail MH		MH Courts		Mobile Crisis		ACT*	
JD/#Counties	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
JD 1 /11	2	9	1	10	0	11	0	11	0	11
JD 2 /22	1	20	1	20	0	21	1	20	1	19
JD 3 /16	1	14	14	1	14	1	2	14	1	14
JD 4 / 9	0	9	0	9	0	9	0	9	0	9
JD 5 /16	3	12	3	12	3	12	5	10	2	12
JD 6 / 6	2	4	3	1	0	6	1	5	2	4
JD 7 / 5	1	4	2	3	2	3	0	5	3	2
JD 8 /14	0	14	0	14	0	14	0	14	0	14
Statewide	10	86	24	70	19	77	9	88	9	85
Percentage	10.1%	86.7%	24.2%	70.7%	19.2%	77.8%	9.1%	88.9%	9.1%	85.9%
Missing		3		5		3		2		5

Source: Durrant Study County Survey, December 26, 2007-January 25, 2008
*Assertive Community Outreach Teams

Jail Diversion and Jail Mental Health Services are frequently provided by community mental health providers who can intervene early in the criminal path of offenders who have mental illnesses. Mental Health Courts provide special treatment plans, interventions and monitoring services that also work toward preventing offenders who have mental illnesses from progressing further into the criminal justice system often leading to incarceration. Mobile Crisis teams may also provide crisis intervention and assist with psychiatric hospitalizations especially when an individual who has mental illness is decompensating. Not only can this prevent further deterioration, but early and

speedy intervention can prevent actions that result in criminal behavior or other risks to the public.

A final survey question inquired about available services for people who are the victims of trauma such as domestic violence, sexual assault, other crime, and supportive services for veterans. These services, while not specific to offenders in general or offenders who have mental illnesses, are services required at times by offenders as well as the general public. Of particular importance are the domestic violence and sexual assault services for females. Many female offenders are victims of both crimes. In addition, the media reports the need for veteran services to assist with their readjustment from war zones. If veterans do not receive services, they may self medicate by using alcohol or drugs and become at risk for involvement in criminal behavior.

Figure IV-B-22: Availability of Trauma and Victim Services

	Trauma/Victim Services											
	Domestic Violence			Sexual Assault			Other Crimes			Veterans		
JD/#Counties	Yes	No	Unk	Yes	No	Unk	Yes	No	Unk	Yes	No	Unk
JD 1 /11	11	0	0	11	0	0	7	0	4	10	0	1
JD 2 /22	21	0	0	21	0	0	2	9	10	4	10	7
JD 3 /16	14	1	0	14	1	0	14	1	0	12	1	2
JD 4 / 9	3	6	0	3	6	0	1	1	7	0	0	9
JD 5 /16	11	4	0	5	7	3	2	9	4	4	7	4
JD 6 / 6	6	0	0	6	0	0	6	0	0	5	0	1
JD 7 / 5	4	1	0	4	1	0	4	1	0	0	2	2
JD 8 /14	4	10	0	4	10	0	0	14	0	0	14	0
Statewide	**74**	**22**	**0**	**68**	**25**	**3**	**36**	**35**	**25**	**35**	**34**	**26**
Percentage	**74.7**	**22.2**	**0**	**68.7**	**25.3**	**3.0**	**36.7**	**35.4**	**25.3**	**35.4**	**34.3**	**26.3**
Missing			3			3			3			4

Source: Durrant Study County Survey, December 26, 2007-January 25, 2008

Figure IV-B-22 shows the availability of these supportive trauma and victim services. These community-based services may assist victims in their time of need and could potentially offer interventions that prevent the development of later criminal behaviors.

d. Results of Judicial Surveys Related to Managing Offenders under Community-Based Supervision who have Mental Illnesses.

It is significant that not only are the numbers of offenders with mental illnesses increasing in the prisons, but there are also significant numbers of offenders with mental illnesses who are under community-based residential and field services supervision. The Durrant/PBA team surveyed the Judicial Districts regarding their ability to manage offenders who have mental illnesses and co-occurring disorders. Of particular interest were strategies that some judicial districts have employed to build community/regional partnerships that increase access to the treatment services required by these offenders. A copy of the survey instrument is available in Appendix C.

Only 4 of the eight judicial districts have probation/parole officers or case managers who work specifically with offenders who have mental illnesses. In general, the responses were consistent in stating that they all have some staff who work well with offenders who

have mental illnesses; however, caseload reductions for those particular staff are not an option due to the current volume of offenders under community supervision. They agree that it would be advantageous to have specialized staff with reduced caseloads to work with offenders who have mental illnesses.

- In the First Judicial District (JD1), Blackhawk County has seven specialized positions to manage offenders with mental illnesses and related treatment needs.
- The Fifth Judicial District (JD5) has five specialized positions. Again, the counties within which they are located were not specified; however it was stated that the number is not sufficient, because "only the severe cases get to the mental health caseloads merely because of the volume." They divert offenders to other Probation Officers who have some mental health background.
- In the Sixth Judicial District (JD6), Linn County has one specialized Probation/Parole Officer, one specialized position assigned to drug treatment court (who will also address mental health issues), and one pre-trial position to address offenders who have mental illnesses. Johnson County has one drug treatment court position.
- The Seventh Judicial District (JD7) stated that they have one position but did not specify within which county.

Where specialized positions have been created to manage offenders with mental illness, strong collaborations have been built among the community-based agencies that provide these services. Partnerships between human service and community corrections agencies and personnel who work with offenders strengthen the opportunities and likelihood that both diversion from deeper penetration into the criminal justice system and reentry back into the community from incarcerations (either local or state) will be more successful.

e. Strategies Implemented to Improve Access to Mental Health Services

As seen in Figure IV-B-23, five of the eight Judicial Districts reported creative strategies that they have implemented to improve access to mental health services. In all cases the districts report that the relationships and collaborations that have been developed have been invaluable. At the same time, these efforts have not solved all of the problems in accessing services.

Figure IV-B-23: Judicial District Strategies

Strategies Implemented to Improve Access to Mental Health Services	
Judicial District	**Strategies**
JD 1	The First Judicial District created a continuum of services in Black Hawk County including a men's and women's dual diagnosis program, jail diversion program, re-entry mental health program, and a specialized officer for the most difficult mental health cases. They have increased partnerships with local providers, CPC's, legislators, attorneys, etc. in all of the counties. They have worked toward creative interventions as much as possible.
JD 2	The Second Judicial District developed collaborative efforts

	through Mental Health/Criminal Justice Task Forces in four major service areas of the District. The Story County Task Force has been successful in developing system improvements (communication, training of criminal justice system) and received a federal grant to implement a Jail Diversion Program. Webster County has implemented Iowa's first rural Assertive Community Treatment (ACT) program.
JD 3	The Third Judicial District has a very successful Mental Health Court in Sioux City. This court works closely with both the criminal justice and mental health services systems.
JD 4	The Fourth Judicial District recently hired an Intensive Supervision Officer who will supervise the chronically mentally ill clients. This position will develop a network of service providers to assist in helping the mentally ill offenders. This position will be filled in March, 2008.
JD 5	In Polk County, the Fifth Judicial District has a jail diversion program which strengthens their relationships with the mental health providers in the community. With other agencies in Polk County, JD5 presented two days of training to the department which was well received. There has also been a joint effort to obtain grants to work with the increasing jail population. PO's are encouraged to be active in various organizations in the community, like the Suicide Prevention Coalition. A lot of providers accompany their clients to the PO meetings which improves collaboration. PO's visit community providers to learn about various agencies and resources.
JD 6	The Sixth Judicial District has worked very hard to establish collaborations that work to improve access to resources for clients. For example, in Johnson County, there is a diversion program funded through the county and the District personnel work with that program extensively. There is also a program with some similar aspects in Linn County. The 6th District uses advisory boards that include many providers in our district (different counties included) to increase ability to utilize services. The 6th District has also established Community Accountability Boards that have community agencies as regular members to increase services and access. A residential mental health treatment facility is under development which will include community collaborations and providers to again increase access and resources for our clients.
JD 7	Scott County works with a staff member of the Vera French Mental Health Center who serves as a liaison between the District staff members and the mental health center staff members.

Source: Durrant Study Judicial District Survey, December 26, 2007 – January, 25 2008

All Judicial Districts collaborative strategies report that regular meetings are the key to improving access to services. These relationships do not stand on their own; they take continued effort, joint problem solving, and on-going cross-system and cross agency communication.

f. Recommended Specialized Training for those Case Managers and /or Coordinators and Probation/Parole Officers who Supervise/Work with Offenders who have Mental Illnesses

The Judicial Districts would like to provide specialized training for supervising offenders with mental illnesses to all probation and parole officers as well as case managers. They report that while some training is available these events are sporadic and not always focused on the specific needs of community-based correctional supervision.

Judicial District training recommendations included:

- A standardized, core curriculum for all Probation and Parole Officers (POs) and Case Managers in the first year training program to include:
    - Strategies to assist and better supervise offenders who have mental illnesses
    - Strategies to improve offenders' compliance with psychiatric medications
    - Skills to develop simple case plans and goals
    - Effective sanctions for MH clients.
- Additional training for those POs/Case Managers who (will) specialize in working with the mentally ill and others who are interested in expanding their skill set to include:
    - How to screen for/identify signs of mental illness
    - Symptoms and types of mental illness
    - Medications - benefits, side effects, how to use incentives to encourage compliance, sources for free medications, financial assistance
    - How to get the most out of Iowa's Mental Health Managed Care System
    - How to work with a mentally ill offender as a corrections staff person - difference in approaches used with non-mentally ill offenders - what's effective and why
    - Referral sources, laws, including HIPPA and confidentiality
    - Funding agencies
    - Medical and legal definitions

- Signs and symptoms of various mental health diagnoses
- Resources available for mentally ill individuals
- How to address and minimize re-entry issues such as the continuity of services between the DOC institutions and the community regarding psychotropic medication management and other services

g. Additional Concerns About Managing Offenders Who Have Mental Illnesses

The following selected comments are direct quotes from the Judicial District surveys. These comments eloquently describe the issues that probation/parole officers, case managers, and residential facility staff cope with every day.

"Smaller counties struggle with mental health services being available and the accessibility of those services due to transportation, distance, medications, etc."

"… would like to see more programs such as ACT teams and Mobile Crisis to follow up with these more difficult cases that revolve through the system."

"….a lack of Psychiatrists available to prescribe medications."

"Offenders quit medications when they leave the facility-- because they don't have funding sources and they just cost too much."

"If the offender was on SSI or Disability before entering the Residential Correctional Facility (RCF), they lose their benefits while in the RCF. This presents a problem when they need to access on-going psychiatric services, and psychotropic medications."

"As an ever-increasing number of offenders--especially female offenders--present with co-occurring disorders, the need for specialized training and greater collaboration with the community mental health service providers becomes more acute."

"…"the community correction centers become our mental health residential centers by default. Residential staff members need specialized training to address the needs of the chronically mentally ill, and the centers must modify program expectations to respond to the needs and deficiencies of this population."

3. Reentry for Offenders with Mental Illnesses and Co-Occurring Disorders

Significant percentages of offenders in Iowa have mental illnesses and co-occurring disorders (mental illness and substance abuse). Once embedded in the criminal justice system, these multi-challenged offenders have numerous social service needs including housing[63] and other basic requirements; medical, substance abuse and mental health care treatment needs (including psychiatric medication); and require specialized correctional supervision. In short, they have multiple service needs from many agencies of both the human services and criminal justice systems. Therefore, it is vital that this

[63] Roman, C.G. (2006). *Moving Toward Evidence-Based Housing Programs for Persons with Mental Illness in Contact with the Criminal Justice System*. Gains Center.

criminal justice subpopulation have reentry planning that begins upon contact with the criminal justice system rather than upon entry into the institutions. While diversion from the criminal justice system may not traditionally be considered within the framework of reentry, it is an important consideration for offenders who have mental illnesses. As discussed in Chapter 3, for the offender with mental illness, early diversion from the criminal justice system must be a key consideration because many of the evidence-based programs with effective outcomes are interventions that occur prior to incarceration in a prison. The outcomes of inadequate reentry planning include compromising public safety, increasing psychiatric symptoms, hospitalizations, new criminal offenses, and rearrest[64].

Reentry planning for offenders with mental illnesses and co-occurring disorders requires bi-directional responsibilities (in-reach into the jails and prisons and outreach into the community) and collaboration among providers. The results of these efforts will only be as good as the correctional-mental health partnerships in the communities where offenders return. Reentry planning can only work if justice, mental health, and substance abuse systems have a capacity and a commitment to work together.

There are programs that have been identified as either promising or effective with the criminal justice involved offender with mental illness. They include the Sequential Intercept Model[65], APIC Model[66], Assertive Community Treatment (ACT) Teams[67], Mental Health Courts[68], Probation/Parole with Specialized Officers and Reduced Caseloads[69], integrated treatment and correctional supervision, Community-Based Correctional Residential Facilities with treatment and programming for offenders with mental illnesses.

Sequential Intercept Model

The Sequential Intercept Model is a conceptual framework for communities to use when addressing the interface between the criminal justice and mental health systems regarding criminalization of people with mental illness. The model uses a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services, initial detention and initial court hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. Once this model is adopted, a community can develop targeted

[64] Osher, F. (2007). *Short-term Strategies to Improve Reentry of Jail Populations: Expanding and Implementing the APIC Model*, in American Jails, Jan-Feb 2007, p. 9-19.
[65] Munetz, M. and Griffin, P. (2006). *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*. Psychiatric Services: 57:4, pp. 544-549.
[66] Osher, F.; Steadman, H.; and Barr, H. (2002) *A Best Practice Approach to Community Reentry from Jails for Inmates with Co-Occurring Disorders: The APIC Model*. National GAINS Center.
[67] Morrissey, J. and Meyer, P. (2005). Evidence-Based Practice for Justice Involved Individuals. A Discussion Paper. GAINS Center and SAMHSA.
[68] *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court (2007).* Justice Center: The County for State Governments,
[69] Skeem, J. and Louden, J. (2006). *Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment.* Psychiatric Services: 57:3, pp 333-342.

strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system.[70]

The APIC Model

The APIC model is a set of critical elements that, if implemented in whole or in part, are likely to improve outcomes for people with co-occurring disorders from jail. Successful bridges between mental health and criminal justice systems lead to coordinated and continual health care for clients in both systems. The APIC model elements are: Assess, Plan, Identify, and Coordinate. The central elements of reentry are associated with successful integration back into the community:[71]

- **Assess** the clinical and social needs, and public safety risks of the offender.
- **Plan** for the treatment and services required to address the offender's need.
- **Identify** required community and correctional programs responsible for post-release services.
- **Coordinate** the transition plan to ensure implementation and avoid gaps in care.

Assertive Community Treatment Teams

Assertive Community Treatment Teams are an evidence based practice of mental health treatment that has recently been extended to the criminal justice population as FACTs which are assertive community treatment teams for forensic populations.[72] ACT is a service delivery model in which treatment is provided by a multi-disciplinary treatment team 24-hour, 7-days a week for as long as the consumer needs the service. The team provides services in the community to offer more effective outreach and to help the consumer generalize the skills to real life settings. The target population is people who have severe mental illness, are functionally impaired, and at high risk of inpatient hospitalization. The consumers often have high rates of co-occurring substance related disorders, medical co-morbidities including hepatitis and HIV infections, and social risks including poverty, homelessness, and incarcerations.

Intensive, Specialized Probation Supervision

There are agencies with probation/parole officers who specifically work with offenders who have mental illness. Research finds that the most promising practice is when these officers have reduced caseloads[73]. A necessary condition for effective supervision of these individuals may be adequate time. One reason for this finding is that large caseloads may prevent probation officers from functioning as "boundary spanners" who

[70] Munetz, M. and Griffin, P. (2006). *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*. Psychiatric Services: 57:4, pp. 544-549.
[71] Osher, F.; Steadman, H.; and Barr, H. (2002) *A Best Practice Approach to Community Reentry from Jails for Inmates with Co-Occurring Disorders: The APIC Model*. National GAINS Center.
[72] Morrissey, J. and Meyer, P. (2005). *Evidence-Based Practice for Justice Involved Individuals.* A Discussion Paper. GAINS Center and SAMHSA.
[73] Skeem, J. and Louden, J. (2006). *Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment.* Psychiatric Services: 57:3, pp 333-342.

develop knowledge about mental health and community resources, establish and maintain relationships with clinicians, advocate for services, and actively supervise these individuals.

Judicial Districts (First, Fourth, Sixth, and Seventh) have a total of 17 "specialty" probation and parole officers in Iowa; these positions should be supported and the numbers should be expanded in an effort to prevent offenders with mental illnesses from further penetration into the criminal justice system and/or reincarceration.

The Second, Third, and Fifth Judicial Districts use other collaborative strategies to improve access to treatment for these special needs offenders. Vital to the successes achieved in these Judicial Districts are the boundary spanner positions and the collaboration that is occurring. Any efforts to expand these collaborations or to build new cross-system collaborations between service systems should be targeted for priority funding.

Integrated Treatment and Correctional Supervision

There are additional models that integrate treatment and correctional supervision in centralized locations. The Community Treatment Resource Centers currently being planned by the Iowa Department of Corrections are consistent with this approach. The proximity of the personnel from both systems builds communication, collaboration and integrated treatment plans with goals that meet the requirements of both service systems. As a result, these Resource Centers promote adherence with correctional supervision and with treatment for a number of reasons. Offenders believe that both systems are communicating and there are fewer conflicts between the systems about what is required by the offenders. In addition, co-location addresses, at least in part, some of the transportation difficulties encountered by these offenders in keeping appointments.

Mental Health Courts

As mental health courts rapidly expand across the United States, the similarities across mental health courts are becoming increasingly apparent. In fact, the vast majority of mental health courts share the following characteristics[74]:

- A specialized court docket, which employs a problem-solving approach to court processing in lieu of more traditional court procedures for certain defendants with mental illnesses.

- Judicially supervised, community-based treatment plans for each defendant participating in the court, which a team of court staff and mental health professionals design and implement.

- Regular status hearings at which treatment plans and other conditions are periodically reviewed for appropriateness, incentives are offered to reward adherence to court conditions, and sanctions are imposed on participants who do not adhere to the conditions of participation.

[74] *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court (2007).* Justice Center: The County for State Governments.

- Criteria defining a participant's completion of (sometimes called graduation from) the program.

The reasons communities give for establishing mental health courts are also remarkably consistent: to increase public safety, facilitate participation in effective mental health and substance abuse treatment, improve the quality of life for people with mental illnesses charged with crimes, and make more effective use of limited criminal justice and mental health resources.

Two key principles underlie the ten essential elements of mental health courts. First, at the heart of each element is collaboration among the criminal justice, mental health, substance abuse treatment, and related systems. True cross-system collaboration is necessary to realize any of these elements and, for that matter, to successfully operate a mental health court. It is generally accepted that achieving this type of collaboration is difficult, particularly in breaking down institutional barriers and mediating the adversarial process. Second, the elements make clear, both explicitly and implicitly, that mental health courts are not a panacea. Reversing the overrepresentation of people with mental illnesses in the criminal justice system requires a comprehensive strategy of which mental health courts should be just one piece.

In Iowa, there are mental health courts in the 3rd, 5th, and 7th Judicial Courts. The mental health court in the 3rd District, located in Sioux City was established in 2001 and is considered highly successful. Underlying that success is the foundation of local community values and cross system collaboration. Consistent with the national research findings, the success of mental health courts in Iowa are dependent upon the courts understanding mental illness and the collaboration between the courts and other agencies within the criminal justice system and the mental health system. In rural areas such as Iowa it is particularly important that the decisions made by the Mental Health Court are consistent with the community's values and culture.

Correctional Residential Facilities

Residential CBC Correctional Facilities that are entirely focused upon the special needs of offenders who have serious mental illnesses are thought to be a missing sector of the reentry process that would be most successful. While there are a number of Iowa CBC residential facilities that accept offenders who have mental illnesses, there are no facilities that focus on the special needs of these offenders, especially those who have serious mental illness and require special considerations for reentry. The Sixth Judicial District is developing a facility that will focus on offenders who have serious mental illnesses and who will require the complex, multi-agency responses to reentry and adjustment to the community.

Conclusion

In conclusion, there are a number of strategies that can be used to prevent offenders who have mental illnesses from further penetration into the criminal justice system and to assist those who are reentering the community from local or state incarceration. Iowa

has adopted a number of those strategies[75]. With the increased focus on reentry, it is vital that offenders who are incarcerated in Iowa's prisons are not forgotten. While the reentry strategies must broaden to include early intervention, it is anticipated that there could be significant impact upon the overall incarceration rate and therefore numbers of offenders who have mental health and co-occurring disorders treatment needs in Iowa's prisons. Every effort should be made to decrease this incarcerated population through non-traditional mental health and criminal justice interventions, strategic treatment, and program planning in both service systems and collaboration at the community, county and state levels.

4. Iowa Public Funding System for Mental Illness and Other Disabilities

In 2006, the Iowa Legislature established the Division of Mental Health and Disability Services (MHDS) within the Department of Human Services (DHS)[76]. With the enactment of HF2780, the general assembly sought a service system for persons with disabilities which emphasizes the ability of persons with disabilities to exercise their own choices about the amounts and types of services received; that all levels of the service system would seek to empower persons with disabilities to accept responsibility, exercise choices, and take risks; that disability services are individualized, provided to produce results, flexible, and cost-effective; and that disability services be provided in a manner which supports the ability of persons with disabilities to live, learn, work, and recreate in communities of their choice.

The public system of mental health and disabilities care in Iowa is meant to provide a safety net for the uninsured or those who do not have available to them commercial health insurance benefits coverage to meet their needs. This public system in Iowa includes the MHDS, the services provided by the ninety-nine (99) Iowa counties through a wide range of community providers, services offered by community mental health centers, services offered by and funded through school districts, Area Education Agencies (AEAs) and the Department of Education, Child Health Specialty Clinics and other services funded through the Department of Public Health, and public facilities such as mental health institutes and resource centers. A large portion of the public system is federally funded through Iowa's Medicaid entity - the Iowa Medicaid Enterprise through a contract with Magellan Behavioral Health. Some federal grants support parts of this public network.

Most of those persons served by the Iowa public mental health and disability service system have serious mental illness or severely disabling conditions, and often as a result of their disabilities, end up poor and dependent on the public system. Each year Iowa's public mental health and disability service system serves over 70,000 people.

Central Point of Coordination (CPC)[77] is the term adopted by the State County Management Committee to define the "Single Point of Entry" required by Chapter 331 of the Iowa Code. CPC is an administrative function and is a component of the managed

[75] Hein, Maria. *An Evaluation of Three Transitional Mental Health Re-entry Programs in Iowa: Fourth Annual Report.* Institute for Social and Economic Development. February 15, 2007.
[76] Source: http://www.dhs.state.ia.us/mhdd/index.html. Retrieved March 17, 2008.
[77] Source: http://www.dhs.state.ia.us/mhdd/county_system/cpc_admin.html. Retrieved March 18, 2008.

system required by Chapter 331 of the Iowa Code (also referred to as SF 69). Some of the CPC duties include: centralized intake for persons wishing to access county funded MH/DD services, determine legal settlement, referral for service coordination, service and cost tracking, collection and reporting of data, authorizing funding within the guidelines established by the county management plan, public education, strategic planning, development of the annual MH/DD budget, quality assurance and collaboration with other funding sources, services providers, consumers and other stakeholders. The CPC is accountable to the County Board of Supervisors. The CPC carries out the management of the system as set forth in the county management plan as designed by the county and its stakeholders and approved by the Board of Supervisors and the Director of the Iowa Department of Human Services in coordination with the State County Management Committee.

The development of a CPC function was in response to the problems in the past of access for individuals to services within the MH/DD service delivery system. The purpose of the management plan is to provide a clear defined process and management of the Mental Health and Developmental Disabilities (MH/DD) funding system within the county. The CPC manages or provides oversight for the management of the system. Some of the components of the plan include: designation of access points, an application process, emergency procedures, delegated functions, services authorization, referral, service and cost tracking, quality assurance, appeals process and how all the parts of the system provide for consumer and stakeholder input and assistance in the development and carrying out of the processes within the system.

A major duty of a CPC is collaboration and coordination with consumers, stakeholders, judicial systems, Iowa Department of Human services, schools, public health, providers, AEA, law enforcement, empowerment areas, ministerial associations, area business, other counties, and the communities within the county. One of the key functions of the CPC is collaboration and coordination with all aspects of the individuals, communities, stakeholders and systems. It is the collaboration that develops the management system and provides the continuation in the development and management of the community based building process. The CPC and the others in the management system, tend to be individuals very involved in their communities as their function is so integral to all aspects of the community.

Allocation Methodology for Funding

There is some sharing of administrative resources across county lines based on economics, past practices and local trade patterns. Each county is required to have a CPC; however, multiple counties may group together (and do) under a single CPC to better leverage services and funding. The counties are allowed to collect a certain amount of property taxes. State funds are allocated upon a legislative formula, which is based on the available cash in the county as well as past use or population. It is not based on the number actually served in the county. There also is no consistency of funds as some counties might not get state funds and other counties get the maximum funds the formula allows. The counties are restricted by code as to how much property tax they can raise for MH/DD services. The level of “base funding” is set by the Iowa legislature. Currently, property taxes are set at the 1996 level.

Services are generally provided by non-profit providers contracted through the county or through the state for those who do not have legal settlement. DHS delivers services in the state institutions. In Iowa there is no entity that provides system wide coordination. There is no coordination between Magellan and the CPC, both coordinate their own piece. DHS does not provide coordination, only oversight. Between Magellan and the state, coordination occurs through a contractual relationship. According to DHS the state has a more distant role with the counties, they approve a county plan and consult with the CPC but DHS has no line of authority.

The counties are required by DHS to collect standardized data, but there is not a process to share this information across the system. There is no state wide system established to provide quality assurance. Both Magellan and the counties are responsible for conducting quality assurance. It can vary from county to county as to what will be measured. Challenges to public policy go the CPC. The counties feel that there is no state leadership in regards to challenges and there is no established policy. Legislation or court authority can require DHS to make changes to public policy.

The county is primarily responsible for the review of service plans. The county has the ability to delegate the approval function to case managers. Magellan relies on case managers to review the service plans as well.[78]

Impact on the Offender Population

Based on the explanation above, it is clear that there are inequities in county funding for mental health services. These inequities impact the ability of offenders and/or criminal justice involved consumers of mental health services who require public assistance to obtain services that may prevent further penetration into the criminal justice system. The current eligibility and funding system also impacts offenders returning to the community from prisons. Some counties do not have public mental health services. If the offenders chooses to move into another county where services are available or perhaps more accessible, it will take a minimum of one year to become eligible for legal settlement in that county.

With the movement toward Reentry Planning by the Department of Corrections for all offenders, it will be particularly challenging to provide the treatment and other community supports required by offenders with serious mental illnesses/co-occurring disorders that would enhance the likelihood of successful and stable return to the community. Perhaps, a parallel funding mechanism that targets services for these particular offenders should be considered in order to reduce risk to public safety and successful community reentry for these vulnerable Iowa citizens.

D. Sex Offender Treatment Programs

During Phase II, the Durrant/PBA team has had limited involvement with the Sex Offender Treatment Programs. The role was primarily consultative and focused on sex offender programs that meet the treatment needs of offenders who have mental illnesses, developmental disabilities, and brain injuries as well as treatment that is appropriate to meet the gender specific needs of female offenders.

[78] Information obtained from interviews with Department of Human Services, two CPC Coordinators, and http://www.dhs.state.ia.us/mhdd/docs/IowaSurvey.doc

1. Sex Offender Treatment for Special Needs Offenders

One of the issues related to sex offender treatment is whether or not special needs sex offenders are able to access mandated treatment services in the institutions. Therefore, an analysis of those offenders with special needs who were on waiting lists was requested.

Figure IV-C-1: Special Needs Offenders Referred but Not Started into Sex Offender Treatment

Active Prison Offenders Referred but not Started into Sex Offender Treatment			
Mount Pleasant Sex Offender Programs	Female	Male	Total
Sex Offender Program	2	573	575
Sex Offender Program - Short Term		13	13
Sex Offender Program - Special Needs		50	50
Gender Totals	**2**	**636**	**638**

Source: 8/23/3007 ICON Data

As seen in Figure IV-C-1, of those offenders referred to, but who have not started treatment in the Mt. Pleasant Sex Offender Treatment Programs, on August 23, 2007, there were fifty (50) special needs offenders. It is unclear whether these individuals were in a referral status and yet to be assessed for appropriateness for Mt. Pleasant sex offender treatment programs or whether they have been accepted into programs and are waiting for a treatment slot to open.

Figure IV-C-2: Special Needs Offenders Referred but Not Started into Sex Offender Treatment with Temporary Discharge Date Sooner than July 2010

Sex Offender Program Waiting List (Referred, not started) by Gender with Temporary Discharge Date (TDD) less than July, 2010				
Status	Intervention Program	Female	Male	Program Totals
SOP Waiting List	Sex Offender Program	1	340	**341**
SOP Waiting List	Sex Offender Program - Short Term		11	**11**
SOP Waiting List	Sex Offender Program - Special Needs		32	**32**
	Gender Totals	**1**	**383**	**384**

Source: 8/28/2007 ICON Data

Figure IV-C-2 shows that of those 50 special needs offenders, 32 had a potential release date sooner than July 2010. Theoretically, this means that they would be a priority offender to receive sex offender treatment.

The Sex Offender Treatment Focus Group has ascertained that sex offenders who "max out" their sentences generally do so because they did not successfully complete the program or refused to be involved in a sex offender treatment program.[79]

Special needs sex offenders require special treatment approaches. If the number of special needs offenders who need sex offender treatment exceeds that which can be provided or is appropriate to be provided at Mt. Pleasant, developing a sex offender treatment program in one of the special needs mental health units described above may be an appropriate alternative to the current programs at Mt. Pleasant.

Some offenders with mental illnesses when stable should be able to maintain mental status and behavioral stability and be mainstreamed into current Mt. Pleasant programs. Others with acute symptoms of mental illness, offenders with developmental disabilities, and brain injuries that compromise cognitive abilities, may be better served by sex offender treatment programs that are provided in a special needs setting.

2. Sex Offender Treatment for Female Offenders

The data presented above, indicates that there is a limited need for sex offender treatment for women. IDOC is currently providing these programs in the Mt. Pleasant Women's Unit (MWU). Female sex offenders are such a limited number, even nationally, that treatment is provided in small groups supported by individual treatment that meets the needs of the offenders. It would naturally follow, that the dynamics involved in female sex offending is different than male offending, and therefore, the approaches would need to be attentive to gender specific issues such as personal boundaries, relationships, history of trauma, and sexuality.

3. Conclusion

With so many offenders who do not have special needs on a waiting list for mandatory sex offender treatment, care must be taken that those offenders with special needs also receive treatment. Carefully planned, stepwise reentry is a necessity for these offenders. Expiration of sentences in prison will result in higher recidivism.

E. Treatment Recommendations

Substance Abuse Treatment Short-Term Recommendations:

The short–term recommendations to be implemented by the end of Fiscal Year 2009 include:

1. Substance Abuse Treatment Continuum

a. Formulate a plan to develop evidence-based co-occurring disorders treatment programs for both male and female offenders. One EBP model to further evaluate is SAMHSA's evidence-based model: Co-occurring Disorders

[79] Smith, Curt. Quarterly Synopsis of Focus Group Progress, Iowa Department of Corrections. March 31, 2008.

Integrated Dual Diagnosis Treatment Program for offenders with mental illness.

2. Substance Abuse Treatment Capacity

a. Continue to determine whether additional short term and relapse prevention programming would require added staffing or reassignment of current staffing across the continuum of care in both institutions and community settings.

b. Continue to study whether some mandated substance abuse treatment, especially short-term, for offender populations could be provided in CBC settings instead of institutions.

Substance Abuse Services Long-Term Recommendations:

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

1. Assessment for Substance Abuse Treatment

a. Continue to monitor population growth and fund additional substance abuse assessment positions as required by data driven service demands.

2. Substance Abuse Treatment Continuum

a. Implement SAMHSA evidence-based treatment model: Co-occurring Disorders Integrated Dual Diagnosis Treatment Program for offenders with mental illness.

b. Implement a similar gender specific program for women offenders who have mental illnesses.

c. Plan to provide this program by dually trained staff (a professional with both mental health and substance abuse training and expertise).

d. Plan to implement this program in IDOC special needs units; consider piloting the program in one or more special needs unit.

3. Substance Abuse Treatment Capacity

a. IDOC should use the LSI-Rs of offenders in each custody classification to determine of level of substance abuse treatment needs. The levels of treatment required for each custody classification should be cross-matched against the current distribution of substance abuse services to determine if there is a need to adjust the substance abuse treatment program distribution.

b. Develop a plan to expand evidence-based substance abuse treatment programs that meet the demand for and level of treatment required by offender population.

c. Monitor the demand for all levels of substance abuse services, including co-occurring disorders and gender responsive treatment programs, on an at least an annual basis.

d. Adjust the level of substance abuse treatment services distribution to meet the data driven demand for services on an annual basis.

e. Once EBP programs are fully developed, complete a program staffing analysis to determine the level of staffing that would be required to meet demand for EBP substance abuse services.

f. Fund additional treatment positions to meet the data driven demand for services.

Mental Health Services Short-Term Recommendations:

The short–term recommendations to be implemented by end of Fiscal Year 2009 include:

1. Training

Training plans should continue to be developed to address the mental health training needs across the continuum of mental health care including both institution and community-based corrections. All training programs listed below should incorporate both didactic and experiential/practice sessions. Use of both classroom and alternative training methods such as e-learning are encouraged.

a. A pre-service and annual training curriculum for security, clinical, program and management staff that addresses updated views of mental illness, including psychiatric medications, and opportunities toward recovery. This program should offer opportunities for staff to practice newly learned skills to manage offenders who have mental illnesses, particularly those with acute and subacute symptoms that affect behavior.

b. McKesson InterQual training for mental health clinicians should be provided on a periodic, regular basis so that all clinicians are trained in the use of this instrument.

c. A training curriculum should be developed that meets the basic mental health training needs of all CBC probation and parole officers and case managers. This training should include an overview of the community mental health service system, psychiatric medications, disability benefit programs, and access points to all community-based services.

d. An advanced training program should be developed for institutional clinical staff, and counselors who work with special needs population and for CBC staff that work primarily with offenders who have mental illnesses and co-occurring disorders. This advanced training program should address building community relationships, case management planning for offenders with mental health treatment needs, and using incentives and Recovery Model interventions to encourage treatment and correctional supervision compliance.

e. Annual training updates should include evaluation and outcome research in community and correctional mental health care.

2. Mental Health Assessment

a. Fully adopt and incorporate the use of the InterQual Clinical Decision Support Tool. Continued use of the McKesson InterQual Clinical Decision Support Tool is highly encouraged.

b. Efforts should continue to recruit psychiatrists to provide timely, initial psychiatric assessments.

3. Mental Health Treatment Continuum

a. Adopt and systematize the Mental Health Policy standards.

b. Continue to review and update current mental health policies; identify and develop additional policies to fully address the scope of mental health services.

c. Continue the development of a full continuum of mental health services. Once the criteria for placement at each level of care are well tested, the development of appropriate evidence based approaches should begin including further evaluation of where SAMHSA's Recovery Model programs should be incorporated.

d. Continue to develop site-specific levels of mental health care with clear criteria for admission (including transfers in), and discharge (including transfer out) of each level of mental health care.

e. Develop a plan to provide EBP treatment modules (psychoeducation, Recovery, etc.) to all special needs unit offenders to increase the breadth of mental health treatment.

f. A step-down approach toward community reentry, including self-administered medication should be used wherever possible to encourage community readiness and management of one's illness (with the appropriate supports in place).

4. Mental Health Treatment Continuity in Community

Continue to build the communication strategies necessary to build collaboration between the institutions, the Judicial Districts, and the community providers to identify and meet offender mental health and co-occurring disorders treatment needs. This may include:

a. Changing access to information in ICON; and/or and rolling some Medical ICON information into the general program ICON database.

b. Developing cross-system methods to improve communication related to reentry planning between the institutions, the Judicial Districts, and community mental health providers.

c. Building community-level multidisciplinary groups in Judicial Districts and/or communities where they currently do not exist.

d. Building collaboration between the human services and criminal justice systems (where they currently do not exist) to problem solve how to access services for offenders who require mental health services.

e. Continue to improve communication and collaboration across the continuum of correctional supervision identifying barriers to reentry and community adjustment for offenders with mental illnesses.

Mental Health Services Long Term Recommendations:

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

1. Culture re: Mental Illness

a. Implement fully developed training plans that address the mental health training needs of institutional security, program, clinical, healthcare and management staff and the CBC residential and field supervision staff. This should include training for any specialized positions that are hired to supervise offenders with mental illnesses. Conduct annual training to update clinical staff re: current trends in community and correctional mental health care.

b. Conduct annual reviews and update of mental health standard operating procedures and post orders to reflect change in culture and approach to managing offenders with mental illnesses.

2. Mental Health Assessment

a. Monitor increases in the offender population and track the need for additional assessment staff; evaluate on an annual basis.

b. Once the McKesson InterQual Clinical Decision Support Tool is well-established, it should be computerized and integrated into the ICON medical system.

3. Mental Health Treatment Continuum

a. DOC should determine if legislative changes are required to Iowa Code Section 904.201 for the use of hospital beds for non-prisoners or if other strategies can be employed on an ongoing basis to limit the civilian population in the prison setting.

b. Decrease the number of "civilian" patients and increase the capacity for acute care for prisoners as/if the demand increases.

c. Continue to monitor the numbers of offenders who have serious mental illnesses; use this data to monitor the numbers of mental health beds across the continuum of care to ensure that the department can meet the demand for mental health services.

d. Adjust and repurpose beds as demand requires.

e. Continue to determine whether repurposing and focusing the type of mental health services provided in each designated setting, especially for acute and partial hospitalization mental health care, would be more cost effective and would also improve the ability to recruit and retain psychiatrists.

f. Adjust clinical staffing for licensed hospital level care to be comparable to staffing patterns in state psychiatric facilities.

4. Mental Health Treatment Capacity

a. Develop additional academic relationships to provide training opportunities and build the potential pool of future clinical staff.

b. Develop new policies to plan for, adopt and implement SAMHSA's Recovery Model for treatment of mental illness across the continuum of mental health care.

c. Over time implement Recovery Model and other Mental Health EBP treatment programs.

d. Consider using mid-level psychiatrically trained Nurse Practitioners and Physician Assistants to extend psychiatric resources.

e. Add psychiatric nursing and social work positions to acute care, partial hospitalization, and special needs unit settings.

f. Use psychiatric RN positions to assist with telemedicine to free psychologists for treatment.

g. Fill nursing vacancies to meet minimum staffing requirements for psychiatric hospital level of care.

h. Fund additional required mental health positions in acute, partial hospitalization and special needs units commensurate with the defined level of care.

i. Incorporate the forthcoming results (IDOC Healthcare Staffing Study) that recommended appropriate mental health personnel numbers per discipline by facility location into a step-wise plan to increase appropriate disciplines and levels of professional mental health care across the continuum of care (acute to outpatient).

j. Develop specialized CBC positions that supervise lower caseloads of offenders who have serious, persistent mental illnesses.

5. Mental Health Treatment Continuity to the Community

a. Incorporate the need for shared information between counselors, clinical staff and CBC offices and case managers into all new technology/databases.

b. Incorporate additional reentry opportunities/programs for offenders with mental illness into system-wide reentry expansion and plans.

c. Support and encourage the development of collaborations between state departments and local and regional organizations/agencies that serve people who have mental illnesses.

d. Developing residential facility programs that will address the special needs of offenders who have mental illnesses.

6. Management Capacity

a. Fund and fill a quality assurance position dedicated to peer review, EBP, and outcome evaluation of mental health programs and services.

b. Determine additional mental health management position demands as part of the IDOC Healthcare Staffing Analysis that will be forthcoming.

Sex Offender Treatment Short-Term Recommendations

The short–term recommendations to be implemented by end of Fiscal Year 2009 include:

1. Sex Offender Treatment Continuum/Capacity

a. Develop a sex offender treatment program(s) that will meet the treatment needs of offenders who have mental illnesses, developmental disabilities and brain injuries.

b. Determine if the sex offender treatment services provided to female offenders incorporate all available gender-responsive approaches.

c. Monitor the numbers of prisoners who "max out" because they are unable to meet the requirements of the programs (duration, change, etc.) of sex offender treatment programs. Special emphasis should be placed on offenders who have mental retardation and other developmental disorders, mental illness, and brain-injuries.

d. DOC should complete a program and treatment staffing analysis to determine required numbers of treatment and counseling staff to meet the current and projected treatment needs and demands of sex offenders. Based on this study, develop a plan to increase sex offender treatment personnel who are able to meet the current and projected treatment needs of sex offenders.

Sex Offender Treatment Long-Term Recommendations

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

1. **Sex Offender Treatment Continuum**

a. Develop additional treatment program slots and /or programs to meet data driven demands for mandated treatment.

b. Develop sex offender treatment programs for those who have mental illness and who are also sex offenders. Recommend identifying an evidence-based program that targets interaction of illness management and sex offending behaviors.

c. Plan and develop consistent evidence-based (EBP) sex offender treatment programs across IDOC institutions and the CBC system.

2. **Sex Offender Treatment Capacity**

a. Monitor demand for services annually and adjust treatment programs to meet data driven demands for treatment services.

b. Develop additional treatment program slots to meet the level of treatment program distribution demands for mandated treatment.

c. Fund additional treatment program staff as the data driven service demands document the need.

d. Continue to monitor the outcome evaluations of sex offender programs of other correctional systems that have decreased intensive sex offender treatment to 12 -16 months to determine whether the decrease in program duration has affected successful outcomes and recidivism rates.

Chapter V:
Women Offenders and Gender Responsive Treatment

Women Offenders and Gender Responsive Treatment

A. Introduction

At the conclusion of the Phase I Master Plan Report, IDOC made the decision to renovate and expand ICIW to include a reception and diagnostic unit (currently based at IMCC) and women currently confined at the Mt. Pleasant Women's Unit. To appropriately plan for the expansion, work during Phase II has focused on developing policy standards and a female-focused custody classification instrument to determine appropriate types of housing and physical plant allocations based upon security and custody needs. In addition, focus on reentry planning has been a priority when noting the projected continued influx of women offenders into correctional institutions. Consistent with Phase I recommendations there has been work toward ensuring that gender responsive programs are appropriately provided. Consultants have also provided consultation and support to ICIW managers during development of their quality improvement plans and evaluation of programs to meet evidence-based practices criteria.

B. Gender Responsive Treatment and Programming

In 2007 in the Phase I Master Plan Report, Durrant/PBA purported that the significant increase in the female population has made it evident that gender-responsive management, programs and treatment are required to maximize women's successful reentry to the community after incarceration and to reduce recidivism.

Gender-responsive strategies are grounded in three intersecting perspectives: the pathways in and out of criminality; the importance of connectedness and relationships; and the provision of integrated, gender-sensitive trauma victim, substance abuse and mental health services. Program and treatment services developed specifically for the female offender are based on women's competencies and strengths and promote self-reliance. Successful programs are designed to support community linkages and education/vocational opportunities as well as continuity of treatment from institution into the community. Programs must also be designed to timely meet the needs of a population who serve a relatively short term and have housing, employment, medical and mental health and parental responsibility needs and issues that must be immediately met upon release if a successful transition is to be experienced.

While IDOC offers numerous programs geared to address offender treatment needs, most of the programs do not include specific discussion from a gender-responsive perspective. In the 2007 report consultants identified some short and long term goals to begin addressing the specific program needs of IDOC female offenders. During the past year, there has been a collaborative effort among IDOC focus groups, institutional and CBC staff, government and community partners and the Durrant group regarding gender-responsive treatment and programs. The following are observations/findings recommendations to address treatment needs and programs paramount to a woman's successful community transition.

C. Treatment and Programs

1. Education/Vocational and Life Skills

National studies indicate the female offender population is disproportionately women of color in their early to mid-30s. Most are unmarried mothers and sole care-givers of minor children. A significant proportion of these women offenders are themselves from single-parent or fragmented families and approximately 50% of incarcerated women had an immediate family member who had been involved in the criminal justice system. While slightly more than 50% have a high school or general equivalency diploma (GED) most have limited vocational training and sporadic work histories[80]. A survey of female jail inmates in the U.S. found that more than 60% were unemployed when arrested, and one-third of them had not been looking for work[81]. The Bureau of Justice Statistics (BJS) noted in 1998 that approximately 40% of women in state prisons reported they had been employed full time when arrested compared to 60% of males and most of the jobs women held were entry level, requiring a low level of skills and providing low pay. Many of these women while struggling to survive and raise children, supplement lowing paying jobs or public assistance by engaging in enterprises that are not legal.

Approximately 70% of all women under correctional supervision have at least one minor child and 66% of these women lived with their young children before incarceration. To this effect when a parent is incarcerated the family structure and relationships are seriously disrupted. Only 10% of these children are placed in foster care with most of them living with grandparents. Usually when the mother is released from incarceration she must assume parental custody and responsibility immediately upon release. If the offender has lost parental custody, pressures are exacerbated as she tries to reestablish herself and satisfy societal confidence that she is capable of resuming care for her children.

The IDOC team identified the following challenges that are particularly affected when the offender is female:

- Parenting/loss of parental rights, interpersonal communications, social skills, and mentoring
- Supporting family via livable wages, financial planning, and consumer education,
- Work readiness and increased and better work opportunities (especially within Des Moines and opportunities that match community work),
- Non-traditional skills and bridge programs that link vocational training and IPI work skills with continued skills training in the community.

To begin addressing some these issues IDOC has in the past year:

- Worked with the Iowa Office for Work Force Development to provide vocational and apprentice training and to better reintegrate offenders into the work place.

[80] Research, Practice, and Guiding Principles for Women Offenders, Gender-Responsive Strategies, US Dept. of Justice, National Institute of Corrections, July 2003
[81] Collins, W., and Collins, A (1996). Women in Jail: Legal Issues. Washington, DC: National Institute of Corrections

The Work Force Development group is a consortium of professionals who provide correctional treatment, reentry, community based residential treatment, probation, education, prison industries, job development, benefits and disability, life skills, and related government and private health and human services.

- Consistent with the IDOC Fourth Judicial District Correctional Services' Victim and Restorative Justice Programs, there has been some discussion for using components of the victim and restorative justice program as part of an offender/family relationship rebuilding process. Restorative justice programs are oriented towards repairing the harm caused by criminal acts, not only to the victims of the crime, but also to the larger community.[82] Offenders are required to take responsibility for their behavior, acknowledge the damage their acts inflict on others and work to restore and strengthen the informal relationships that are damaged through criminal activity. The treatment philosophy can be very useful to help female offenders understand the impact of their behavior upon not just their victims but the harm caused to their children and other family members. Women offenders are also good candidates for participation in restorative justice and community corrections because they commit fewer serious or violent offenses and pose less risk to public safety than male offenders.

2. Substance Abuse Treatment

IDOC statistics in 2005 reported 34.5% of female crimes were drug related and 57.6% of women offenders identified their priority one need was drug/alcohol related. On March 12, 2008, 22% of the female prison population was on the waiting list for substance abuse treatment programming.

Substance abuse studies have found that women's issues are different from those of men because:

- Women often use drugs more suddenly and heavy and for a specific reason such as depression or a family problem[83],
- Women experience the adverse physiological effects of alcohol on the liver, cardiovascular system and gastrointestinal system more quickly than men[84],
- The link between HIV/AIDS and drug use is greater in women[85],
- Women are more likely than men to have been initiated into drug use by a male sexual partner, they often continue to use drugs to maintain the relationship and women are also more likely to have a partner with an addition problem[86], Female

[82] Bazemore, G (1999) The Fork in the Road to Juvenile Court Reform" Annals of the American Academy of Political and Social Science".
[83] Center for Substance Abuse Treatment (1999) Substance abuse treatment for women offenders: Guide to promising practices. Rockville, MD; US Department of Health and Human Services
[84] Alexander, M. (1966). Women with co-occurring addictive and mental disorders: An emerging profile of vulnerability. American Journal of Orthopsychiatry, 66 (1), 10
[85] National Institute on Drug Abuse, 2000
[86] Covington, S., and Surrey, J. (1997). The relational model of women's psychological development: Implications for substance abuse. In S. Wilsnack & R. Wilsnack (Eds.), Gender

substance abusers have a greater number of life problems related to employment, family issues, childcare and mental health[87],

- Women who abuse substances also have higher rates of childhood physical and sexual abuse than men and non-substance abusing women[88],
- Treatment programs for women recognize the need for comprehensive services and for a focus on relationship issues[89], and
- Culture, race and ethnicity have an impact on women's development of substance abuse problems, especially when combined with lower income, less education and unemployment[90].

Therefore it is consensus that comprehensive services for women should include, but not be limited to, life skills training, housing, education, medical care, vocational counseling, and assistance with family preservation.

There is evidence that the STAR therapeutic community (TC) at ICIW has great potential for reducing recidivism. During recent discussions staff has recommended strengthening STAR by adding a gender-responsive Cognitive Thinking Substance Abuse (CTSA) module along with gender responsive family, reentry and vocational components. STAR, however only has the capacity for forty-five offenders.

In order to expand substance treatment opportunities, STAR-Light is being developed as a four month extended out-patient TC designed to serve 45 offenders. The Rafferty Group is working with the Grants Management Enterprise System (GEMS) which is a work group that originated out of the IDOC Central Office to locate grants to fund various programs. Staff has indicated Star-Light could replace and better address the current outpatient OWI education/awareness. STAR-Light's core curriculum would include Criminal Conduct and Substance Abuse, Helping Women Recover, Life Skills and a Work Readiness component. A social worker/case worker and Reentry specialist will team to assist with community transition through use of additional wrap-around services such as relapse prevention, mental health services, transportation vouchers, housing and child care services. The Office for Workforce Development would continue to train and focus on vocation/placement.

3. Mental Health Services

The mental health services needs of the female population continue to be significant. While Figure V-B-1 shows a slight decline in female offenders with mental illness, this is misleading since these are only one day snapshots of the population. At best, the

---

and alcohol: Individual and social perspectives (pp 335-351). New Brunswick, NJ: Rutgers University Press

[87] Straussner, S.L.A. (1997). Gender and substance abuse. In S.L.A. Straussner & E. Zelkin (Eds), Gender issues in addiction: Men and women in treatment (pp 3-27). Northvale, NJ: Jason Aronson.

[88] Covington, S. (1997). Women, addiction and sexuality. In S.L.A. Straussner & E. Zelkin (Eds), Gender issues in addiction: Men and women in treatment (pp 71-95). Northvale, NJ: Jason Aronson.

[89] Center for Substance Abuse Treatment. 1999

[90] Center for Substance Abuse Treatment (1994). Practical approaches in the treatment of the eleven original grantees that piloted residential treatment for women and children for CSAT. Rockville, MD. US Department of Health and Human Services.

percentage of females diagnosed with mental illnesses is consistent across the last two years. This represents slightly more than two-thirds of the female offender population, who require significant mental health personnel and program resources.

Figure V-B-1: Comparison of Offenders with Mental Illnesses on 12/31

Incarcerated Female Offenders with Mental Illnesses 12/31/2006 and 12/31/2007

Year	Total	%	Total Inmate Population	% of Population That is MI
12/31/2006	530	15.0%	789	67.2%
12/31/2007	476	13.3%	715	66.6%

Source: DOC: Prell, ICON Data

Figure V-B-2
Female Offenders with Mental Illnesses by Most Serious Charge Type

Crime Type	Gender	Serious MI	Other MI	Total	Serious MI Total %
Violent	F	128	24	152	31.9%
Property	F	119	18	137	28.8%
Drug	F	103	19	122	25.7%
Public Order	F	21	5	26	5.4%
Other	F	30	4	34	7.2%
Unknown	F	5	0	5	1.0%
	MI Totals	**406**	**70**	**476**	**100.0%**

Source: DOC: Prell, ICON Data

Figure V-B-2 shows the most serious offenses committed by female offenders who have mental illnesses. This is of particular importance due to the complexities in reentry planning for offenders who have mental illnesses. These offenders face many barriers to community reentry and therefore require significant and early planning for community release in order to meet their need for housing and treatment stability as well as the requirement for public safety.

Surveys of offenders in CBC residences and under field supervision were completed by the Mental Health CBC Focus Group, CBC Residential staff and Field Officers in October 2007 to determine the numbers of offenders under CBC supervision had mental health and co-occurring disorders treatment needs. A significant number of offenders under CBC supervision were found to have mental health services needs. Although gender was not captured by the surveys, it is anticipated that based on the known mental health services needs of female offenders, those under community corrections supervision have considerable mental health services needs as well.

4. Co-Occurring Disorders Treatment

Offenders who have co-occurring disorders are those who have a mental illness as well as a substance abuse problem. All offenders who have been diagnosed with co-occurring treatment needs should be provided with services. It is important to point out that the definition of co-occurring disorders varies across theories. There are also different approaches to co-occurring disorders treatment. Evidence-based programs use an integrated approach to providing services that incorporates the SAMHSA's recovery models.[91] Integrated co-occurring disorder treatment[92] is most effective when provided by dually trained (mental health and substance abuse) clinician.

The ICIW Treatment Director has acknowledged that further development of treatment programs is needed to effectively treat women who have co-occurring disorders treatment. This will become magnified when the Mt. Pleasant Women's Unit population is moved to ICIW. When that occurs there will be a significantly greater demand for gender-responsive co-occurring disorders treatment.

The team also recommends mental health education that is gender-responsive to include building and maintaining healthy relationships, improving the Violator's Program trauma treatment module.

5. Sex Offender Treatment

The data presented in Chapter 4, indicates that there is a limited need for sex offender treatment for women. IDOC is currently providing these programs in the Mt. Pleasant Women's Unit (MWU). Female sex offenders are of such a limited number, even nationally, that treatment is provided in small groups supported by individual treatment that meets the needs of the offenders. It would naturally follow, that the dynamics involved in female sex offending is different from male offending, and therefore, the approaches would need to be attentive to gender specific issues such as personal boundaries, relationships, history of trauma, and sexuality.

D. Gender Responsive Medical Treatment

Incarcerated offenders have generally aged physically ten years beyond their chronological age. This advanced aging is due to a number of factors including lifestyle, addictions, poor health care prior to incarceration, and stressors inherent to both their lifestyle and incarceration. Therefore, the offenders who participate in risky behaviors are diagnosed with chronic health care needs earlier; and as the offender population ages, there will be an increasing number of offenders who require ongoing medical treatment

In addition to their need for gender responsive healthcare education, female offenders have significant healthcare issues including reproductive health issues, high risk pregnancies, infectious diseases (tuberculosis, Hepatitis C, HIV/AIDS) and numerous

[91] SAMHSA EBP Recovery Model: http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/about.asp

[92] Source: SAMHSA. http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/IDDTUsersguideAJ1_04.pdf. Retrieved March 15, 2008.

chronic illnesses such as cardiovascular disease, asthma and other respiratory illnesses, and endocrine and neurological disorders.[93]

Figure IV-D-1 is a one day snapshot of diagnosed chronic medical conditions of women incarcerated at ICIW. Clearly, these medical conditions not only require treatment during incarceration, but will also require follow-up care upon return to the community. Women reentering the community cannot hope to obtain stability or meet their employment and family responsibilities if they are in poor health. In addition, if they must self-manage chronic pain they are at greater risk to return to substance abuse.

Figure IV-D-1

Snapshot of Chronic Health Problems of Women at ICIW

November 13, 2007

Medical Diagnosis	# Offenders	Percentage of Population
Infectious Diseases	117	21.59%
Endocrine	36	6.64%
Blood Diseases	14	2.58%
Neurological	6	1.10%
Cardiovascular	96	17.71%
Respiratory	113	20.85%
Gastrointestinal	69	12.74%
Gynecological	47	8.67%
Pregnancy	5	.0.09%
Dermatological	32	5.90%
Musculoskeletal	35	6.46%
Offender Census	**542**	

Source: DOC Prell-Medical ICON Data

[93] Braithwaite, Ronald et al (Editors), Health Issues Among Incarcerated Women. (2006) Rutgers University Press.

E. Reentry

Like men, women who are returning to their communities from correctional facilities must comply with conditions of supervised release, achieve financial stability, access health care, locate housing, and try to reunite with their families. These tasks are often complicated by gender. In addition to the stigma of offending, the female usually carries additional burdens such as single motherhood, decreased economic potential, lack of services and programs targeted for women, reporting and supervision responsibilities to multiple agencies, and a general lack of community support. Having to navigate though numerous systems that often provide fragmented services and conflicting requirements can interfere with supervision and successful reintegration.

Challenges to successful completion of community supervision and reentry for women offenders have been documented in research literature. These challenges can include housing, transportation, child care, and employment needs; reunification with children and other family members; peer support; and fragmented community services. There is little coordination among community systems that link substance abuse, criminal justice, public health, employment, housing, and child welfare services. Research has shown that women offenders have a great need for comprehensive and collaborative community-based wraparound services that offer a multidisciplinary approach in order to foster successful outcomes among women. This case management approach has been found to work effectively with women because it addresses their multiple treatment needs without having to undergo assessments/treatment at a variety of different locales.

During discussion of the current reentry program at ICIW and what is important to the female offender, the team identified the need for more family involvement in the treatment process. Currently, family therapies are very limited at the ICIW. Among the women, who account for nine percent (9%) of the IDOC prison population more than half are reported as having minor children. Research surmises that fragile family connections can be maintained and strengthened through programming during imprisonment and just before release[94]. Events in the hours and days following release can make the difference between successful reintegration and relapse and recidivism. Relational theory indicates that approaches to service delivery based on women's relationships and the connections among the different areas of their lives are especially congruent with female characteristics and needs.[95]. An understanding of the interrelationships among the women, the programs, and the community is critical to the success of a comprehensive approach. Family and other close social connections are the most likely people to provide the needed emotional and financial support to a returning prisoner[96]. So a "comprehensive approach" also means taking into

[94] (Gadsden, V., ed. 2003. Heading Home: Offender Reintegration into the Family. Lanham, MD: American Correctional Association. Papers originally prepared for the Annual Research Conference of the International Community Corrections Association, September 23-26, 2001. Hairston, C. F. 2002. "Prisoners and Families: Parenting Issues During Incarceration" Paper prepared for the From Prison to Home: The Effect of Incarceration and Reentry on Children, Families, and Communities National Policy Conference convened by the US Department of Justice and the Urban Institute, Washington, DC, January 30-31, 2002.

[95] Research, Practice, and Guiding Principles for Women Offenders, Gender-Responsive Strategies, US Dept. of Justice, National Institute of Corrections, Guiding Principle 6: Establish a System of Community Supervision and Reentry with Comprehensive, Collaborative Services

[96] (Christopher J. Mumola, Incarcerated Parents and Their Children, Bureau of Justice Statistics Special Report Aug. 2000). Travis, Jeremy, Amy L. Solomon, and Michelle Waul, 2002.

consideration a woman's situation and desires related to her children, other adults in her family or friendship network, and her partner.

Data from various female offender focus groups indicate that if the following critical components of a gender-responsive prevention program are not met, they are put at risk for continued criminal justice involvement:

- Housing
- Physical and psychological safety
- Education
- Job training and employment opportunities
- Community-based substance abuse treatment
- Economic support
- Positive role models
- Community response to violence against women

The team decided that surveying women offenders about her needs and goals would be beneficial in developing gender-responsive IDOC reentry programming. The team is exploring use of the NIC Transition from Prison to Community (TPC) Initiative to guide IDOC's survey development.

Members of the Women's Focus Group also recommended implementation of the TPC program at ICIW if funds can be located to do so. The Grants Management Enterprise System (GEMS) may be asked to write a grants proposal for funding to implement both the Star Light Substance Abuse and the TPC program at ICIW.

The TPC model assesses the offender's:

- History of abuse,
- Current relationship status,
- Mental health issues (especially post traumatic stress disorder),
- Family issues including how many children she has and whether she is caring for parents or other family members and who is caring for these individuals in her absence,
- What concerns she has about their wellbeing, and whether or not she needs assistance in working with child welfare agencies to ensure that her parental rights are not terminated, and

---

Background Paper: The Effect of Incarceration and Reentry on Children, Families, and Communities, Washington, DC.: The Urban Institute.

- Socioeconomic history and what she will need in order to be economically self-sufficient.

Assessment then becomes part of the plan that will follow an inmate through her incarceration and into her transition. Use of this assessment format is individualized; allowing the unique history and experience of each inmate to dictate the behavioral program planning. TPC recommends the institution, parole board, and community supervision agency have access to the same information about the offender's strengths, needs, risks and goals and allow offender to take ownership of her experience, successes and failures and to hold themselves accountable. Research is underway to test whether and how these gender specific factors actually predict risk[97].

F. Evidence-Based Practices

Evidence-based practices began in efforts to identify "treatments that work" using the results of research evidence. Much work has been done to assure that IDOC program operation is evidence-based and the team has worked to identify modules that are also creative, flexible, realistic and women-centered. The Durrant/PBA team consulted with ICIW staff as they developed their quality improvement plan (QIP). Corrective actions were identified to:

- Define institutional program placement criteria and scheduling so that offenders are placed in the right intervention at the right time,
- Define specific intervals for individual offender program reviews to assess and better coordinate the offender's participation and progression through recommended programs, and
- Develop a self-audit tool to document if the program is achieving its expected outcomes.

On April 1, 2008, ICIW personnel presented its quality improvement plan (QIP) to the IDOC EBP Steering Committee.

G. Policy Revisions

It was recommended in the Durrant/PBA 2007 Phase I Master Plan Report that IDOC revise key policies to ensure they are gender-responsive and taking into consideration mental health issues within the population while ensuring a physically secure, safe and supportive and treatment environment.

Gender-impact assessments incorporate a gender perspective into policies, taking into account the different needs, characteristics and behaviors of female offenders. Consideration should be given to whether the policy will deliver equality of opportunity and treatment and question the assumption that policies and services affect everyone in the same way. An example provided in the Phase I report is that IDOC disciplinary policy currently does not apply discipline in a manner that may consider the differences

[97] McCampbell, Susan W (2005). National Institute of Corrections Gender Responsive Strategies project: Jail Applications. Gender-Responsive Strategies for Women Offenders Bulletin Series, April 2005 (NIC Publication No. 020417).

in female and male behavior and their different responses to incarceration. A number of studies show female offenders commit more disciplinary offenses than males during the first year of incarceration, although these offenses are far less serious. Research has indicated that women in prison often receive penalties for minor types of behavior that in a male facility would only warrant informal discipline. Female offenders lost 19% of the total 200,534 days of earned time that offenders forfeited for disciplinary reasons during the period 7/1/04 and 6/30/06. 83% of the offenses for which females lost this earned time were for *Class C* (moderate) offenses.

In order to comprehensively identify policies for gender-responsive initiatives, the Women Offenders Group in conjunction with the Quality Improvement and EBP Focus Groups could collaborate to:

- Define policy issues and goals
    - Define what the policy is trying to achieve and
    - Understand the different problems and concerns
- Collect data
    - Gather statistics, race and disability statistics
    - Consult experts, women and men, black and minority ethnic and disability groups
    - Interpret from different perspectives
- Develop Options
    - Determine impact/implications for different groups
    - Remove stereotyped perceptions
    - Design different strategies as appropriate
- Monitor and Evaluate
    - Develop indicators
    - Examine differential impact
    - Learn lessons

Relationship Issues

Policies and procedures that promote healthy relationships and improved family connections for women are a major key to the offender's success institutional programming. Examples of policy considerations could be:

- Visiting Policy
  - Ensuring an adequately sized child friendly visiting space,
  - Providing flexible visiting hours and family-oriented programs,
  - Providing an annual family day, using contributions from community resources to assist with snacks, transportation for grandparents and children, provide child- friendly activities, and
  - Consideration should be given to expanding visiting opportunities to include structured time between mothers and their children, and longer term family activities (e.g., preparing meals, etc.).
- Telephone
  - Providing opportunities for non-collect phone calls when the care giver has limited income
- Reentry (Family Oriented) Policy
  - Job and industries priority placement for women with short term sentences,
  - Increased use of Furloughs (especially for family reunification purposes), and
  - Employment Training and subsequent job placement through the Office of Work Force Development in positions that pay prevailing wages.
  - Providing parenting classes with therapeutic visiting/counseling sessions,
  - Creating family reunification counseling and mother/child literacy/ correspondence programs that help prepare offenders, their children and their significant others for the challenges of reentry, and
  - Providing additional legal assistance when parental rights have been taken or to help the female offender obtain child support for minor children.

Classification Policy

The team has worked closely with IDOC staff to develop a female Custody Classification program. The team recognizes that reentry planning should begin the moment the offender is committed and the treatment/needs assessment process begins.

The Women Offender Focus Group is exploring the use of the LSI-R Tailor assessment tool for gender responsive assessment.

ICIW is updating the classification policy to include an initial screening check list and define the schedule for program reviews.

Other Gender Responsive Issues

Other practical considerations supported in studies about the different needs of female offenders are institutional custody and supervision, staff/offender communications, gender specific reentry, and policies regarding clothing, feminine and cultural hair care and hygiene, and helping them improve their self-image. Policies suggested for review include but are not limited to:

- Disciplinary Code and Sanctions
    - Incorporate gender-responsive application of rules and sanctions through correctional staff and Administrative Judge training, and
    - Ensuring disciplinary sanctions do not include long-term loss of family visiting or family telephone calls
- Supervision and escort of female offenders is gender appropriate,
- Offender Property
    - Allowing feminine and two-piece uniforms, feminine hygiene and cultural hair care products.

H. Gender-Responsive Facility Planning and Design

In considering facility pre-design consultants conducted a needs assessment to identify IDOC's facility challenges and potential solutions and subsequently developed operating principles which are a series of broad assumptions about how ICIW will operate and the space needed to implement the operation. These principles are guidelines in the pre-design and master planning phase for identifying the preliminary functional and space requirements, as well as basic delivery strategies to determine which existing spaces may be reused, renovated and/or expanded and which must be newly constructed to meet the future bed and programming needs for the institution. Guidelines used for a gender-responsive ICIW were based upon meetings with the Women's Focus Group and established research regarding facility planning for female offenders.[98]

The Durrant/PBA developed macro Operating Principles and Architectural Program for ICIW to guide both the master plan and capital budget process for the institution. These are discussed in Chapter 7.

I. Championing

[98] Elias, Gail, Bulletin From the Jails Division of the National Institute of Corrections: Facility Planning to Meet the Needs of Female Offenders, May 2007

It was recommended in the Phase I Master Plan Report that IDOC create the opportunity to have open dialogue with the legislature and courts about the special needs of women so that treatment when ordered for women is gender responsive and not reflecting the same treatment that may be recommended for males. To this effect, the Iowa legislature and other stakeholders spent an entire day on October 11, 2008 touring ICIW and further discussing the special needs of female offenders.

The Durrant/PBA team also met with the Parole Board in October to gain further insight into their goals and objectives in the collaborative effort to provide successful institutional and community adjustment for female offenders.

J. Recommendations

Short Term Recommendations

1. Focus Groups

   IDOC is commended for implementing the Focus Groups as they have been substantially instrumental in achieving both IDOC and Phase I Master Plan Report goals. Therefore, priority consideration should be the continuation of the DOC Focus Groups to continue their collaborative work identifying issues and solving problems across the continuum of correctional supervision.

2. Program Needs Assessment

   It is recommended that the Women Offenders Focus Group prepares a plan of action to develop female offender needs self-assessment survey to determine the specific needs of female offenders. Input should be obtained from, but not limited to, the female offender population, information and established guiding principles and help from experts in the various disciplines related to female corrections and statistical collection and evaluation strategy from IDOC Quality Assurance staff.

   Thereafter, it is recommended that the Women Offenders Focus Group develop and complete the Female Offender Needs Survey.

3. Substance Abuse

   It is recommended that the Substance Abuse and Women Offenders Focus Groups continue collaboration with the Grant Enterprise Management System (GEMS) to explore all avenues for funding additional gender-specific prison to community transition/reentry plans.

   It is recommended that the Star-Light Program be implemented to allow an additional number of female offenders to meet both treatment needs and parole release criteria.

4. Medical and Mental Health

It is recommended that the prescribed plan for the future ICIW facility to meet gender-responsive medical, mental health, co-occurring disorders treatment needs be implemented.

5. EBP

It is recommended that ICIW staff complete corrective actions to its quality improvement plan (QIP) based upon feedback received from the IDOC EBP Steering Committee after the April 2008 presentation.

6. Reentry

a. Gender Responsive Reentry. It is recommended that gender-responsiveness be incorporated in current and future CBC and Reentry programming.

b. Gender Responsive Reentry Coordinator Training. To be responsive to gender specific reentry issues, it is recommended that Reentry Coordinators participate in NIC e-learning modules that may include but not be limited to:

- "Women Offender Workforce Development" that talks about the typical characteristics and external barriers that affect the employability of female offenders and effective intervention strategies (nic.learn.com).

- "Workforce Development of Offenders with Mental Illness" to gain a better understanding of issues and appropriate and effective interventions (nic.learn.com).

- Other suggested training curricula are:

    - Offender Employment Specialist (OES): Building Bridges which is an entry-level training for practitioners who assist offenders in securing and retaining employment through assessment, job readiness, job development strategies (Request Item 021698)

    - Building Futures: Offender Job Retention for Corrections Professionals that covers the skills, strategies and resources needed for offenders to retain successful employment (Request Item 017699).

    - Training for Career Resource Center Clerks is a self-paced or group facilitated curriculum that offenders may use to assess their own vocational aptitudes and interests, develop skills needed to obtain/retain employment and use available resources to assist in their transition to the work force (Request Item 020931

7. Proposed Gender Responsive Needs Assessment. It is recommended that Reentry issues be of priority when developing the Program Needs Assessment.

8. Staff Training and Development

It is recommended that gender-responsive training be developed and implemented and that MPWU and ICIW staff receive priority participation.

9. Policies and Procedures

- It is recommended that ICIW develops a schedule for program reviews to better ensure offenders are timely and appropriately placed in recommended programs and to better coordinate the release/reentry process.

- It is recommended that the Women Offenders Focus Group, in conjunction with facility staff and other focus groups determine policies and procedures that should be revised to address gender-responsive needs and develop both methodology for evaluation and a work schedule.

10. Facility Renovation

It is recommended that funds be appropriated to fund the ICIW renovation and expansion project.

Long Term Recommendations

Gender Responsive Long Term recommendations to be completed by end of Fiscal Year 2012 include:

Gender-Responsive Policies and Procedures

- It is recommended that policy revisions to address gender responsive issues be completed based upon the schedule set forth in FY '09

- It is recommended that a plan be developed regarding the future ICIW facility to attract female correctional and treatment staff from some of the IDOC male facilities and aggressively recruit female correctional officers.

- It is recommended that IDOC provide gender-specific training that will help staff be more effective in working with female offenders.

- It is recommended that consistent with established IDOC goals, ICIW programs are appropriately enhanced by FY 2012 to provide gender-responsive components.

- It is recommended that IDOC, in conjunction with IPI and The Office for Work Force Development, continue to expand prevailing wage and training opportunities for female offenders.

Chapter 6:
Policy Standards

Policy Standards

A. Introduction

A key foundation for determining future needs is the development of a series of policy standards to guide short and long-range planning decisions. These decisions, made during the planning process, will impact the way the Iowa Department of Corrections operates and constructs and/or renovates its current and future facilities. These policy standards are derived from the American Correctional Association (ACA) standards. The policy standards are a series of physical, operational, staffing and treatment criteria that describe how offenders should be housed and managed based on their classification, custody level and special needs. These standards will also provide a framework and help guide the subsequent design, master planning and budgetary decisions for the Department's facilities.

B. Policy Standards

The policy standards represent vision statements of what the Iowa Department of Corrections aspires to be in the coming years, not necessarily what it is today. They are intended to represent "best practices" within the fields of adult corrections, and not minimum or constitutional standards, and will serve as performance measures whereby the Department can perform future self audits. The policy standards incorporate all applicable national standards as well as the experience of the Durrant /PBA team. In particular, the core standards represent idealized configurations for facilities, recognizing that the existing Department facilities in many instances cannot conform to this ideal. The policy statements and core standards were generated in collaboration with and reviewed and approved by a Policy Standards Committee including the Director, key executive staff, and facility administrators prior to being issued as the new Iowa Department of Corrections and Rehabilitation Policy Standards.

A draft of the policy standards was used in the development of the gender responsive program for the expansion of ICIW. As a result of those meetings further refinements were made to the policy standards prior to their approval at the end of 2007.

In the future, it is intended that the policy standards be used by the Department of Corrections to develop an audit system whereby a comparison of existing institution's physical characteristics and operating practices against the policy standards will establish performance goals and objectives for the Department to strive towards achieving. This audit process, coupled with the new classification system that will be put in place in the near future, will also allow the Department to repurpose institutions as well as housing units within institutions to achieve an appropriate balance between an offender's custody level, treatment needs and available resources.

The policy standards that follow are organized and divided into three primary categories as follows:

- General Population
- Special Needs/Management, and
- Medical/Mental Health

Each category is further subdivided either by custody classification, management categories or health/mental health care treatment needs addressing the full range of offenders housed within the Department of Corrections Institutions. The full list of categories follows in the policy standards matrix.

Within each subcategory a series of standards are applied to define the physical plant, in terms of housing and other facility components, housing operations, offender movement, programs and services and staffing requirements for that population. These standards are intended to establish the least restrictive environment for the population while recognizing the security risk and program/treatment needs of the specific population. The most cost effective approaches to accomplishing the operational and security requirements are likewise considered. Finally, the policy standards set a framework for increased privileges as offenders are moved to lower custody levels.

The full set of policy standards appears at the end of this chapter.

C. Recommendations

Policy Standards Short Term Recommendations

The short–term recommendations to be implemented by end of Fiscal Year 2009 include:

1. The Department of Corrections should develop an audit instrument whereby a comparison of existing institution's physical characteristics and operating practices can be evaluated against the policy standards to establish performance goals and objectives for the Department to strive towards in the coming years and to assist in developing future capital and operating budget request for the Governor's office and legislature.

2. The Department of Corrections should formalize the Policy Standards Committee and expand its mission system-wide to develop a companion set of policy standards for the CBCs. These facilities are constructed with state moneys and should likewise follow a set of policy standards similar to the adult institutions. We would recommend that the Policy Standards Committee draw in members from CBC-Bed focus group to develop these new policy standards. The timing for this effort is critical as capital funding will likely be appropriated in the 2008 legislative session for expansion of CBCs in the 1st, 2nd, 5th and 8th Judicial Districts.

Policy Standards Long-Term Recommendations:

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

1. The Department of Corrections should self-administer the audit instrument described above. This process will provide a data basis for determining where it stands relevant to the performance measures detailed in the policy standards.

2. The data developed from the audit process should then be overlaid with the results achieved after disaggregating the offender populations based on the new classification system once it is put into effect. This outcome of this effort will be a

potential re-purposing of institutions and/or components of institutions (e.g. housing units or buildings) to achieve an appropriate balance between an offender's custody level, treatment needs and available resources. The Department will be able to utilize the results of this analysis coupled with future projections of bed needs by the CJJP in defining cost-effective future capital and operating budget requests beyond those already identified in the Phase I and II Master Plan documents.

3. A similar audit process should be performed for all the CBCs based on the new policy standards for those facilities once they are developed. The results of those audits will likewise be important for future planning and budgetary recommendations coming from the Department of Corrections and the Judicial Districts.

4. A more complete set of policy staffing standards should be developed that will serve as the department's staffing standards system-wide. These new standards should be derived from the current policy standards as well as the various staffing analyses that will have been completed by the end of FY 2009, including the health care staffing analysis that is presently underway. The staffing standards should serve as the vehicle by which all positions for new and existing institutions are requested and/or justified. In addition they will serve as performance measures for institutions to measure their current staffing complements coupled with annual accurate updates of pertinent shift relief factors.

IDOC - POLICY STANDARDS INITIATIVE
GENERAL POPULATION

Standard	Minimum - Out	Minimum	Medium	Maximum	Therapeutic Community	Gender Responsive
Housing						
Management Style	Podular / Direct	Podular / Direct	Podular / Direct	Podular / Direct	Podular / Direct	
Disciplinary Detention Housing -% of this category -Location	0% One short term holding cell	.25% One short term holding cell	4% 1 per institution	6% 1 per institution	Consistent with Individual Program Plan	10 cells for the facility
Housing Type	Males: Dormitory Females: 4 Person Cubicles or Dry Rooms	Males: Dormitory Females: 4 Person Cubicles or Dry Rooms	Male: 80% Double Dry Cells; 20% Single Wet Cells Female: 90% Dry Double Rooms; 10% Single Wet	Male: Single Cells Female: 90% Double; 10% Single	Dormitory: 4 Person Cubicles or Dry Rooms; Female: Dry Rooms	Recommend 90% Medium custody females in 2-4 person dry rooms
Pod Capacity	Dormitory: 64 Dry Rooms: 96	Dormitory: 64 Dry Rooms: 96	64 Beds Males 64-72 Beds Females	56 Beds Males 56 Beds Females	Dry Rooms: 96 (increments of 24)	
Management Unit Capacity	192	Males: 384 Females: 256	256	224	192	
Living Area Space	25 unencumbered s.f. per inmate	25 unencumbered s.f. per inmate	D:25 unencumbered s.f./ inmate; S:35 unencumbered s.f./inmate	35 unencumbered s.f. per inmate	25 unencumbered s.f. per inmate	
Dayroom Space	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy	More dayroom space as women congregate & spend less time in outside sports
Plumbing Fixtures	Vitreous China; Toilets 1:12 (Women 1:8); Showers 1:8; Provide for reasonable privacy for cross gender supervision	Vitreous China; Toilets 1:12 (Women 1:8); Showers 1:8; Provide for reasonable privacy for cross gender supervision	Male: Stainless Steel Female: Vitreous China Toilets: 1/cell (females w/ lid); Showers 1:8; Provide for reasonable privacy for cross gender supervision	Male: Stainless Steel Female: Vitreous China Toilets: 1/cell (females w/ lid); Showers 1:8; Provide for reasonable privacy for cross gender supervision	Vitreous China Toilets 1:12 (Women 1:8) Showers 1:8; Provide for reasonable privacy for cross gender supervision	
Cell/Sleeping Area/Common Walls	Reinforced Dry Wall	Hollow CMU	CMU	CMU	CMU	
Cell/Sleeping Area Doors	Frame: Standard Commercial. Door: Standard Commercial	Frame: Standard Commercial Hollow Metal Door: Solid wood or 16 gauge hollow metal	Frame: 14 gauge; Door: Security Hollow Metal 14 gauge, swinging; Females: 90% Standard commercial hollow metal frame, solid wood or 16 gauge hollow metal door	Frame: 12 gauge Door: Security Hollow Metal 12 gauge, swinging; lockable food pass	Frame: Standard Commercial Hollow Metal Door: Solid wood or 16 gauge hollow metal	

IDOC - POLICY STANDARDS INITIATIVE
GENERAL POPULATION

Standard	Minimum - Out	Minimum	Medium	Maximum	Therapeutic Community	Gender Responsive
Cell/Sleeping Area Locking Systems	Commercial Hardware	Commercial Hardware	Electronic Narrow Jamb Security Lock Females: Commercial Hardware	Electronic 120 Series Type Security Lock	Commercial Hardware	
Cell/Sleeping Area Furnishings	Bed, Locker, Shelf, Writing Surface, Chair(not Fixed), Clothing/Towel Hooks	Bed, Locker, Shelf, Writing Surface, Chair(not Fixed) Breakaway Clothing/Towel Hooks	Bed, Locker, Shelf, Writing Surface, Fixed Seating, Breakaway Clothing/Towel Hooks; Female Moveable furniture	Bed, Locker, Shelf, Writing Surface, Fixed Seating, Breakaway Clothing/Towel Hooks	Bed, Locker, Shelf, Writing Surface, Chair(not Fixed) Breakaway Clothing/Towel Hooks	No bunk beds
Dayroom Furnishings	Standard Commercial Quality	Light Correctional Movable	Heavy Correctional Movable	Fixed Steel	Light Correctional Movable	
Access to Natural Light	Window 3 s.f. Direct access or borrowed light	Window 3 s.f. Direct access or borrowed light	Window 3 s.f. Direct access or borrowed light to interior of complex	Window 3 s.f. Direct access or borrowed light to interior of complex	Window 3 s.f. Direct access or borrowed light	
Other Facility Components						
Dining Location/Type	Male: Decentralized to management unit; in bulk; in serving areas. Female: Decentralized to Outside/Cafeteria Style. Allows for serving 4 or few shifts / 20 minutes each.	Male: Decentralized to management unit; in bulk; in serving areas. Female: Female: Single bldg w/3 serving lines Centralized/ Cafeteria Style 128 eat in ea.	Male: Decentralized to management unit; in bulk; in serving areas. Female: Female: Single bldg w/3 serving lines Centralized/ Cafeteria Style 128 eat in ea.	Decentralized to management unit; in bulk (males); pre-portioned (females) in serving areas	Decentralized to management unit; in bulk (males); Female: Single bldg w/3 serving lines Centralized/Cafeteria Style 128 eat in each.	Centralized except max
Secure Central Control/Armory	n/a	1 per facility	1 per facility	1 per facility	1 per facility	
Recreation	Ball Field / Game Room / Weight Area	Ball Field / Gym / Weight Area	Ball Field / Gym / Weight Area	Ball Field / Gym / Fixed Weight Equipment	Ball Field / Gym / Weight Area	Game room, gym, 1-2 smaller yards, shaded benches around middle yard area
Classrooms	Provide for classrooms and Carrels for Individual and computer based learning. Centralized and Decentralized	Provide for classrooms and Carrels for Individual and computer based learning. Centralized and Decentralized	Provide for classrooms and Carrels for Individual and computer based learning. Centralized and Decentralized	Provide for classrooms and Carrels for Individual and computer based learning. Centralized and Decentralized	Provide for classrooms and Carrels for Individual and computer based learning. Centralized and Decentralized	
Library Services	Centralized	Centralized	Centralized	Centralized and decentralized	Centralized	
Law Library	Service provider or web-based	Service provider or web-based	Service provider or web-based	Service provider or web-based	Service provider or web-based	Keep attorneys

IDOC - POLICY STANDARDS INITIATIVE
GENERAL POPULATION

Standard	Minimum - Out	Minimum	Medium	Maximum	Therapeutic Community	Gender Responsive
Programs	Centralized at Facility Level	Centralized at Facility Level	Centralized and Management Unit	Management Unit	Consistent with Individual Program Plan; centralized or management unit.	Centralized and decentralized
Regular Personal/Official Visits	Contact Centralized at Facility Level	Contact Centralized at Facility Level	Contact Centralized at Facility Level	Contact Centralized at Facility Level Non-Contact/Video for security reasons	Contact Centralized at Facility Level	Mother/child, semi-nursery, play area, rocking chairs
Religion	Centralized at Facility Level Multipurpose Room	Centralized at Facility Level Multipurpose Room	Centralized at Facility Level Multipurpose Room	On-unit Multipurpose Room Decentralized - Individual	Centralized at Facility Level Multipurpose Room	
Industries	Centralized at Facility Level	Centralized at Facility Level	Centralized at Facility Level	Centralized at Facility Level	N/A	increase
Counseling	Centralized at Facility Level or Management Unit	Centralized at Facility Level or Management Unit	Centralized at Facility Level or Management Unit	Centralized at Facility Level or Management Unit	Consistent with Individual Program Plan	Centralized and decentralized
Maintenance Location and Contents	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping ; Outside the secure perimeter	
Administration	Outside the secure perimeter	Outside the secure perimeter	Outside the secure perimeter	Outside the secure perimeter	Outside the secure perimeter	
Warehouse	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	
Exterior Housing Wall Construction	CMU and/or wood	CMU	CMU fully grouted	CMU fully grouted Rebar 16" on center	CMU	
Security Perimeter Construction	None / Intrusion Fence	Single secure fence Perimeter Road Intermittent Patrol	Double secure fence; Perimeter Road; 24 hour Patrol; Dual Redundant intrusion alarm Females: Single secure fence, perimeter road, intermittent patrol	Double secure fence; Perimeter Road; (2)24-hour Patrol; Dual redundant intrusion alarm; Additional high mast lighting. Towers - option for discussion; Females: Single secure fence, perimeter road, intermittent patrol	Single secure fence Perimeter Road Intermittent Patrol	

IDOC - POLICY STANDARDS INITIATIVE
GENERAL POPULATION

Standard	Minimum - Out	Minimum	Medium	Maximum	Therapeutic Community	Gender Responsive
HOUSING OPERATIONS						
Management	Direct	Direct	Direct	Direct	Direct	
Supervision in the Housing Pod	Intermittent	Intermittent	Constant	Constant	Intermittent	
Frequency of Direct Observation w/ ability to intervene	Once every 120 minutes	Once every 60 minutes	Once every 30 minutes	Once every 30 minutes	Once every 60 minutes	Every 60 minutes in Min out
Housing Pod Activities	Census/Headcount at least 2X daily; count in place Random Searches (1/wk)	Census/Headcount at least 3X/daily; count in place Random Searches (1/wk)	Census/Headcount at least 4X/daily; count in place Random Searches (1/wk) Females: Census/ Headcount at least 3X daily; count in place, Random Searches (2/wk)	Census/Headcount at least 6X/daily; count in place Random Searches (3/wk) Females: Census/ Headcount at least 3X daily; count in place, Random Searches (2/wk)	Census/Headcount at least 2X/daily; count in place Random Searches (2/wk)	
Supervision	Cross Gender Females: No cross gender in housing unit	Cross Gender Females: No cross gender in housing unit	Cross Gender Females: No cross gender in housing unit	Cross Gender Females: No cross gender in housing unit	Cross Gender Females: No cross gender in housing unit	No cross gender in sleeping/ bathing areas
MOVEMENT						
Within Housing Pod Within Zone Within Institution Outside of the Facility	No Escort	No Escort No Escort No Escort Non-Secure Escort	No Escort No Escort No Escort Armed Escort	No Escort Non-Secure Escort Non-Secure Escort Armed Escort	No Escort No Escort No Escort Armed Escort	
Massing Numbers at one time	>100	250	112 Females: 200	56	>100	
PROGRAMS AND SERVICES		*Supported by EBP*				
% Industries Instructor:Inmate Ratio(Indoors)	0%	25% 1:25-50	50% 1:25-50	10% 1:10-25	N/A	
% Vocational Training Instructor:Inmate Ratio	100% of those not on work release; 1:15	50% 1:250 General Population Inmates (class 1:15)	40% 1:250 General Population Inmates (class 1:15)	20% 1:250 General Population Inmates (class 1:15)	50% 1:250 General Population Inmates (class 1:15)	Increase vocational/work prep minimum and short term
% Academic Instructor:Inmate Ratio	0%	75% where High School Equivalent not attained 1:25	50% where High School Equivalent not attained 1:20	20% where High School Equivalent not attained 1:15	50% where High School Equivalent not attained 1:25	Increase GED for Medium and long term Minimum,

IDOC - POLICY STANDARDS INITIATIVE
GENERAL POPULATION

Standard	Minimum - Out	Minimum	Medium	Maximum	Therapeutic Community	Gender Responsive
% Substance Abuse Treatment Counselor:Inmate Ratio	100% where needed and within 12-18 months of release. Community substance abuse resources.	100% where needed and within 12-18 months of release. Gen Pop: 1:500; Therapeutic Comm 1:25	100% where needed and within 12-18 months of release. Gen Pop: 1:500; Therapeutic Comm 1:25	100% where needed and within 12-18 months of release. Gen Pop: 1:500; Therapeutic Comm 1:25	100% where needed and within 12-18 months of release. Gen Pop: 1:500; Therapeutic Comm 1:25	
% Work Assignment (In-house, Community Service, Work Release)	100% Work Release, Community Service, In-house	75% Community Service or In-house Work Force	50%; In-house Work Force	25% Housing In Management Unit	N/A	
% Other Treatment (Relates to EBP Goals) e.g. Life Skills, Anger Management	100%	75% Females: 90%	50% Females: 75%	25%	Consistent with Individual Program Plan	
Recreation Access Type/Location Frequency	Centralized Within activity times	Centralized Within activity times	Centralized Within activity times	Centralized Based on Level At least 1 hour daily	Centralized Within activity times	consider small yards to decentralize more
Library Access Type/Location Frequency	Centralized Within activity times	Centralized Within activity times	Centralized At least 2 hours a week Females: Within activity times	Centralized Scheduled separate from other populations	Centralized Within activity times	
Religion Type/Location	Group Religious Programming.	Group Religious programming. Maximum 96 per program.	Group Religious Programming. Maximum 64 per program	Group Religious Programming. Maximum 20 per program.	Group Religious programming. Maximum 50 per program.	
Commissary Type/Location	Bagged; 1x per week	Bagged; 1x per week	Bagged; 1x per week	Bagged; 1x per week	Bagged; 1x per week	
Visiting Type/Location Frequency	Contact Visitation >5 hours a week	Contact Visitation >5 hours a week	Contact Visitation >5 hours a week	Contact Visitation 5 hours / week	Contact Visitation >5 hours a week	
Sick Call/Triage Type/Location Frequency	Sick Call/Meds as needed Centralized Self medication	Sick Call/Meds daily Centralized Dispensed by medical staff Self Medication	Sick Call/Meds daily Centralized Dispensed by medical staff Self Medication	Sick Call/Meds daily Centralized and Decentralized Dispensed by medical staff	Sick Call/Meds daily Centralized Dispensed by medical staff Self Medication	Self Medication where appropriate

IDOC - POLICY STANDARDS INITIATIVE
GENERAL POPULATION

Standard	Minimum - Out	Minimum	Medium	Maximum	Therapeutic Community	Gender Responsive
Other Medical Type/Location	Centralized at Facility Level; Outpatient psychiatric services at each facility; Dental Care at each facility Females: OB/GYN at facility	Centralized at Facility Level; Outpatient psychiatric services at each facility; Dental Care at each facility Females: OB/GYN at fac.	Centralized at Facility Level; Outpatient psychiatric services at each facility; Dental Care at each facility Females: OB/GYN at facility	Centralized at Facility/ Zone Level; Outpatient psychiatric services at each facility; Dental Care at each facility Females: OB/GYN at facility	Centralized at Facility Level; Outpatient psychiatric services at each facility; Dental Care at each facility	Increase OB/GYN on site
STAFFING						
Inmates per Housing Pod	96 / rooms 64 / dorm	96 / rooms 64 / dorm	64 Females: 64-72	56	Increments of 24 in each grouping; up to 96 in one unit.	Consider 64 in dry rooms
Officer:Inmate Ratio --Day --Evening --Night	1:96 / rooms 1:64 / dorm	1:96 / rooms 1:64 / dorm 1:128 dorm/rooms	1:64 1:64 1:128	1:56 1:56 1:56	1:96	
Caseworker Ratio	1:50	1:50 - 1:75	1:64	1:56	1:25-1:50	1:50 in Minimum for reentry prep
Unit Management	1:200	1:400	1:256	1:224	1:200	Add Asst Unit Managers
Work Crews Crew Leader:Inmate Ratio	Case by case basis; generally not to exceed Males: 1:15 Females: 1:12	Case by case basis; generally not to exceed 1:10	Case by case basis; generally not to exceed 1:6	n/a	N/A	1:15 Minimum out 1:12 Minimum

DOC - POLICY STANDARDS INITIATIVE
SPECIAL NEEDS / MANAGEMENT

Standard	Administrative Segregation	Investigation/ Pre-Hearing	Protective Custody	Reception and Diagnostic
PHYSICAL PLANT STANDARDS				
Housing				
Management Style	Podular / Indirect	Podular / Indirect	Podular / Direct	Podular / Direct
Number of Locations in system	1 per region for males and 1 per system for females	1 per region for males and 1 per system for females	1 per region for males and 1 per system for females	1 per system for males and 1 per system for females
Housing Type	Single Cells	Single Cells	Single or Double Cells	Single or Double cells
Unit/Pod Size	32	32	64	64
Management Unit Capacity	n/a	n/a	256	256
Living Area Space	80 s.f./cell	80 s.f./cell	35 unencumbered s.f. per inmate	80 s.f./cell
Dayroom Space	35 s.f. per each inmate in the dayroom; minimum 25% of occupancy	35 s.f. per each inmate in the dayroom; minimum 25% of occupancy	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy
Plumbing Fixtures	Stainless Steel Combination Fixtures 1/cell Provide for reasonable privacy for cross gender supervision	Stainless Steel Combination Fixtures 1/cell Provide for reasonable privacy for cross gender supervision	Vitreous China Toilets 1/cell Showers 1:8 Provide for reasonable privacy for cross gender supervision	Stainless Steel Toilets 1/cell Showers 1:8 Provide for reasonable privacy for cross gender supervision
Cell/Sleeping Area Construction	CMU fully grouted	CMU fully grouted	Hollow CMU	Fully grouted CMU
Cell/Sleeping Area Doors	Frame: 12 gauge Door: Security Hollow Metal 12 gauge, swinging with food pass	Frame: 12 gauge Door: Security Hollow Metal 12 gauge, swinging with food pass	Frame: 14 gauge Door: Security Hollow Metal 14 gauge, swinging	Frame: 12 gauge Door: Security Hollow Metal 12 gauge, swinging
Cell/Sleeping Area Locking Systems	Electronic 120 Series Type Security Lock	Electronic 120 Series Type Security Lock	Electronic Narrow Jamb Security Lock	Electronic 120 Series Type Security Lock
Cell/Sleeping Area Furnishings	Bed, Shelf, Writing Surface, Chair (Fixed),Breakaway Clothing/Towel Hooks	Bed, Shelf, Writing Surface, Chair (Fixed),Breakaway Clothing/Towel Hooks	Bed, Locker, Shelf, Writing Surface, Chair(not Fixed),Breakaway Clothing/Towel Hooks	Bed, Locker, Shelf, Writing Surface, Chair(not Fixed),Breakaway Clothing/Towel Hooks
Dayroom Furnishings	Fixed Steel	Fixed Steel	Heavy Movable	Heavy Movable

DOC - POLICY STANDARDS INITIATIVE
SPECIAL NEEDS / MANAGEMENT

Standard	Administrative Segregation	Investigation/ Pre-Hearing	Protective Custody	Reception and Diagnostic
Access to Natural Light	Window 3 s.f. Direct access but view to interior courtyard	Window 3 s.f. Direct access but view to interior courtyard	Window 3 s.f. Direct access or borrowed light	Window 3 s.f. Direct access or borrowed light to interior of complex
Other Facility Components				
Dining Location/Type	Decentralized at cell. Served prepared Tray	Decentralized at cell. Served prepared Tray	Centralized /Cafeteria Style. Cannot eat with other custody classifications	Decentralized at pod / cell. Served prepared Tray Females: centralized dining in unit
Secure Central Control	1 per facility	1 per facility	1 per facility	1 per facility
Recreation	Individual area No Ball field / no gym	Individual area No Ball field / no gym	PC Yard recreation/ Access to gym separate from other custody classifications	No Ball Field / Access to gym/small yard recreation
Classrooms	In Cell	In Cell	Provide for classrooms and Carrels for Individual and computer based learning. Schedule separate from other custody classifications.	n/a
Library Services	Mobile Cart	Mobile Cart	Provide space for reading area, legal research and mobile cart. Separate scheduling	Mobile Cart
Law Library	Service provider or web-based	Service provider or web-based	Service provider or web-based	Service provider or web-based
Programs	Decentralized at the Cell/Management Unit/Pod Level (No citizen volunteer participation)	Decentralized at the Cell/Management Unit/Pod Level (No citizen volunteer participation)	Decentralized at the Pod / Management Unit level. Scheduled separate from other custody classifications	Centralized at the Facility Level (diagnostics and cadre) (No citizen volunteer participation)
Regular Personal/Official Visits	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level	Centralized at Facility Level
Religion	Decentralized at the Pod Level via CCTV or in Cell	Decentralized at the Pod Level via CCTV or in Cell	Management Unit Multipurpose Room	Decentralized at the Management Unit Level Multipurpose
Industries	n/a	n/a	Management Unit or facility scheduled separate from other custody classifications	n/a

DOC - POLICY STANDARDS INITIATIVE
SPECIAL NEEDS / MANAGEMENT

Standard	Administrative Segregation	Investigation/ Pre-Hearing	Protective Custody	Reception and Diagnostic
Counseling	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level
Maintenance	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter
Administration	Outside the secure perimeter	Outside the secure perimeter	Outside the secure perimeter	Outside the secure perimeter
Warehouse	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	Central and maintenance storage, institutional supplies. Outside the secure perimeter.
Exterior Housing Wall Construction	CMU fully grouted Rebar 8" on center	CMU fully grouted Rebar 8" on center	CMU fully grouted Rebar 16" on center	CMU fully grouted Rebar 16" on center
Perimeter Construction	Double secure fence; Perimeter Road; (2)24-hour Patrol; Dual redundant intrusion alarm; Additional high mast lighting.	Double secure fence; Perimeter Road; (2)24-hour Patrol; Dual redundant intrusion alarm; Additional high mast lighting.	Consistent with custody level	Double secure fence; Perimeter Road; 24 hour Patrol; Dual Redundant intrusion alarm
HOUSING OPERATIONS				
Management	Direct and Control Rooms	Direct and Control Rooms	Direct	Direct
Supervision in the Housing Pod	Intermittent	Intermittent	Constant	Constant
Frequency of Direct Observation w/ ability to intervene	Once every 15 minutes	Once every 15 minutes	Once every 30 minutes	Once every 30 minutes
Housing Pod Activities	Census/Headcount at least 6X/daily Random Searches (3/wk)	Census/Headcount at least 6X/daily Random Searches (3/wk)	Same as GP in facility where housed	Census/Headcount at least 4X/daily Random Searches (1/wk) Females: Census/ Headcount at least 3Xdaily; count in place, Random Searches (2/wk)
Supervision	Cross Gender Females: No cross gender in housing unit	Cross Gender Females: No cross gender in housing unit	Cross Gender Females: No cross gender in housing unit	Cross Gender Females: No cross gender in housing unit

DOC - POLICY STANDARDS INITIATIVE
SPECIAL NEEDS / MANAGEMENT

Standard	Administrative Segregation	Investigation/ Pre-Hearing	Protective Custody	Reception and Diagnostic
MOVEMENT				
Within Housing Pod Within Zone Within Facility Outside of the Facility	Escort Escort Escort Armed Escort 1:2	Escort Escort Escort Armed Escort	Escort Escort Escort Armed Escort	No Escort No Escort Escort Armed Escort 1:2
Massing Numbers at one time	8	8	64 contingent upon individual separations in effect	64
PROGRAMS AND SERVICES		*Supported by EBP*		
% Industries Instructor:Inmate Ratio	0%	0%	25% In Management Unit Recommend 0 unless industries being moved to unit	0%
% Vocational Training Instructor:Inmate Ratio	0%	0%	50% Separate from general population Inmates (class 1:15)	0%
% Academic Instructor:Inmate Ratio	0%	0%	50% ACA=equiv to GP; recommend % based on custody and release date centralized on unit	0%
% Substance Abuse Treatment Counselor:Inmate Ratio	0%	0%	100% where needed and within 12-18 months of release. Gen Pop: 1:500; Therapeutic Comm 1:25	0%
% Work Assignment (In-house, Community Service, Work Release)	0%	0%	25% In-house Work Force Zone	Required: Housekeeping
% Other Treatment (Relates to EBP Goals) e.g. Life Skills, Anger Management	Anger Management/Control for inmates who do not pose immediate threat. No more than 8 at one time in Pod	Anger Management/Control for inmates who do not pose immediate threat. No more than 8 at one time in Pod	50% ACA=equiv to GP; recommend % based on custody and release date centralized on unit	0%
Recreation Access Type/Location Frequency	Decentralized At least one hour daily Maximum 8 at one time	Decentralized At least one hour daily Maximum 8 at one time	Centralized/Decentralized; At least one hour daily; Scheduled separate from GP	Decentralized At least one hour daily

DOC - POLICY STANDARDS INITIATIVE
SPECIAL NEEDS / MANAGEMENT

Standard	Administrative Segregation	Investigation/ Pre-Hearing	Protective Custody	Reception and Diagnostic
Library Access Type/Location Frequency	 Decentralized By request only	 Decentralized By request only	 Centralized At least one hour each week. Scheduled separate from General Population Decentralized research on unit	 By request
Religion Type/Location Frequency	Individual Programming	Individual Programming	Group Programming. Separate from general population or within management unit	Group Programming. Located within Management Unit
Commissary Type/Location Frequency	Bagged	Bagged	Bagged	Bagged
Visiting Type/Location Frequency	Non-contact Visitation 1 hour per week contingent on behavior	Non-contact Visitation 1 hour per week contingent on behavior	Contact Visitation Scheduled separate from GP 3 hours a week	Contact Visitation 1 per week after 14 days
Sick Call/Triage Type/Location Frequency	Sick Call/Meds daily Pod / Cell	Sick Call/Meds daily Pod / Cell	Sick Call/Meds daily Pod	Sick Call/Meds daily Pod
Other Medical Type/Location Frequency	Decentralized at the Pod Level	Decentralized at the Pod Level	Centralized at the Facility / Zone Level	Management Unit/Facility Level
STAFFING				
Inmates per Housing Pod	32	32	64	64
Officer:Inmate Ratio --Day --Evening --Night	 1:16 1:16 1:64	 1:16 1:16 1:64	 1:64 1:64 1:64	 1:64 1:64 1:64
Caseworker Ratio	1:25 - 1:50	1:25 - 1:50	1:64	1:25
Unit Management	n/a	n/a	256	256
Work Crews Crew leader:Inmate Ratio	n/a	n/a	n/a	n/a

DOC - POLICY STANDARDS INITIATIVE
MEDICAL / MENTAL HEALTH

Standard	Acute	Transition	Special Needs	Medical Infirmary	Assisted Living/ Chronic Debilitated	Hospice Care	University Hosp Outpatient Transport
PHYSICAL PLANT STANDARDS							
Housing							
Management Style	Podular Direct	Podular Direct	Podular Direct	Podular Direct	Podular Direct	Podular Direct	
Number of Locations in system	1 per system for males and females Temporary holding at each facility	1 per system for males and females	1 per system for females; designated types of SNUs for males	1 per system for males and females for acute/emergent care; 1 primary/infirmary for males and females per facility	1 per system for males and females for acute/ emergent care; 1 primary/infirmary for males and females per facility	1 per system for males and females for acute/emergent care; 1 primary/infirmary for males and females per facility	1 per system for males and females for acute/ emergent care; 1 primary/infirmary for males and females per facility
Housing Type	Single Cells	Mixed Single Cell and Doubles-- subpods of no more than 8	Mixed singles and doubles	Single Rooms/Cells or Wards	Mixed 4-8 bed shared wards or subpods	Single and double rooms	Single Rooms/Cells Wards
Unit/Pod Size	16-32	16-32	48	48	48	16-24	24-48
Management Unit Capacity	Within Medical / Mental Health Component	Within Medical / Mental Health Component	Within Medical / Mental Health Component	Within Medical / Mental Health Component	Within Medical / Mental Health Component	Within Medical / Mental Health Component	Within Medical / Mental Health Component
Living Area Space	80 s.f./cell	80 s.f./cell		Hospital Rooms: 120 s.f., Single Rms/Cells: 80 s.f. Wards:100 s.f./inmate	Mixed 4-8 bed shared wards or subpods; 100 s.f./inmate	Single and double rooms; 100 s.f./inmate	Single Rms/Cells: 80 s.f. Wards:100 s.f./inmate
Dayroom Space	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy	35 s.f. per each inmate in the dayroom	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy	35 s.f. per each inmate in the dayroom for a minimum of 50% occupancy
Plumbing Fixtures	Stainless Steel Toilets 1/cell Showers 1:8 Provide for reasonable privacy for cross gender supervision	Stainless Steel Toilets 1/cell Showers 1:8 Provide for reasonable privacy for cross gender supervision	Male: : Stainless Steel; Women: Vitreous China; Provide for reasonable privacy for cross gender supervision	Stainless Steel Toilets 1:12 (Women 1:8)/Ward or 1/cell Showers 1:8; Provide for reasonable privacy for cross gender supervision	Toilets 1:12 (Women 1:8)/Ward or 1/cell; Showers 1:8; Provide for reasonable privacy for cross gender supervision; All ADA compliant; Tub	Toilets 1:12 (Women 1:8)/Ward or 1/cell; Showers 1:8; Provide for reasonable privacy for cross gender supervision; All ADA compliant; Tub	Toilets 1:12 (Women 1:8)/Ward or 1/cell; Showers 1:8; Provide for reasonable privacy for cross gender supervision; All ADA compliant; Tub
Cell/Sleeping Area Construction	CMU	CMU	CMU	CMU	CMU	CMU	CMU

DOC - POLICY STANDARDS INITIATIVE
MEDICAL / MENTAL HEALTH

Standard	Acute	Transition	Special Needs	Medical Infirmary	Assisted Living/ Chronic Debilitated	Hospice Care	University Hosp Outpatient Transport
Cell/Sleeping Area Doors	Frame: 12 gauge Door: Security Hollow Metal 12 gauge, swinging with food pass	Frame: 12 gauge Door: Security Hollow Metal 12 gauge, swinging	Frame: 14 gauge; Door: Security Hollow Metal 14 gauge, swinging; Females: 90% Standard commercial hollow metal frame, solid wood or 16 gauge hollow metal door	Frame: 12 gauge Door: Security Hollow Metal 12 gauge, swinging	Frame: Standard Commercial Hollow Metal Door: Solid wood or 16 gauge hollow metal	Frame: Standard Commercial Hollow Metal Door: Solid wood or 16 gauge hollow metal	Frame: 12 gauge Door: Security Hollow Metal 12 gauge, swinging
Cell/Sleeping Area Locking Systems	Electronic 120 Series Type Security Lock	Electronic 120 Series Type Security Lock	Electronic 120 Series Type Security Lock	Electronic 120 Series Type Security Lock	Commercial Hardware	Commercial Hardware	Electronic 120 Series Type Security Lock
Cell/Sleeping Area Furnishings	Bed, Locker, Shelf, Writing Surface, Chair (Fixed)	Bed, Locker, Shelf, Writing Surface, Chair (Fixed)	Bed, Locker, Shelf, Writing Surface, Chair(not Fixed),Breakaway Clothing/Towel Hooks	Hospital Bed or Cell Bed, Locker, Breakaway Towel Hooks	Hospital Bed or Cell Bed, Locker, Breakaway Towel Hooks	Hospital Bed, shelf, Writing Surface, Chair (not Fixed), Breakaway Clothing/Towel Hooks	Hospital Bed or Cell Bed, Locker, Breakaway Towel Hooks
Dayroom Furnishings	Heavy movable	Heavy movable	Heavy movable	Heavy Movable	Heavy Movable	Heavy Movable	Heavy Movable
Access to Natural Light	Window 3 s.f. Direct access or borrowed light to interior of complex	Window 3 s.f. Direct access or borrowed light to interior of complex	Window 3 s.f. Direct access or borrowed light to interior of complex	Window 3 s.f. Direct access or borrowed light to interior of complex	Window 3 s.f. Direct access or borrowed light to interior of complex	Window 3 s.f. Direct access or borrowed light to interior of complex	Window 3 s.f. Direct access or borrowed light to interior of complex
Other Facility Components							
Dining Location/Type	Decentralized at pod / cell. Served prepared Tray	Decentralized at pod / cell. Served prepared Tray	Decentralized at pod / cell. Served prepared Tray or Serving Carts	Decentralized at cell/room. Served prepared Tray	Decentralized at pod / cell. Served prepared Tray or Serving Carts	Decentralized at cell/room. Served prepared Tray	Decentralized at pod / cell. Served prepared Tray or Serving Carts
Secure Central Control	1 per facility	1 per facility	1 per facility	1 per facility	1 per facility	1 per facility	1 per facility
Recreation	n/a	No Ball Field / access to gym Programmed activities	Ball Field/Access to gym; programmed activities	No Ball Field / No gym	Access to gym; programmed activities	Program Activities	Programmed Activities
Classrooms	n/a	n/a	classrooms	n/a	Classrooms	n/a	n/a

DOC - POLICY STANDARDS INITIATIVE
MEDICAL / MENTAL HEALTH

Standard	Acute	Transition	Special Needs	Medical Infirmary	Assisted Living/ Chronic Debilitated	Hospice Care	University Hosp Outpatient Transport
Library Services	Mobile Cart	Mobile Cart	Library Services per individualized treatment plan	Mobile Cart	Mobile Cart	Mobile Cart	Mobile Cart
Law Library	Service provider or web-based	Service provider or web-based	Service provider or web-based	Service provider or web-based	Service provider or web-based	Service provider or web-based	Service provider or web-based
Programs	Decentralized at the Pod Level	Decentralized at the Pod Level	Decentralized at the Pod Level	Decentralized at the Pod Level	Decentralized at the Facility/Management Unit Level	n/a	n/a
Regular Personal/Official Visits	Decentralized at the Management Unit Level	Centralized at the Facility / Management Unit Level	Centralized at the Facility / Management Unit Level	Centralized at the Facility / Management Unit Level	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level
Religion	Management Unit Multipurpose	Management Unit Multipurpose	Management Unit Multipurpose	Management Unit Multipurpose	Management Unit Multipurpose	Management Unit Multipurpose	Management Unit Multipurpose
Industries	n/a	n/a	Management Unit or facility scheduled separate from other custody classifications	n/a	n/a	n/a	n/a
Counseling	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level	Decentralized at the Management Unit Level
Maintenance	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter	Carpentry, Electrical, HVAC, Plumbing, Machine, Paint, Grounds keeping Outside the secure perimeter
Administration	Outside the secure perimeter	Outside the secure perimeter	Outside the secure perimeter	Outside the secure perimeter	Outside the secure perimeter	Outside the secure perimeter	Outside the secure perimeter
Warehouse	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	Central and maintenance storage, institutional supplies. Outside the secure	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	Central and maintenance storage, institutional supplies. Outside the secure perimeter.	Central and maintenance storage, institutional supplies. Outside the secure perimeter.

DOC - POLICY STANDARDS INITIATIVE
MEDICAL / MENTAL HEALTH

Standard	Acute	Transition	Special Needs	Medical Infirmary	Assisted Living/ Chronic Debilitated	Hospice Care	University Hosp Outpatient Transport
		perimeter.					
Exterior Housing Wall Construction	CMU fully grouted Rebar 8" on center	CMU fully grouted Rebar 16" on center	CMU fully grouted Rebar 16" on center	CMU fully grouted Rebar 16" on center	CMU fully grouted Rebar 16" on center	CMU fully grouted Rebar 16" on center	CMU fully grouted Rebar 16" on center
Perimeter Construction	Double secure fence; Perimeter Road; (2)24-hour Patrol; Dual redundant intrusion alarm; Additional high mast lighting.	Double secure fence; Perimeter Road; 24 hour Patrol; Dual Redundant intrusion alarm	Double secure fence; Perimeter Road; 24 hour Patrol; Dual Redundant intrusion alarm	Double secure fence; Perimeter Road; 24 hour Patrol; Dual Redundant intrusion alarm	Double secure fence; Perimeter Road; 24 hour Patrol; Dual Redundant intrusion alarm	Double secure fence; Perimeter Road; 24 hour Patrol; Dual Redundant intrusion alarm	Double secure fence; Perimeter Road; 24 hour Patrol; Dual Redundant intrusion alarm
HOUSING OPERATIONS							
Management	Direct	Direct	Direct	Direct	Direct	Direct	Direct
Supervision in the Housing Pod	Constant	Constant	Constant	Constant	Constant	Constant	Constant
Frequency of Direct Observation w/ ability to intervene	15 minutes or continuous as required	15 minutes or continuous as required	15 minutes or continuous as required	30 minutes or as required by condition	Once every 15 minutes	Once every 15 minutes	Once every 30 minutes
Housing Pod Activities	Census/Headcount at least 4X/daily Random Searches (1/wk)	Census/Headcount at least 4X/daily Random Searches (1/wk)	Census/Headcount at least 4X/daily Random Searches (1/wk)	Census/Headcount at least 4X/daily Random Searches (1/wk)	Census/Headcount at least 4X/daily Random Searches (1/wk)	Census/Headcount at least 4X/daily Random Searches (1/wk)	Census/Headcount at least 4X/daily Random Searches (1/wk)
Supervision		Cross Gender	Cross Gender	Cross Gender	Cross Gender	Cross Gender	Cross Gender

DOC - POLICY STANDARDS INITIATIVE
MEDICAL / MENTAL HEALTH

Standard	Acute	Transition	Special Needs	Medical Infirmary	Assisted Living/ Chronic Debilitated	Hospice Care	University Hosp Outpatient Transport
MOVEMENT							
Within Housing Pod Within Zone Within Facility Outside of the Facility	No Escort/Escort Escort 1:1-2 Escort 1:1-2 Armed Escort 1:1-2	No Escort/Escort Escort 1:1-2 Escort 1:1-2 Armed Escort 1:1-2	No Escort/Escort Escort 1:1-5 Escort 1:1-5 Armed Escort 1:1-2	No Escort No Escort Escort 1:5 By Custody Level	No Escort No Escort Escort 1:5 By Custody Level	No Escort No Escort Escort 1:5 By Custody Level	No Escort No Escort Escort 1:5 By Custody Level
Massing Numbers at one time	8	16	32	48 Contingent upon custody level	48 Contingent upon custody level	48 Contingent upon custody level	48 Contingent upon custody level
PROGRAMS AND SERVICES		*Supported by EBP*					
% Industries Instructor:Inmate Ratio	0%	0%	Should have access to based on ITP	0%	0%	0%	0%
% Vocational Training Instructor:Inmate Ratio	0%	0%	Combined with Mental Health programming as appropriate	0%	Consistent with Treatment Plan	0%	0%
% Academic Instructor:Inmate Ratio	0%	0%	10% where High School Equivalent not attained 1:15	0%	10% where High School Equivalent not attained 1:15	0%	10% where High School Equivalent not attained 1:15
% Substance Abuse Treatment Counselor:Inmate Ratio	0%	0%	Integrated Co-occurring Treatment programming	0%	100% where needed and within 12-18 months of release. Gen Pop: 1:500; Therapeutic Comm 1:25	0%	0%
% Work Assignment (In-house, Community Service, Work Release)	0%	0%	10% In-house Work Force consistent with Mental Health Programming	Housekeeping as able	Housekeeping as able	Housekeeping as able	Housekeeping as able

DOC - POLICY STANDARDS INITIATIVE
MEDICAL / MENTAL HEALTH

Standard	Acute	Transition	Special Needs	Medical Infirmary	Assisted Living/ Chronic Debilitated	Hospice Care	University Hosp Outpatient Transport
% Other Treatment (Relates to EBP Goals) e.g. Life Skills, Anger Mgt	Consistent with Mental Health Programming	Consistent with Mental Health Programming	Consistent with Mental Health Programming	0%	25%	0%	0%
Recreation Access Type/Location Frequency	Decentralized At least one hour daily consistent with Mental health programming	Decentralized At least one hour daily consistent with Mental health programming	Decentralized At least one hour daily consistent with Mental health programming	Decentralized At least one hour daily	Decentralized At least one hour daily	Decentralized At least one hour daily	Decentralized At least one hour daily
Library Access Type/Location Frequency	Decentralized At least one hour each week.	Decentralized At least one hour each week.	Centralized; At least one hour each week; Scheduled separate from GP	Decentralized or request	Decentralized At least one hour each week.	Decentralized or request	Decentralized At least one hour each week.
Religion Type/Location Frequency	Consistent with Individual Treatment Plan	Consistent with Individual Treatment Plan	Group Programming. Separate from general population	Individual/Group Programming.	Group Programming. Located within Management Unit	Individual/Group Programming.	Group Programming. Located within Management Unit
Commissary Type/Location Frequency	Bagged	Bagged	Bagged	Bagged	Bagged	Bagged	Bagged
Visiting Type/Location Frequency	Contact Visitation / up to 3 hours as deemed appropriate by treatment team	Contact Visitation / up to 3 hours as deemed appropriate by treatment team	Contact Visitation / up to 3 hours as deemed appropriate by treatment team	Contact Visitation 3 hours week	Contact Visitation 3 hours week	Contact Visitation 3 hours week	Contact Visitation 3 hours week
Sick Call/Triage Type/Location Frequency	Sick Call/Meds daily Pod	Sick Call/Meds daily Pod	Sick Call/Meds daily Pod	Sick Call/Meds daily Pod / Room	Sick Call/Meds daily Pod / Room	Sick Call/Meds daily Pod / Room	Sick Call/Meds daily Pod / Room
Other Medical Type/Location Frequency	Decentralized at the Pod/Management Unit Level	Decentralized at the Pod/Management Unit Level	Decentralized at the Pod/Management Unit Level	Decentralized at the Pod/Management Unit Level	Decentralized at the Pod/Management Unit Level	Decentralized at the Pod/Management Unit Level	Decentralized at the Pod/Management Unit Level

DOC - POLICY STANDARDS INITIATIVE
MEDICAL / MENTAL HEALTH

Standard	Acute	Transition	Special Needs	Medical Infirmary	Assisted Living/ Chronic Debilitated	Hospice Care	University Hosp Outpatient Transport
STAFFING							
Inmates per Housing Pod	16-32	16-32	16-32	48	48	16-24	24-48
Officer:Inmate Ratio Day Evening Night	 1:16 1:16 1:32	 1:16 1:16 1:32	 1:16 1:16 1:32	 1:48 1:48 1:48	 1:48 1:48 1:48	 1:24 1:24 1:24	 1:48 1:48 1:48
Caseworker Ratio	1:16	1:20	1:32	1:96	1:48	1:12	
Unit Management							
Work Crews Crew Leader:Inmate Ratio	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Chapter 7: Facilities

ICIW – Operating Principles and Macro Space Program

Introduction

The operating principles are a series of broad assumptions about how a facility will operate and the space needed to implement the operation. The resulting macro-program is intended to provide general planning guidelines to anticipate site design and cost implications for renovation combined with new construction of the Iowa Correctional Institution for Women.

An important component of the macro-programming effort was reaching agreement on key operating principles for the Women's facility located at the Iowa Correctional Institution for Women (ICIW) in Mitchellville. These principles serve as guidelines for the pre-design and master planning phase in identifying the preliminary functional and space requirements, as well as basic delivery strategies to determine which existing spaces may be reused, renovated and/or expanded and which must be newly constructed to meet the future bed and programming needs for the institution.

The operating principles were developed through a combination of documents provided by the ICIW staff and facilitated discussions with IDOC and other stakeholders (e.g., legislative aides, etc). The discussions were held on site at the ICIW facility and at Central Office. Numerous tours were conducted throughout the Phase I and the Phase II master planning efforts.

A key foundation for the operating principles and associated space needs are the recently developed IDOC Policy Standards as described in Chapter 6, which also conform to the American Correctional Association (ACA) standards. These standards are a series of physical, operational, staffing and treatment criteria that describe how offenders should be housed and managed based on their classification, custody level and special needs. These standards, which are included in Chapter 6 of this report, will also provide a framework and help guide the subsequent pre-design, master planning and budgetary decisions.

The operating principles are an assessment of the basic issues, options and alternatives including the number of beds to be constructed, required security levels, size of housing units, programs needed and options for meeting these needs. Decisions made during the planning process will impact the way IDOC operates the facility.

Several system wide changes were also discussed. These changes include gender-responsive consideration for classification, programming, custodial and physical plant design and are also reflected in the new IDOC Policy Standards. Additional changes include the use of video technology and opportunities to implement reentry programs.

The use of video technology for visitation and expanding its use for other existing services (e.g. telemedicine, parole board hearings, etc.) provides opportunities to reduce cost and increase services. Video visitation, court hearings, probation officer video conferencing and video based health care support are a few of the uses of this technology that have been successfully implemented in correctional facilities across the country, including in Iowa on a limited basis. While there are consequences of depersonalization, the increased opportunity to meet these needs creates an acceptable

balance. The implementation and expansion of these video conferencing technologies could significantly reduce the current time, staffing, security risks and transportation costs of escorting offenders to IMCC, the University Hospital in Iowa City and to other hospitals as well and could minimize costly facility physical space. The one-time cost of implementing video technologies is far less than the ongoing costs associated with escorting/transporting and supervising offenders under the current operation. In addition, video technology can be applied to programming services including education (e-learning), vocational training and religious services

Video visitation should be implemented with considerable thought to the impact on the female population. Currently, ICIW uses video visitation on site for no contact status. Women generally receive far fewer visits than men, are alienated by mentally & physically by mere incarceration; therefore they have a greater need for social connection and definitely need hands-on contact with their children. The ICIW currently uses video technology for the telemedicine, though only one system is used. Video technology requires high speed electronic connectivity at all facilities on the compound and the satellite location of, in this case, the health care provider participating in the telemedicine procedure. These costs should be included in the overall project costs. This same connectivity will increase opportunities for all of the video applications mentioned above.

The Women's Facility planning process is in itself a pilot for facility repurposing and program restructuring for a more seamless and interactive prison system throughout IDOC. More importantly, the design of the Women's Facility affords the IDOC the opportunity to implement more significant system wide operations on a much smaller scale and to address some of the larger statewide implementation issues prior to the expansion and/or new construction at the remainder of institutions throughout the IDOC system. The initiatives include the implementation of the reentry process as well as the better utilization of, and transition to, the Community Based Corrections facilities (CBCs).

Bed Distribution

This section describes the process used for determining both the bed needs (e.g., projected total population, custody classification and special management/needs) and the determination of the number and types of beds to be constructed. Generally, prison facility design is based upon a specific offender profile, security, custody, treatment, length of incarceration and special needs. However, the master plan for ICIW must be designed to house and meet the myriad of functional needs all in one location. This strategy also assumes that needs will be consistent with the most recent population projections developed by the Division of Criminal and Juvenile Justice Planning (CJJP) in December 2007[99], for an average daily population of 1071 female offenders in 2017. It is anticipated that in the future ICIW will also house all the special needs women currently housed at the Mount Pleasant facility and the women who are received and classified presently at IMCC.

The initial draft of this chapter was completed prior to receiving revised population projections and the revised classification system criteria to include new objective gender-responsive risk and needs assessment instruments. These revised documents are now

[99] Source: Iowa Prison Population Forecast FY 2007-2017. Iowa Department of Human Rights Division of Criminal and Juvenile Justice Planning. December 28, 2007.

available and are the basis of the information contained in this macro program. However, much of the methodology for determining special populations was developed prior to the revised data being received by the Durrant/PBA team. Therefore, the new data appearing below is based on a revised percent of increase applied to the figures originally calculated with the ICIW staff in August 2007. The methodology is described in further detail in the ensuing sections.

It is rare for the number and types of beds to exactly match the average offender population on a given day. Using the total average daily population of 1071 female offenders for the year 2017 as a baseline, the planning team[100] determined the disaggregation of the population[101] as well anticipating peak periods when a higher number of offenders may be housed in the facility. These peaks often occur in prison systems just after transports are made from the local jails, and just prior to Parole Board Hearings. Based on best practices and validation from the planning team, a peaking factor of 5% was applied. Additionally, there is a need to provide sufficient beds to account for various classification and custody level distinctions. For example, a female in acute mental health crisis would not be appropriately housed in a vacant minimum custody bed. Therefore, sufficient beds must be available to ensure offenders are appropriately housed. This classification factor was also determined to be 5% which accounts for a total increase in the number of beds needed to successfully accommodate the female population of 10% (5% peaking factor; 5% classification factor), or 1178 beds.

CJJP population projections were generated in late 2007 and reflect a ten year projection. Clearly the master plan needs to recognize future growth to account for the next 20 years. Absent 20-year projections, the planning team applied an approximate growth factor consistent with the last ten year growth patterns of 26% to the projections to ensure appropriate infrastructure is constructed during the first phase of the project. This will allow for the future construction of general population beds in a phased manner without affecting the core services such as the kitchen, centralized programs, administration and other applicable areas. By applying this factor to the ten year bed needs of 1178, a future bed need of 1484 in the year 2027 would be required.[102]

The table below illustrates the potential projected population and number of female offender beds. It is hoped that the trend lines for the future will show a lower rate of increase in the years to come as a result of expanded reentry, programming and treatment alternatives coupled with expanded diversion from prison. However, at this juncture we must be conservative in the planning process and develop master plan solutions for ICIW that could accommodate this many female offenders as a worse case scenario for the next ten to twenty years.

[100]The planning team included representatives of the existing Women's facility, representatives of various focus groups, and other key decision makers relating to facilities planning and in particular, the Women's facility.
[101] These figures have since been revised based on the findings of the validated classification system described in Appendix D coupled with current practice as described further in this section.
[102] Figures are approximate based on rounding.

Table 1
Summary of Population Projections and Bed Needs

Total average daily female population based on CJJP projections to 2017	1071 offenders
Classification factor at 5%	1125 beds for 2017
Peaking factor generally at 5%	1178 beds for 2017
Total number of Beds projected to 2027 (for master planning purposes)	**1484 beds for 2027**

In addition, IDOC presently utilizes many initiatives to reduce the offender population within its institutions. These initiatives include housing offenders in more appropriate beds such as Community Based Corrections beds. The current waiting lists for these beds and the corresponding lack of programs and services that respond to the criminogenic factors in the community suggest that there will still need to be a major push in the future to expand these beds rather than add additional bed capacity at ICIW.

Similarly, the IDOC seeks to work more closely with the Parole Board to ensure the institutions and the Board continue to consider the same criteria in determining offender eligibility for release to the community. As noted throughout this report, initiatives are well underway seeking to reduce the prison population by providing evidence based reentry programming and expanding opportunities to manage the offender population in the community.

Beyond the projected bed needs for the female offender population, opportunities exist to hold Federal offenders at a per diem cost. Offenders could be housed in empty beds that are available to meet a specific classification need. IDOC bed needs would always take precedence.

One significant issue that must be resolved prior to occupying a new facility is finding an alternative to housing juveniles (persons under the age of 18). There have been only three female juvenile offenders housed at ICIW in the past ten years. Therefore, it would ***not*** be cost effective to house these few offenders in the facility. The alternative could be addressed with the Department of Human Services to hold these few juveniles in the future. This decision will need to be finalized prior to detailed programming but for the purpose of this document it is assumed that an alternative solution will be found for the female juveniles rather than being incarcerated at ICIW since these offenders would require the construction of additional housing and program areas and the staff to monitor these offenders moving throughout the campus.

Disaggregation by Custody Levels

Once the total bed need was determined, the disaggregation of beds was addressed. The population report pulled on August 29, 2007[103] was used as the foundation document that illustrated the percentages of the different classifications, sub-classifications and special needs categories of women presently at ICIW or MPWU. These categories are summarized below:

[103] The population report included a review of custody status at both the ICIW and the MPWU.

- Classification – includes the more traditional classification categories of (i.e., maximum, medium, and minimum custody).
- Subclassification – includes several of the program placement categories within the classification category such as: "minimum live out" who are the subclassifications referenced in this report include:
    - Minimum
        - Minimum Live Out – Minimum custody offenders working in the community living in housing adjacent to the institution.
        - Minimum Work Out – Minimum custody offenders who are housed within the secure perimeter but work outside of the grounds of the institution or in the community under supervision of ICIW staff or other authorized work supervisor.
        - Minimum Secure – those minimum custody offenders who are not eligible for release programs.
    - Medium
        - Medium Work Out – Similar to the minimum work out population, these medium custody offenders are housed within the secure perimeter but work in the outside of the grounds of the institution or community under supervision of ICIW staff or other authorized work supervisor.

- Special Management/Special Needs Offenders – these offenders have distinct housing needs (described below) that go beyond their custody level. As such, persons who require mental health transition housing or segregation due to their victimization potential will be assigned based on their special needs, rather than their custody level (the security level under which they must be housed) .

Since the initial exercise to disaggregate the offender population, new custody distributions have been generated based on the proposed new classification system for female offenders which are described in Appendix D. The new classification system focuses on the major classifications of maximum (4.0% of the total population), medium (28.1% of the population), and minimum custody (67.9% of the population). In addition, estimates were made for the sub-classification categories in the new classification system based on the maximum number of offenders who could qualify for these sub-classifications rather than those who would necessarily be placed in those categories. This is an important distinction since staff discretion cannot be accounted for in determining these sub-classifications. An example provided in Appendix D shows that had the new classification system been in effect in November of 2007, the total number of women offenders eligible for the Minimum Live Out sub-classification category would have been 286, or 40.9% of the total female offender population whereas the actual program participation in November 2007 for Minimum Live Out was 40 women or 5.71% of the total offender population. This disparity lead the planning team to continue to use the planning methodology for the sub-classifications and special management/special needs offenders (described later in this section) that was developed during the preliminary discussions rather that apply the maximum program eligibility figures that appear in Appendix D for purposes of the facility master plan.

The resulting custody level disaggregation is based on the proposed new classification system and the percentage applied to the sub-classification has been applied in Table 2

below. Detailed descriptions of operational requirements for managing these custody levels in the facilities are included under Section 10.000 of this chapter. In summary, this disaggregation focuses on the custody levels that are expected once the new classification system is put into operation based on the risk the offender presents while incarcerated and these percentages are applied to the year 2017 bed needs identified above. It is assumed that the housing being planned for the ICIW expansion will meet the needs through 2017 while the support infrastructure and specialized housing (discussed in the next section) will be planned to meet the year 2027 needs.

Table 2
DISAGGREGATION OF CUSTODY LEVELS

	Maximum 4.0%	**Medium 28.1%**		**Minimum 67.9%**				**Total Beds**
	Max	Med	Med Work Out	Min	Min. Work Out	Min. Live Out	Min. Secure	
Percentage of Total Beds	4.0%	25.9%	2.2%	52.7%	3.2%	11.5	<1%	100.0%
Total Beds	47	305	26	621	38	136	5	1178

Disaggregation by Special Populations

Beyond the custody level disaggregations, there are other special populations that must be classified and housed separately. These populations include the following:

- *Administrative Segregation* (Intractable) – those offenders who must be separated (and housed in a single cell) because of the seriousness of their offense, prior history of violence or escape or their continued disruptive behavior.
- *Administrative Segregation (Pre-Hearing Detention)* – Offenders who, due to their behavior, are housed separate from other offenders.
- *Mental Health* – those offenders who are diagnosed as having a mental illness that requires careful monitoring of medication and behavior (e.g., suicidal tendencies or erratic behavior) and treatment by properly qualified and trained personnel.
- *Protective Custody* – those offenders who must be separated from the general population due to their potential for victimization. Often the victimization potential is a result of the crime (e.g., sex offenders or other offenses involving children) or the person's personal history (e.g., former criminal justice officials, etc.). Some of these offenders must be separated from all other offenders (i.e., individually housed), although some may be housed in a modified dormitory setting designed for this purpose.
- *Disciplinary Detention* – Disciplinary segregation is a progressive behavior management tool to remove offenders from general population and program/service opportunities due to their failure to comply with the facility rules. These beds are in addition to the projected population.
- *Medical* – offenders with certain medical conditions must be separated from the general population to avoid infecting other offenders and/or to facilitate the delivery of health care by medical staff. Infirmary care will be provided to address recovery for minor surgery conducted off-site, as well as for short-term

observation when the need arises. Special needs populations also include geriatric care, hospice care and assisted living.

The special population beds require additional consideration because unlike a standard custody level bed, expansion of the core requirements of the beds/units is difficult once a facility has been constructed. For example, medical beds must be located adjacent to the medical and clinical functions so that the staff and resources of these two functions can be shared. Minimum, medium and maximum custody beds can be expanded, site permitting, as long as the core program operations, administrative functions, etc., are already in place. Because of this need to ensure that sufficient specialized beds are planned correctly in the near term during the first phase of construction, the planning team agreed to use an expansion figure of 26% that corresponds to the year 2027 projections described above. It is important to note that only the specialized beds figures were increased to meet the anticipated 2027 bed needs. The general population beds remain at the 2017 projected figure. The specialized beds were deducted from the 2017 bed needs before the 2027 projected increase was added to the specialized beds. As a result, the general population beds are based on the 2017 projected population and the specialized beds are based on the 2027 population (see Table 4 that follows for calculations methodology).

The breakdown of the specialized beds was partially derived from the breakdown of the current population and extrapolated to the projected future population. From discussions with the Warden and representative ICIW personnel, the number of beds within each classification/special population was determined and then the revised population projection increases were applied. A unique consideration in determining future bed needs is the recognition that medical infirmary, acute mentally ill, and disciplinary detention beds are not typically considered permanent “beds” when considering the total bed needs for the offender population. In each of these cases, it is likely that the offender’s original bed is essentially reserved anticipating the offender’s return. The offenders in these cases are generally expected to occupy one of these beds for a short time period and then return to general population, or in the case of the acute mentally ill, will return to transition housing. However, for the purpose of anticipating total bed needs, these beds were included in the total bed needs for the facility.

The specialized bed needs were determined by applying the existing specialized bed utilization[104] factor to the projected future population. The disaggregation of the specialized populations is listed in Table 3 that follows.

Table 3
DISAGGREGATION OF SPECIALIZED BEDS

Population	Future Projected Bed Need
Total Beds Projected *(Based on 2027 assumed population)*	1484
Reception	105
Administrative Segregation – Intractable	8
Administrative Segregation – Pre Hearing Detention	17
Disciplinary Detention	27
Protective Custody	4
Competency Evaluations	2
Mental Health – Acute	8
Mental Health – Transition	25
Mental Health – Special Needs	209
Medical – Infirmary	10
Medical – Assisted Living	63
Total Special Population Beds	**478**

Table 4 that follows summarizes the process and methodology used in determining the total future bed needs. Column B reflects the current population as described in Table 2, Disaggregation of Custody Levels. The numbers in column B were derived by assuming that with each classification/custody level, approximately 37% of the offender population would fall into one of the special population categories described above. Column D is the remainder of Column C subtracted from Column B. The Special Population figures noted in Column E reflect the Disaggregation of Specialized beds as described in Table 3. Column F includes the sum of Columns D and E for a potential total projected bed capacity of 1220 in 2017. In the next section of this chapter, we will describe why Durrant/PBA in consultation with IDOC agreed that the first phase of construction at ICIW would require far fewer beds than 1220 while at the same time providing the necessary infrastructure to allow the facility to expand as the need arises.

[104] The current and anticipated future specialized bed utilization is approximately 37% of the total offender population.

Table 4
BED NEEDS SUMMARY

Recommended Bed Distribution

A Classification/Custody Level	B Total Future Bed Needs 2017	C Special Population Beds 2017	D Remaining General Population Beds 2017	E Special Population Beds 2027	F Total Bed Capacity 2017
Maximum Custody	47	17	30		30
Medium Custody	305	113	192		192
Minimum Custody	621	230	391		391
Minimum Work Outside	38	14	24		24
Medium Work Outside	26	10	16		16
Minimum Live Outside	136	50	86		86
Minimum Secure	5	2	3		3
Reception				105	105
AS: Intractable				8	8
AS: Pre-Hearing				17	17
Disciplinary Detention				27	27
Protective Custody				4	4
Competency Evaluations				2	2
MH – Acute				8	8
MH – Transition				25	25
MH – Special Needs				209	209
Medical – Infirmary				10	10
Medical – Assisted Living				63	63
Totals	***1178***	***436***	***742***	***478***	***1220***

With the preceding analysis of various disaggregation needs by custody and specialized populations, it now becomes possible to determine the full picture of projected bed distribution needs for the women's institution for the first phase of construction that is proposed to commence in FY 2010.

In addition to the actual bed disaggregation needs, national standards were considered in determining space and operational requirements. These standards not only served to inform the disaggregation discussed previously, but they also profoundly affect the actual distribution of beds in terms of unit size requirements In some cases, housing units will be somewhat flexible in their design and configuration to allow one officer to supervise more than a single population of offenders. These separations may be achieved by creating smaller housing sub-units within the larger unit enabling an officer to supervise both areas at the same time. Another alternative may be creating housing units with separating walls that allow two offender population groups to be supervised by one officer while maintaining appropriate staffing ratios. After applying the new IDOC Policy Standards as well as the extensive correctional facility experience of the planning team, the recommended bed distribution was developed as shown below. In an effort to conform to the new standards, in particular the housing unit sizes, the total beds required differs somewhat from the projected beds described above.

Once the bed needs were determined, the bed needs were applied to the existing ICIW bed availability to assess what new beds would likely need to be constructed. Many of the housing units are not suitable from a physical plant or operations and security perspective to meet the longer term future bed needs. These housing units, as described in further detail later in this chapter, were therefore not included in the future bed availability as shown in Table 5. However, the housing units that are viable for use could be occupied through the year 2017 were included in the overall bed availability.

The additional considerations for determining the actual number of beds to be constructed in the first phase of work at ICIW are described below.

- While specialized beds were projected through the year 2027, the Durrant/PBA team proposed that fewer beds be initially constructed for these populations. For example, while there are nearly 100 female offenders at Mt. Pleasant today, it was agreed with the staff at ICIW that nearly all these women could successfully be mainstreamed into general housing environments despite their special needs treatment requirements (see discussion that follows).

- The planning team also realized that the availability of higher security beds could meet the bed-type required for lower custody levels; conversely a higher custody offender could not be housed in a lower custody bed. As such, the focus of ensuring necessary but cost efficient beds to meet the medium custody range of future bed needs was given a higher priority. This decision was reinforced by the recognition that there is a need to provide a Therapeutic Community treatment program for this custody level which presently does not exist at ICIW.

- The projected number of female offenders is based on current practices at IMCC. It is anticipated that once all female offenders are relocated to ICIW, the classification process will be greatly streamlined and be more efficient. That coupled with greater bed availability, should allow the number of reception beds to be reduced to 64 with the possibility of future expansion of capacity should the need arise.

- The realities of funding availability coupled with the policy decisions to divert more females into the community that would be drawn from the projected minimum custody projected beds resulted in more beds being constructed for medium populations and fewer beds for minimum custody.

- The medical bed projections from August 2007 have been updated to reflect both the CJJP female offender population projections for 2027 and the anticipated new custody classification impact upon the percentages of minimum, medium and maximum beds within the female population. In Phase I, only 48 medical beds will be constructed instead of the projected total of 73 beds as shown in Table 4. It is anticipated that due to the impact of the new custody classification system and maximized use of community corrections supervision, fewer medical beds than previously anticipated will be needed for the female offender population. In the event that additional infirmary beds are required, they can be accommodated in the new infirmary wings at IMCC.

- In August 2007 it was anticipated that there would be a need for 8 acute, 20 transition, and 196 special needs female offenders. This was based on CJJP projections, current populations, and discussions with mental health and corrections staff. These 196 special needs beds included the movement of 100 female offenders from the Mt. Pleasant special needs unit to ICIW. However, it must be noted that the Department of Corrections has never had any designated mental health beds for female offenders who require acute or transition/step-down mental health care. Some of these women have received "acute" care in "safety cells" and/or "disciplinary units" which are not the most conducive environments for a person with acute symptoms of mental illness. Others may have been moved to special needs units earlier than would be optimum and therefore have inflated the special needs bed number. Therefore the number of beds initially identified for special needs inmates has been reduced to 64 beds for the first phase of work from the original estimated number.

- Persons undergoing competency evaluations will be served at IMCC and not at ICIW.

- Similarly, it is anticipated that the reentry initiatives will continue to be expanded to meet the supervision, treatment, education, housing and employment needs of the offender population being released to the community. Should these initiatives continue to demonstrate positive results, the likely result will be to reduce the growth trend line as discussed earlier and the number of beds required for female offenders. At this juncture, it would not be cost effective or prudent to build beds that may not be necessary in the future. If these diversion initiatives are not successful, the planning team would recommend that future new beds, particularly those appropriate for "minimum live out" custody offenders be constructed in the community where the offenders are closer to the community and services they will use upon release.

In conclusion, Table 5 illustrates the specialized beds for the future 2027 projected population and the general population beds for the future 2017 population and the actual Phase 1 bed needs that were determined based on the applied corresponding policy standards and accepted architectural practices to ensure efficiency in the building construction. In addition the table delineates re-use of existing housing buildings versus new housing construction. The final figures are described in the following in Table 5.

Table 5
RECOMMENDED BED DISTRIBUTION

Housing Unit	GP Population for 2017 & Specialized Beds for 2027	Existing Phase 1 Capacity	Existing Housing Unit Number	New Housing Phase I
Maximum Custody	30	32	6A	0
Medium Custody	192	0	0	192 (3 units @64 ea)
Minimum[105]	394	184	9	64 (1 unit –double dry rooms)
Minimum Work Out Medium Work Out	24 16	32		32 (1 unit –double dry rooms)
Whiskers Paws	16 16	16 16		32 (1 unit –double dry rooms)
Minimum Live Out	86	64	7&8	0
Segregation -Intractables -Pre-Hearing Detention -Disciplinary Detention	 8 17 27	64	6B	0
Reception	105	0	0	64 (1 unit- single cells)
Medical -Infirmary, -Assisted Living	 10 63	0	0	48 (8 isolation; 8 singles; 8 dbl. rooms (16 beds); 16 bed ward)
Mental Health -Acute -Transition -Special Needs	 8 25 209	0	0	112 (16 acute; 32 transition; 2, 32-bed special needs beds)
TOTAL BEDS		**344**		**544**

It is important to note that several of the housing units were oversized to allow for an element of flexibility in housing. For example, it would not be cost effective to design and construct a housing unit for the four protective custody offenders. Rather, the protective custody population will be housed similarly to other similar populations and county hold parole violators. These offenders may be housed in one of several areas

[105] The minimum secure beds (3) were combined with the minimum custody beds (391) for a total bed need of 394.

depending upon their classification and bed availability in reception, medical infirmary or other appropriate location.

Operating Principles

This section includes the operating principles for the proposed ICIW facility master plan at its full build out in 2027. As noted in the introduction, the operating principles consider the physical and operational criteria for managing offenders and also outline the general support and program operations. In addition, the operating principles incorporate the gender–responsive IDOC Policy Standards that appear in Chapter 6 of this report. These functional components are organized as listed below:

1.000 Administration
2.000 Staff Support
3.000 Security Operations
4.000 Reception
5.000 Release
6.000 Visitation
7.000 Programs and Services
8.000 Prison Industries
9.000 Support Services
10.000 Housing
- Minimum "live out" Custody
- Minimum Custody
- Medium
- Maximum
- Segregation (Intractables, pre-hearing and disciplinary)
- Reception

11.000 Medical/Mental Health
- Outpatient
- Inpatient Medical
- Inpatient Mental Health

Beyond the significant operational changes listed above there are many other more detailed assumptions that are listed in the operating principles that follow.

1.000 Administration

Major Components:

- Public Lobby
- Visitor Processing
- Reception area
- Offices for Administrative Staff

1. Administration will be located outside of the secure perimeter for all new construction.

2. To the degree feasible, the administrative support functions should be centrally located at the facility. All of the executive staff will be located in this component including information technology staff, personnel staff and personnel records.

3. The lobby/reception area will accommodate official visitors to the Administration as well as personal and professional visitation for offenders.

4. The Administration component should be located in close proximity to the Security Operations component to enhance a response to an emergency incident.

5. Unit management staff will be located within their respective management units.

2.000 Staff Support

Major Components:

- Roll Call room
- Offices for training, and accreditation staff.
- Training room
- Locker rooms
- Physical fitness

1. Staff support includes the locker rooms for male and female staff, the physical fitness room and the line up (i.e., roll call room) and ancillary spaces for supervisors to meet with staff during the shift change process. These spaces are located outside of the security perimeter.

2. The ICIW plans to begin roll call operations to share information between shifts and receiving brief training sessions. The roll call room, located outside of the secure perimeter, can be used as multipurpose space if activities are scheduled so that they do not interfere with shift change.

3. A facility Field Training Officer will be located in this component with the associated workspace.

4. A multipurpose training room is required for staff training. The training room should be sufficiently sized to accommodate up to 60 participants and divisible into two separate training areas. The room can be segmented through the use of moveable privacy panels. Computers will be located in this component to allow for computer program training for staff.

5. Training staff will be located in this area. A shared office for field training staff will also be provided.

6. Accreditation staff will have work space within this component. Although these staff may not be assigned on a full-time basis, sufficient space must be provided for file preparation and storage.

7. Appropriate support space such as restrooms, pantry, break room, file storage and copy/fax/mail functions will also be provided.

8. A dedicated fitness room for staff will be equipped with universal weight equipment. This space will be sized to accommodate at least one shift of personnel with locker space, etc., for all staff.

3.000 Security Operations

Major Components:

- Offices for security operations staff
- Investigator office / interview space
- Central control
- Ancillary control rooms for segregation housing or segregation.
- Armory
- CERT area

1. The security operations component includes the control rooms and associated spaces along with the security administration.

2. Central Control will be located in its own security zone. No unauthorized staff will be permitted in this area.

3. Ideally, the security operations staff will be located in close proximity to Central Control. The security operations component will be located inside the secure perimeter.

4. Like Central Control, an armory, an incident command center and emergency response team muster room will be located outside of the secure perimeter but within the same security zone as Central Control and accessible by vehicle, and ideally they will be visible either directly or by camera monitoring by staff.

5. Although control rooms will be limited as much as reasonably possible, they must be sufficient to meet the security demands of the facility and the population. Other than the control rooms listed herein, decentralized or remote control rooms will be design-dependent and required only if housing zones are not located in close proximity to the facility core. Central control will have total redundant control and can assume control of ancillary control rooms.

6. A separate vehicle sallyport control may be required to receive the high volume of vehicular traffic. This post may be staffed only during periods of high volume (e.g., day shift from Monday through Friday). At all other times, the controls will be transferred to central control. A drive through vehicle sallyport will be located in the Reception component.

7. A separate control room may be required at locations where more than 50 segregation offenders may be housed. This would provide secondary observation of units in activity areas when the housing staff are monitoring offenders on lockdown. The segregation population and the acutely mentally ill require the greatest supervision. Depending on the physical layout of the segregation housing, secondary observation of the unit (i.e., control room) may be considered.

8. The security operations staff, Corrections Emergency Response Team and space for the investigators and secure storage will be located in this area.

9. The armory will be located so that it is within its own secure perimeter but accessible by vehicle.

4.000 Reception

Major Components:

- Secured drive through vehicle sallyport
- Open seating
- Holding cells
- Work stations for processing, medical/MH screening
- Search / shower
- Property
- Offender records

1. The centralized Reception components include a secure entry, the offender identification, reception processing, offender waiting/ holding, property exchange and inventory, and medical and mental health screening. It is assumed that the admissions, release and transfers area will be located in close proximity.

2. The Reception area will include a series of screening stations to assess offenders' ability to be housed in Reception Housing.

3. Gender sensitivity is particularly important during the reception and orientation phase because the necessary security and safety activities (e.g., searches and personal interview questioning) during this process have the potential to trigger feelings that result from physical and/or sexual abuse. To the degree feasible, only female officers should be assigned to these functions.

4. Offender classification will be conducted once offenders are housed in Reception.

5. The Reception area is expected to eventually process more than 20 new admissions daily between 0600 and 1800 Monday through Friday.

6. A secure, drive-through vehicle sallyport will be located adjacent to the reception, transfer and release component.

7. The area will be operated using the open processing concept whereby 95% of the total population in this area will be assumed to be compliant throughout the process. These new admissions will sit in an open waiting area to be called to the station that is appropriate for the status of their processing.

8. The remaining 5% are those who are not compliant with the process, were combative in the transport vehicle, or are creating disruptions to the remainder of the population or have special needs. These new admissions would be held in one of two individual or group holding cells and will be processed as the appropriate staffing permits.

9. Off-ground work crews will be processed in this area therefore space will be provided for substance testing, personal property storage, electronic and paperwork processing.

10. Upon admission, the offender paperwork will be provided to the Reception Officer and offenders will be escorted to a shower area for search, inspection for infestations/infections and clothing exchange. Items that are not authorized in the facility will be mailed to the offender designee. Efforts will be made to modify this procedure in the future so that items that are not authorized are not received at the facility. The offender's property (both valuable and clothing) is inventoried and stored in the property room. Property storage is required including space for a property bank for offenders prior to release.

11. Offender identification will include administering a means of identifying the offender throughout their incarceration. This will be accomplished through biometrics and some form of identification system and entered into the ICON system.

12. Various stations will be provided in the Reception area. Offenders will wait in designated areas to be called or escorted to the appropriate station. The admissions stations include:

    a. Full admissions record including emergency contact information, verifiable enemies and other basic admissions information. A record and Offender Number will be generated at this time.
    b. Fingerprinting and photographing
    c. Medical/mental health screening – will be conducted prior to assigning housing. The screening will include taking vitals, blood draws, mental health screening (completed by mental health staff), medication review, tuberculosis testing, suicide ideation, etc. A small medical examination room will be provided for this purpose.
    d. PREA Screening.

13. Offenders who are not compliant with the process will be held in a single or group holding cell depending on the offender's behavior. Persons suspected of having a communicable disease will be taken to the medical infirmary. Parole violators who are extremely intoxicated or who require additional supervision (e.g., mental health concerns) will be located in a cell providing maximum supervision by booking staff. Upwards of four parole revocations are received each week.

14. When not undergoing processing, offenders will be staged in a waiting area that will include restrooms, and telephones. Reception processing could take from two to four hours to complete.

15. The admissions housing determination will be made by the Unit Manager based on information received during the reception processing. Unless there is a reason for specialized housing (e.g., acute mental health, medical, protective custody, PREA, etc), the offender will be assigned to Reception Housing described in Section 10.000.

16. Centralized and decentralized case management and institutional records maintenance will be provided at this location. Primary offender records will be entered into the ICON system. Hard copy records will be accessible in this area for up to three years.

5.000 Release / Transfer

Major Components:

- Release processing
- Offender identification verification
- Property exchange
- Offender waiting

1. The release component includes the release processing area, offender identification, offender waiting, and property release functions.

2. Offenders may be located in a subunit of the reception housing area prior to release or transfer. This practice will minimize the distribution of unauthorized property to other offenders prior to release. This area will also allow for intensive preparation for release to occur.

3. This function should be located adjacent to the Reception area so that in cases where transfers occur, these offenders can load onto the vehicle in the secure sallyport

4. A separate station will be required for staff to review release paperwork and to verify the offender's identity.

5. Space for a property bank of clothing or other supplies required for offenders upon release will be provided in this area.

6.000 Visitation

Major Components:

- Public lobby
- Visitor registration
- Visitor visitation station
- Offender visitation stations
- Contact Visitation

1. Visitation will be a combination of centralzed and decentralized visitation. Central visitation will typically be on a contact basis, while decentralized visitation will be via video visitation.

2. Personal and professional visitors will register for visits in the public lobby.

3. If video visitation is used, offenders would visit from video visitation carrels in their respective housing units. Carrels for up to 25 visiting groups system-wide will be provided and sized for up to three visitors at one time, but assuming an average of two visitors per carrel. If video visitation is used, the visitor site can be located off-site or even at other facilities or central locations so visitors are not required to travel long distances. The carrels are intended to provide reasonable visual and audio privacy for the visiting groups. Headsets may be a consideration; however they would require significant ongoing maintenance. High speed electronic infrastructure must be in place to accommodate video visitation.

4. Visitation for attorneys and professionals located off-site could also be conducted via video. At the facility space should be centralized to the degree feasible, and proximity to the public lobby should be considered to avoid having non-facility

personnel enter too far into the secure perimeter. Space for biometric positive identification of professional visitors should be considered.

5. A contact visiting area will be located in an interstitial space (its own security zone) with access through a secure sallyport from the public lobby and from a secure corridor of the facility.

6. The contact visiting area will need to support family interaction including the ability for mothers to bond with their children. A play area, program space and a kitchenette will be required to encourage family focused programming.

7. The contact visiting area will require multipurpose space for professional visits and parole hearings (live and via video). Two conference areas will be provided for this purpose.

8. A non-contact visiting area will be provided for offenders whose behavior would not support contact visitation. Although video visitation is anticipated in the facility, non-contact visiting booths will be provided as a backup system to in the event of short-term video electronics failures.

7.000 Programs and Services

Major Components:

- Library
- Academic/Vocational Instruction
- Religious Services
- Treatment Services
- Multipurpose program space.
- Computer stations in housing units
- Recreation yards.
- Hair care
- Commissary
- Personal Leisure Activities

1. To the degree feasible, program space will be centrally located with decentralized spaces located within each management unit.

2. A combination of paid and volunteer staff will be used to conduct programs. Volunteers will be screened at the public lobby prior to entry.

3. At least one multipurpose room for every 120 offenders should be provided, although it is anticipated that offenders may travel via pass or by escort to other designated areas for specific programs.

4. Offenders housed in the mental health or other specialized units would receive programming in their respective units. Offenders in segregation will be provided cell-side programming as appropriate.

5. The program space needs are based on the custody classification results described in the Bed Distribution Section at the beginning of this chapter and reflect the potential total number of offender program and industry assignments in the year 2027. The number of offenders eligible for programs was determined by applying the percentage of offenders eligible to the total number of offenders within the custody classification. The table that follows illustrates the potential number of

offenders anticipated to attend each program/service and the number of program spaces required to meet the program needs. While Industries is not a program, it was included here to illustrate the total number of offender slots being proposed.

TABLE 6
PROGRAM SPACES REQUIRED IN THE 2027

	Minimum	Medium	Maximum	Protective Custody	Total	#Classes/ Participants	Number of Spaces Required
Industries	166	166	5	1	338	25-50 workers	7
Vocational Programming*	332	133	10	2	477	15 participants	11
Academic Education**	331	110	10	1	452	20 participants	10
Treatment	200	240	10	2	452	20 per class / 22 classes per week	8

* Each vocational program is assumed to accommodate three program groups per day.
** Each academic program is assumed to accommodate two program groups per day.

6. Educational services are provided by the Des Moines Area Community Classes program will likely expand for high school level education programming. Educational assessment will occur during Reception. Post secondary education may be available through correspondence courses, etc., but will not be provided by ICIW as an organized program. Provisions for e-learning will be provided.

7. Life skills programming should focus on transition for minimum custody offenders preparing for release into the community. The logistics of the life skills program will not be impacted by the facility housing options described herein.

8. The multipurpose room can be used for religious programming as well as other programs although a Chapel will be provided. To the degree possible, multipurpose rooms should be located to minimize offender movement. Separate storage for distinct program functions should be provided in each multipurpose room. Where the multipurpose rooms are co-located, the storage areas could be shared by two multipurpose rooms with access to the storage area from each room. The distinct materials storage should include:
   - Religious
   - Educational
   - Substance abuse

9. A separate art and music room will be provided on a centralized basis. Hobby crafts will be available through the recreation/leisure time activities.

10. Library books will continue to be brought to the housing units by mobile cart, although a centralized library will be provided for book storage and for authorized

offenders to browse the library. Additionally, computer stations will be located in the library for digital library access.

- If the systems/electronic infrastructure is in place, a computer work station may be considered in the housing unit (e.g., in the interview room) to allow offenders to look up what books are available and to make a specific request for books/publications.
- The central library will be located in the programs area and sized to accommodate upwards of 45,000 volumes.
- Mobile cart storage is also required.

11. Law library services will continue to be provided by the State Public Defender's Office. As a supplement, an electronic means to include either a web based application or cd-rom will be provided. If this technology can be incorporated, the need for legal staff is not as critical, although at least one law associate would be required to oversee the operation.

12. A centralized hair care area should be provided in a centralized and supervised location.

13. Sufficient storage will be provided.

14. A centralized gym/fitness area will be provided and scheduled to allow management units to access the space on a scheduled basis. This area will serve a variety of functions including hobby crafts, arts and crafts and computer workstations behind glazed partitions that allow control of these areas with observation from the gym/fitness area. Along with the ancillary spaces, a large open area will be provided for major muscle exercise which may include a walking area surrounding a volley ball court or something similar. Space for leisure activities such as pool tables and ping pong tables will also be provided.

15. Space will be provided for the Whiskers (16 participants) and Paws (16 participants) Programs. This will require outside kennel areas and space for grooming and instruction. To the degree feasible, it is preferable if housing can be located adjacent or in close proximity to the program areas. This will minimize dander or other allergens to be transferred to areas of the facility where staff or other offenders may be impacted. A separate protocol laundry must be located in this area since clothing and linens, etc. may come into contact with pet waste products.

16. Vocational programming should include non-traditional opportunities for the women. Although hair-styling may be included in the programming, it will not be a focal vocation; rather carpentry and other non-traditional vocations will be the focus. The Iowa Work Initiatives may provide staff in the facilities.

17. A career resource center will be provided with several banks of computers to for testing purposes for Work Force Development and education levels.

8.000 Support Services

Major Components:

- Maintenance shops
- Laundry operation
- Warehouse
- Chillers and boilers
- Access to loading dock and secure staging
- Kitchen
- Commissary

The support services component includes the maintenance, laundry, kitchen, storage functions, and recycling for the facility.

Maintenance

1. Space for facility maintenance will be centralized to avoid unnecessary duplication (e.g., key/lock maintenance). The maintenance staff and operation should be located outside of the security perimeter. A basic maintenance workshop is required with sufficient spare parts, maintenance supplies and tool storage.

2. Maintenance activities will include landscaping, snow removal, and general facility maintenance. Specialty maintenance activities such as welding, lock repair, woodworking, HVAC, complex electrical, and plumbing, security camera and electronics repair, and complex vehicle maintenance are outsourced or performed elsewhere (the ICIW is expected to continue to maintain their ten transport vans).

3. A storage garage should be provided for upwards of ten vehicles ranging from a snow tractor with blower to a series of push mowers. Two vehicle maintenance bays are required.

4. Space should also be provided to accommodate vocational training related to automobile detailing.

5. Storage for maintenance equipment must be provided. Separate rooms are required for substantially distinct components such as the information systems parts. A small storage area inside the compound is necessary where a tool crib that contains routinely needed Class B tools can be stored and is conveniently accessible to maintenance staff. A locked maintenance cart that maintenance can roll into and out of facility each day will be considered in lieu of the storage area inside the perimeter.

6. It is preferable to have a remote central energy plant building located outside of the secure perimeter. The components of this building will include chillers and boilers.

Laundry

7. A combination of centralized and decentralized laundry services will be provided. Most general population offenders will access laundry washers and dryers on their housing unit to wash personal underclothing and uniforms. Linens, blankets and other bulk items (e.g., coats) will continue to be washed centrally. These items will be exchanged on a scheduled basis.

8. State clothing and linens will be distributed on a scheduled basis. Space for issuing this property will be located in an area easily accessible to offenders for laundry

exchange. (One side with access to State issued items and the offender – and one side will be the laundry).

9. The decentralized laundry may include consideration of token operated commercial washers and dryers in each unit (indigent women would continue to have their personal clothing laundered at no cost in the central laundry. In this case, their personals laundered for free at ICIW laundry) or where a detail worker washes women's personals in small batches to save water & reduce machinery breakdown.

Warehouse

10. All requests for supplies will be centralized through the warehouse supervisor. The business office will coordinate with the centralized warehouse supervisor but is responsible for setting up contracts and purchase orders through the Central Office, but otherwise does not intervene in the day-to-day ordering.

11. The warehouse will be located outside of the perimeter; a small staging area may be located inside the perimeter to reduce the number of times the perimeter is breeched. Space will be required for appropriate receiving areas whereby supplies, laundry, etc. will be loaded and unloaded. A multi-bay loading dock is required to meet these functional requirements. Supplies are expected to be delivered by the provider several times each week. The space must be sufficient and appropriate to accommodate separate and palletized storage including paper goods, mattresses and up to seven days of needed supplies. Some food supplies will be stored for up to six months. If the maintenance building and warehouse building are located in close proximity to each other, the loading dock can be shared.

12. Appropriate ventilation and climate control is required for paper goods and storage of bio-hazardous and other potentially hazardous materials.

13. The warehouse will also be sized to accommodate up to 180 days of storage for food items including dry, cooler and frozen storage.

Kitchen

14. A combination of centralized and decentralized kitchen operations will be required. Offenders will assist in food preparation, tray assembly and dishwashing.

15. Sufficient space for food storage, preparation, cooking and tray assembly is required. Additional space for washing carts, carriers, pans and trays is also required. A training room for classroom instruction will be included to support a culinary arts program.

16. Dry, cold and freezer storage in the kitchen should be sufficiently sized for storing up to seven days of meals.

17. Three adjoining dining rooms and serving lines with each sized to seat 128 general population offenders is required. This will permit meals to be served in an expedited manner affording more time for offenders to attend their programmatic and industry or work related daily activities. Decentralized food services will be provided for segregation offenders and other specialized populations who should remain separate

from other populations (e.g., medical, protective custody). Space for staff dining is required at each facility.

18. A separate loading dock bay will be provided at the kitchen storage area so that supplies and perishable food product can be unloaded.

Commissary

19. The existing commissary operation will continue in the future with Iowa Prison Industries bagging the commissary items and with the majority of the ICIW population receiving their commissary from a central location. Commissary staff will use the loading dock shared with the kitchen for offloading commissary orders and place them in a central staging area.

20. Offenders in general population will come to the central commissary staging area where they will queue in a weather protected environment to receive their orders. Three pass-through windows facing into the staging area will be provided for this function. Other offenders who cannot freely walk through the compound will receive their commissary in their respective housing areas. Commissary bags will be alphabetized to speed up commissary distribution.

9.000 General Population Housing – Overview

There are many variations of housing requirements based on the classification plan and projected offender populations. The population and security requirements for each custody level are outlined in the policy standards and summarized in this section. Technology tools will be put in place to maximize staff's ability to roam the unit to better manage the population.

The relevant classification policies were provided during the site visit. These definitions are included since they are the current custody classification designations. These definitions may be modified following the revised classification system.

All housing will operate under the unit management concept whereby a unit manager oversee a grouping of housing units, assigned staff and relevant programs to meet the education and treatment needs of the population.

A shared support area will be provided at each unit grouping that will include the following:

- Classrooms
- Group Rooms (2)
- Storage
- Laundry
- Triage Room
- Unit Manager Office
- Correctional Supervisors (shared office)
- Counselors
- Clerical Support
- Staff Meeting/Break Room

- Staff Restrooms

Minimum Custody (Also includes offenders who work outside of the institution and the animal care programs)

Major Components:

- Open, podular design 4-person cubicles or dry rooms
- Interview room
- Staff work station
- Dayroom
- Visitation carrels
- Recreation areas

1. Minimum – Custody grade assigned to offenders considered to be a minimal escape risk and who demonstrate stable behavior. During movement or work assignments outside of the perimeter, appropriate restraints and continuous immediate correctional supervision is employed to prevent escape and protect the community. There are two additional populations that would be similar in the custody requirements as minimum custody. These are the minimum secure offenders who, but for their remaining sentence of one year or more, would be eligible for minimum work out status.

2. Minimum Work Out – These are offenders designated to work outside of the perimeter and return inside following each work shift. These offenders will be under correctional supervision (i.e., supervision by trained correctional officers or trades leaders; or by other correctional staff or staff from other agencies who have been trained by the IDOC) and observed at least once every two hours. Offenders returning from a work detail outside of the perimeter will be search, identified and accounted for prior to the end of the shift. Medium custody offenders who work outside of the institution without restraints will be housed together with and managed similarly to minimum custody "work out" offenders. Medium custody offenders authorized to work outside of the secured perimeter will be observed at least every ten minutes.

3. Offenders in minimum work out status are those who are eligible to work outside of the facility. These offenders will be housed along with the ***medium*** custody work out offenders.

4. Animal care programs (i.e., Whiskers and Paws programs) are available for offenders whose custody level and behavior while in the facility warrant placement into this highly desired program. These programs are separate programs but the housing configuration should be somewhat similar. For example, the animals are expected to live in the housing unit; some of the animals may actually sleep in the offender rooms. There will also be outdoor area where offenders can work with their assigned animal, although this space will primarily be used for dogs. Depending on the final configuration of this unit, it is important operationally that the Paws program be located on the ground level adjacent to the interior and exterior canine training areas. The flooring will be easily cleanable and storage for pet foods will be provided.

5. A comprehensive substance abuse therapeutic community currently operates at the ICIW. These programs will continue to operate in the future in minimum custody housing.

6. Open dormitories or double dry rooms housing 64 offenders (or up to 96) in a dry room configuration may be used to house minimum custody offenders. These offenders will be classified as minimum custody based on their continued positive behavior and compliance with the rules. Housing for minimum custody and minimum "work out" custody offenders will be housed similarly except that they will be housed in separate units. Minimum secure offenders will be housed with minimum custody.

7. Many of the offenders will be participating in programs or preparing for work opportunities or release, so it is expected that a significant percentage of these offenders will not be using the dayroom space at the same time (i.e., more than of 50% will be out of the unit during program periods.

8. All minimum custody housing will be operated as direct supervision with one Officer supervising the unit.

9. Movable bunks may be utilized for this population.

10. Vitreous china toilets with lid, sinks and showers may be centralized in the units or otherwise located to provide easy access and to accommodate design needs.

11. Additional spaces provided in minimum custody housing would be interview rooms, beverage station (i.e., juicer, hot/cold water), and three seating areas. The seating areas may include television viewing, group rooms or reading rooms or any combination thereof. Up to three kiosks or carrels are required in each housing unit for two video visitation stations and one intranet capable computer for legal and recreational library access.

12. Sufficient seating and tables should be provided for all offenders at one time. The moveable seating can be relocated to television or activity areas as necessary.

13. All offenders who are not working during meal hours will be expected to report to the dining room at the scheduled time for meals. Offenders who are too sick to walk to the dining room would likely be housed in the medical infirmary.

14. Management unit staff and support space (e.g., classrooms and offices) will be provided for the minimum custody housing. This space will be sized larger than the other management unit support spaces as they will have to accommodate additional program staff and program operations (e.g., search rooms, training space dedicated to the Paws and Whiskers program, etc).

Medium Custody

Major Components:

- Podular Design
- 10% single and 90% double cell housing.
- Interview room
- Staff work station
- Dayroom
- Visitation carrels

15. Medium - Custody grade assigned to offenders presenting moderate risk to the community based on the committing offense, escape risk, threat to other offenders, or chronic behavioral problem.

16. Up to 72 medium custody offenders may be housed in either 2-person cells or single cells (90% double/10% single). Work force offenders may require single cell housing due to their work schedule or perhaps as an additional incentive for working.

17. All medium custody housing will be operated as direct supervision with one officer supervising the unit.

18. One housing pod will be designated as a therapeutic community.

19. Metal bunks may be utilized for this population. The cells will be equipped with toilet and sink however they may be vitreous china fixtures. Sufficient toilets and sinks are required in each housing area to meet accreditation standards. Showers can be centralized in the common areas or they can be located within the housing area, provided that the minimum number of showers is provided.

20. Offenders are expected to use the adjoining dayroom when they are not sleeping, therefore the dayroom space should be sized to accommodate all offenders at one time.

21. Additional spaces provided in medium custody housing would be interview rooms with intranet access for legal and recreational library access, beverage station, video visitation carrels, and three seating areas. The seating areas may include television viewing, group rooms or reading rooms or any combination thereof.

22. Appropriate security technology, to include computerized watch tour systems and hand held door controls should be available for staff in medium custody housing.

23. All offenders who are not working during meal hours will be expected to report to the dining room at the scheduled time for meals. Offenders who are too sick to walk to the dining room would likely be housed in the medical infirmary.

24. Recreation will be centralized and will include a combination of indoor and outdoor options and both physical and leisure activities such as crafts.

Maximum Custody

Major Components:
- Podular design
- 10% Single and 90% double cell housing
- All cells are wet
- Interview room
- Staff work station
- Dayroom
- Visitation carrels

25. Maximum - Custody grade assigned to an offender considered to be a serious community risk due to the violent nature of the committing offense, escape risk, threat to staff or other offenders, or chronic behavioral problem.

26. Single and double cell housing for up to 56 offenders per housing unit is required for this population. The cells would be configured in a pod design with a mezzanine. This unit is sized larger than the anticipated population of 30 to ensure there are sufficient future beds to meet the need as these beds are more expensive than lower custody beds.

27. All high custody housing will be operated as direct supervision with one officer supervising the unit.

28. Metal bunks may be utilized for this population. The cells will be equipped with toilet and sink however they will be vitreous china fixtures with lids.

29. Additional spaces provided in maximum custody housing would be interview rooms, beverage station, video visitation carrels, and three dayroom seating areas. The seating areas may include television viewing, group rooms or reading rooms or any combination thereof. Infrastructure should be put in place to support programs such as e-learning and law library access to supplement the public defender resources.

30. Appropriate security technology, to include computerized watch tour systems and hand held door controls, must be available for staff in maximum custody housing.

31. All offenders who are not working during meal hours will be expected to report to the dining room at the scheduled time for meals. Offenders who are too sick to walk to the dining room would likely be housed in the medical infirmary.

32. An adjacent recreation area is preferred for maximum security housing, however most offenders will use the centralized indoor and outdoor recreation areas.

Segregation Housing

Major Components:

- Single cell housing
- Interview room
- Staff work station
- Dayroom
- Visitation carrels

33. The segregation population includes disciplinary segregation, administrative segregation (i.e., intractables and pre-hearing detention) whose behavior requires the highest level of security). To the degree feasible, these populations should be housed in separate units but with access to a shared corridor to the remainder of the facility.

34. Single wet cell housing for up to 32 offenders per housing unit is required for this population.

35. Appropriate security technology must be provided for this population to include: watch tour system, duress system, and hand held door controls.

36. Consideration may be given to locating disciplinary segregation and perhaps administrative segregation offenders in closer proximity to the centralized functions and primary support services as these populations will have virtually all services brought to them. These services include:
    - Legal and professional visits
    - Meals
    - Programs (e.g., religious services)
    - Medical
    - Psychological

37. A controlled access area is required for the temporary storage of offender property that is permitted in general population but is not permitted in segregation.

38. Concrete, fixed bunks are required for this population. Each cell will be equipped with stainless steel toilet/sink combination unit. All cell doors should be equipped with food slots. Offenders will eat primarily in their cells although opportunities to eat in the dayroom in small numbers will be provided.

39. Interview rooms, video visitation carrels, and a small seating area will be provided in the dayroom.

40. A control room with visibility into all three units is required. This control room should also provide direct observation of offenders who are in acute mental health crisis if possible.

41. Cameras, monitored by either zone control or central control, are required in the dayrooms with visibility to cell fronts.

42. Recreation will be provided in individual recreation yards located adjacent to the housing areas.

Reception and Orientation Housing

Major Components:

- Single cell housing
- Interview room
- Staff work station
- Dayroom
- Visitation carrels

43. Dedicated housing will be provided for the 100 anticipated offenders expected to be housed in Reception Housing. Offenders will generally be housed in this unit for two to four weeks during which time they will undergo a series of detailed assessments and orientation to the facility and the rules and regulations.

44. Gender sensitivity is particularly important during the reception and orientation phase for the reasons described in Reception processing.

45. The reception component is based on a team concept with the various service providers working together to determine the appropriate housing and treatment provision for the offender.

46. Single cells would be provided for this population. The housing requirements will be comparable to maximum custody housing since there may be very little information available about the potential behaviors. A small subunit of eight cells will be provided for housing offenders who may require separation from the remainder of the population (e.g., protective custody, competency evaluations, county holds, etc.)

47. Classification requires space for staff assigned to the component; classification should be located in close proximity to central records if the automated information systems technology is not sufficient to reduce paper flow. Classification staff require access to inactive and active offender records.

48. Additional assessments will include the application of the Jessness Inventory, Level of Service Inventory – Revised for classification and treatment needs. The intake counselor must be a BFOQ[106] position. Function specific assessment may also include:
    - Psychologist – intake screening
    - Substance Abuse assessment
    - Medical and Dental Screening

49. Space is required for offenders to undergo orientation that include distribution of the rule book, overview of PREA[107] and other operational considerations. Approximately 4-5 orientation sessions are scheduled per month.

50. When appropriate, these offenders will eat in the dining room separate from other offenders. The dayrooms will sized to allow for this population to eat in the dayroom if necessary.

[106] Bona Fide Occupational Qualification – in this case, only female intake counselors should be assigned.
[107] Prison Rape Elimination Act

51. A sub-unit of up to four rooms for release/discharge/transfer will be provided to prepare offenders for their release or transfer.

10.000 Medical/Mental Health

Major Components:

- Outpatient medical and mental health care
- Clinic for inpatient care
- Negative pressure rooms
- Pharmacy
- Video visitation
- Sufficient storage

1. The institution will be equipped for outpatient medical and mental health care including overnight infirmary care and medical screening.

2. The outpatient medical and mental health care components include initial screening, triage, sick call, and pharmacy.

3. Clinics will likely increase if national trends of offenders requiring more medical care continue at the current rate. This impacts both the number of exam rooms and the holding areas for offenders waiting to be seen.

4. Examples of clinics that will likely expand include:

   - Obstetrics/Gynecology
   - Chronic Illness
   - Specialty clinics such as on-site dental extractions
   - Wound care
   - Mammograms
   - EKG
   - Mobile Unit Radiology
   - Laboratory
   - Optometry

5. Dialysis will occur at IMCC or UIHC. Offenders with high risk pregnancies or those within three weeks of delivery will be moved to the IMCC for specialized treatment and ready access to the University Hospital. However, with subacute, skilled nursing care available at both IMCC and ICIW, those hospital stays will often be of shorter duration. In addition, for female offenders who require nursing home level of care for the remainder of their sentences, efforts will be maximized to return them to the community where they can receive the appropriate level of nursing and medical care.

6. Triage areas are required in each housing cluster so that the providers can perform some medical triage as well as medication administration on a decentralized basis.

7. Provisions for video telemedicine will be provided at the infirmaries and in each examination room located in the outpatient medical component and triage rooms in the housing unit.

8. A system-wide centralized pharmacy will likely be located at IMCC; however, there will be a small pharmacy storage area at each facility. In support of primary care

nursing, medication administration will be decentralized. Medication will be packaged for offenders at the centralized pharmacy within each facility and then the medical staff will transport the medication via secure medication cart to the designated decentralized area where the medication will be dispensed as directed. If possible, offenders should be directed to the triage area (if sufficiently sized) to receive medication. Medical staff and a security escort officer will be present for this function. If the triage area is not sufficiently sized, medical staff will proceed directly to the housing unit where medications will be dispensed. The extensive use of SAMS (Self Administered Medication System) will continue.

9. Sufficient storage will be provided for storing medical supplies, gurneys, wheel chairs, etc.

10. At least two dental chairs will be provided so that the dentist can attend to more than one patient at a time. A dental hygienist is also required.

11. Sufficient Laboratory space to perform in-house lab services.

12. A break room for medical staff will be provided.

Inpatient Medical Care

13. Inpatient medical beds include the infirmary, assisted living and hospice care. If necessary, offenders who require separation from the general population (i.e., protective custody offenders) may be housed in one of the units where their classification and the housing availability can be met. The use of medical beds can include a variety of different types of illnesses or conditions that may change over time. Examples of the bed needs include the following:

    a. Post operative care
    b. Long term medical care
    c. MRSA – negative and positive pressure
    d. Hospice Care
    e. Detoxification

14. The IMCC will be an option for expansion or a consideration for serious medical conditions. The determination of the appropriate housing facility will be made by the medical care provider and the facility administrator. It is anticipated that female offenders who require prolonged infirmary care will be treated in the new infirmary at IMCC.

15. Most of the population requiring a medical bed can be co-mingled in terms of their medical condition as long as the appropriate security requirements and access to appropriate health care can be provided. Therefore, all medical housing must provide for a high degree of flexibility.

16. Skilled nursing care includes a combination of single and double rooms, and open dormitories equipped with hospital beds.

17. Offenders who are ambulatory but do not require 24-hour nursing care can be housed in general population in close proximity to the medical component.

18. Negative pressure rooms are required at the centralized medical component. Negative/positive pressure single cells constructed as maximum custody will include an ante room. Higher security rooms with low bunks and high visibility will be provided for offenders who are in Suicidal or Self-Injurious behavior status (SSIP).

19. Visibility by both medical and security staff is a critical issue for offenders in infirmary care.

20. A combination of single and double rooms will be constructed to meet the custody and security requirements of the populations to be housed here.

21. Dormitory beds in a ward environment will be constructed as minimum custody (some hospital beds will be provided in this unit).

22. If beds are available, inmate medical workers will be located within the medical unit to assist with hospice and suicidal inmates. This vocational program aides in teach skills necessary to serve as a medical assistant.

23. Meals will be served in the housing unit for those that are not mobile. Non-mobile offenders will go to the central dining room depending on their level of care. Several fresh air courts will be located conveniently to the housing areas for this population. ADA compliant program space will be provided including space for individual and group treatment programming and leisure activities. Library materials will be brought to the units on carts.

24. Video visiting kiosks will be provided. Offenders will go to the central visiting if they are ambulatory.

Inpatient Mental Health Care

25. Inpatient mental health includes acute crisis, transition, and offenders who are low functioning requiring SNU (special needs unit) housing.

26. Acute crisis offenders are those who are experiencing acute episodes of serious mental illness, acute situational distress, and/or risk to self or others. Treatment will be primarily psychotropic medication to rapidly stabilize the offender's mental status. Sixteen beds will be dedicated for housing this population. These beds need to have sound isolation from each other as well to other units. Each two cells will be accessed from a vestibule separate from the other cells. Persons undergoing competency evaluations may also be housed in this component if necessary. The acute crisis unit could be located adjacent to segregation housing solely for the purpose of improving observation from a control room.

27. The transition population includes offenders in need of extended psychiatric treatment or when treatment in less intensive housing has proven to be ineffective in maintaining an offender's stable mental status. The transition housing operates as a "step-down" unit from the acute crisis unit to either a special needs unit or general population depending upon the functional level of the individual. The transition offenders will be housed in a mixture of single and double cells. Space for transition offenders will be provided using the same physical plant standards found in the

maximum custody housing. The transition offenders could be located adjacent to, but separate from the acutely mentally ill population. This population should be located in a sub-housing unit that has a fully glazed wall separating the sub dayroom from the larger adjacent dayroom.

28. Special Needs Units (SNUs) will house persons who are low functioning or whose serious mental illness or cognitive impairment compromises their ability to function with general population offenders. These offenders will require less intensive mental health treatment than those housed in acute or transition housing, but will require more intensive treatment, structured programming, and a higher level of observation than that available in general population because they are unpredictable and vulnerable. These general population housing units will be constructed as a mix of single and double celled housing. The construction of this unit will be comparable to a typical medium custody unit.

29. Most of the acute and transition programming will occur within the housing unit, although the transition population may be permitted to attend programming with special needs population as their treatment plan permits. In these cases, the co-mingling of transition and special needs offenders will be on a trial basis for those individuals who will transition to the special needs housing. All meals for acute and transition populations will be served in the housing units. Recreation areas, or fresh air courts, will be provided in areas adjacent to the housing units.

30. The special needs population will be encouraged to eat in the centralized dining room in an area separate from the general population. Offenders who would not be able to cope outside of the unit may be permitted to stay back in the housing unit.

31. Recreation and other activities will be provided on a centralized basis but at time other than when general population offenders are using these spaces. A separate area will be provided within the inpatient mental health component for offenders to access recreational and program activities. This ADA compliant program space will include space for individual and group treatment programming and leisure activities. Library materials will be brought to the units on carts.

11.000 Minimum Live Out (MLO)

Major Components:

- Open, podular design dormitories
- Interview room
- Staff work station
- Dayroom
- Visitation carrels
- Recreation areas
- Appropriate common plumbing fixtures

1. This population is for offenders who meet the classification for minimum live out. These offenders have demonstrated consistent stable behavior and require only limited custodial supervision. This population can live and work outside of the secure perimeter without constant supervision by staff.

2. The MLO should be located in close enough proximity to the perimeter so that the housing could be enclosed within the perimeter if a fence was constructed around the MLO with an opening into the secure campus.

3. Eligibility for the program is generally defined by the institution in which the offender is housed; however, all of these offenders have 18 months to their mandatory release date or one year to their minimum release date.

4. The focus of this program will be to assist offenders to gain employment and make connections in the community. For those offenders who have completed programming within the facility, programs addressing relapse prevention and reinforcing major components of the institutional based program will be the focus.

5. The minimum "live out" population will be housed outside of the secure perimeter of the institution. For planning purposes, we are assuming 66 beds. An intrusion fence will surround this facility to prevent unauthorized persons from entering the area.

6. The minimum "live out" facility will be self contained to the degree feasible. Only under limited circumstances (e.g., medical infirmary housing) will offenders enter the secure perimeter, and most of the operations occurring inside the perimeter will be handled in this facility but on a much smaller scale. Meals will be brought from the institution and served in serving carts; personal laundry will be washed at the unit level with blankets and sheets being exchanged and then laundered in the institution.

7. Open dormitory podular design housing will accommodate up to 64 offenders may be used to house minimum "live out" custody offenders. Offenders will sleep in four-person cubicles. One officer per housing unit will provide direct supervision of the offenders.

8. Many of the offenders will be employed or participating in job searches or community based program, so it is expected that a significant percentage of these offenders will not be using the dayroom space at the same time (i.e., more than 75% will be out of the unit during program periods).

9. Movable bunks may be utilized for this population.

10. Vitreous china toilets with lid, sinks and showers may be centralized in the units or otherwise located to provide easy access and to accommodate design needs.

11. Additional spaces would include interview rooms, beverage station (i.e., juicer, hot/cold water), and three seating areas. The seating areas may include television viewing, group rooms or reading rooms or any combination thereof. Up to three kiosks or carrels are required in each housing unit for two video visitation stations and one intranet capable computer for legal and recreational library access. Sufficient seating and tables should be provided for all offenders at one time. The moveable seating can be relocated to television or activity areas as necessary.

12. Contact visitation will be provided on a scheduled basis in the visiting area.

13. Office space should be sufficient for all facility and community corrections staff. Centralized meeting space should be provided in this component so that the various component staff can discuss offenders seeking placement on more than one program.

14. A pantry and staff and resident restrooms should be located in this component.

15. A processing area will be provided for offenders to change into an employer uniform (e.g., Department of Transportation) or facility attire. This area should include storage for offender property when going to court, etc. All offenders returning to the facility will be searched for contraband. Two additional restrooms should be configured for monitoring urine screenings.

16. Provide storage for offender uniforms and other offender clothing.

17. Sufficient parking will be provided for program participants and staff.

12.000 Prison Industries

Major Components:

- Industry work space
- Industries storage
- Administrative offices
- Loading dock access

1. ICIW needs to begin to develop a work plan which increases gender responsive work opportunities for prison industries for both the general and special needs populations.

2. The current prison industries include the following:

    - Construction of Chairs
    - Upholstering modular systems
    - Printing
    - Archiving records on compact disks
    - Data entry
    - Picture frame assembly

3. A committee should be formed to address equally viable, but perhaps more gender responsive and non-traditional industries that support partnership programs.

4. It is desirable to locate the industries so that offenders do not have to move by vehicle to access the individual industry program.

Macro Space Program

The macro space program needs define the square footage requirements necessary to ensure the site is sufficiently sized to accommodate the anticipated spaces (whether new or renovated) to operate the ICIW based on the projected population of 1484 offenders and the policy standards. While the infrastructure, program and support space are sized for the 2027 projected build-out needs, the housing components are being planned for the initial Phase 1 population of 888 offenders. Although this table does include support spaces and new housing, it does not include the existing housing units. Table 6 represents the general space requirements within each component described above. These figures are based on the information provided during the planning team discussions, the policy standards and the experience of the consultants. It does not represent a detailed space program that would be developed from an operational program describing the facility operations; rather it is an approximation of the space requirements.

Table 6
SUMMARY OF SPACE NEEDS

2017 New and Renovated Space for Phase I ***Infrastructure To Support the Potential 2027 Offender Population Of:*** **1484 offenders**		
Functional Components	**New Space (square feet)**	**Existing Space (square feet)**
1.000 Lobby and Administration	10,000	
2.000 Staff Support	12,000	
3.000 Security Operations	5,000	
4.000 **5.000 Reception; Release and Transfer**	7,000	
6.000 Visitation	10,000	
7.000 Programs and Services[108]	15,850	18,150
8.000 Support Services • ***Food Service***	5,320	8,680
• ***Laundry***	3,000	
• ***Maintenance/Central Plant (includes vehicle maintenance)***	9,570	4,430
• ***Warehouse***		37,000[109]
• ***Commissary***	2,000	
9.000 Housing		
Medium Security: 192 Beds **Three, 64bed -double occupancy cell units total (with 1 Unit Management Component)**	33,000	
Reception Housing: 64 Beds	14,500	
Maximum Custody: 32 Beds **One, 32 bed single occupancy maximum custody unit**		8,250
Segregation Housing (including segregation housing and shared control room):64 Beds **One, 64 bed single occupancy special management unit**		16,140

[108] Total space is 34,000 s.f. without the existing Chapel (4,000 sf)
[109] This space is the existing IPI building which will become the new warehouse.

2017 New and Renovated Space for Phase I ***Infrastructure To Support the Potential 2027 Offender Population Of:*** **1484 offenders**		
Functional Components	**New Space (square feet)**	**Existing Space (square feet)**
Minimum Security Unit: 128 Beds • **One, 64 bed double dry room unit;** • **One 32 bed double dry room Minimum/ Medium "Work Out" unit** • **One, 16 bed double dry room unit for Paws** • **One, 16 bed double dry room unit for Whiskers** **One, unit management component and animal training area**	24,000	
Existing Minimum Custody: 184 Beds		22,300
10.000 Medical and Mental Health: 160 Beds		
• **Outpatient Medical and Mental Health Services**	8,000	
• ***48 Medical Inpatient Beds: 16 beds single occupancy, 16 beds double occupancy, 16 bed ward***	9,000	
• ***112 Mental Health Inpatient Beds: 16 bed Acute, 16 bed Transition; two 32 bed Special A mixture of single and multiple occupancy***	34,500	
11.000 Minimum "Live Out" – 66 Beds[110]	8,500	9,040
12.000 Prison Industries (Site design should allow for an additional 22,000 s.f. of space for future expansion.	37,000	
Subtotal GSF	248,240	
Facility Grossing Factor: 10%[111]	21,600	
Total New Square Feet	269,840	
Parking		120,000*

*A staffing study has not been conducted, therefore the parking figures are assumed.

[110] The existing housing will be supported by a new program and support building of 8,500 sf.
[111] The 10% factor was not applied to the new industries building as the 37,000 sf allocated reflects the total building allocation

ICIW Master Plan

The following sections outline the process for developing the master plan and cost projections for ICIW. The first step was to take the physical plant analysis of the campus from the Phase I Master Plan and overlay the Operating Principles and Macro Space Program from the prior section to determine how the campus could best be developed for future growth and expansion. In this regard a more refined evaluation of the existing buildings was completed to see if there was an appropriate fit between the operational, spatial and physical condition of existing buildings and their potential re-use. This analysis appears below.

ICIW – Existing Building Functional Adequacy Assessments

Existing Medical and Laundry Building (*proposed for demolition*)
The existing Laundry and Medical services are not sufficient to support the increased population of the Campus. To satisfy the future needs of these services, new facilities need to be provided. As a result the existing 6,000 sq. ft. building could be available for repurposing as program space, however, it is not configured to properly accommodate this function. The building's age and condition would require system upgrades in order to be repurposed. Also, due to the location within the campus, it inhibits the construction of a new programs and future housing buildings. With these concerns, the Team concluded more benefit would be gained by removing the building and constructing new space that would be designed to better house future program spaces instead of adjusting the program to fit the space.

Housing Units 1, 2, 3 and 4 (*proposed for demolition)*
Because of their age and current condition, along with the existing configuration that is not conducive for proper supervision, the team is proposing removing them. The Whiskers and Paws Programs which are located in these units would be housed in the new housing building where the spaces can be properly designed to accommodate the specific needs of these programs. Removing Housing Units 1 and 2 would functionally connect the existing campus courtyard with a new courtyard configuration extending west. The new courtyard will be formed by the construction of the new housing and program buildings. Connecting the existing and new courtyards increases supervision capabilities.

Housing Unit 5 (*proposed for demolition)*
Being the oldest building on Campus and requiring extensive repairs, Housing Unit 5 has deteriorated beyond the point that would be feasible to renovate and was recommended for demolition in the Phase I master Plan Report. Moreover, like Housing Units 3 and 4, the configuration of the cells is not conducive to sound supervision. As a result, the Team is recommending removal of Building 5. Removing Housing Unit 5 would further physically and visually connect the existing and new areas of the campus.

Housing Unit 6A and 6B
Housing Units 6A, constructed in 1991, and 6B constructed in 2001 are in good condition. The configuration of the cells and dayrooms work well for their intended housing purpose however, infrastructure / maintenance repairs are needed. The building requires repairs to function properly at housing unit 6A including the installation

of proper flashing at the roof to prevent water infiltration and upgrading the door control systems.

Housing Unit 7 and 8

Constructed in 1991, Housing Units 7 and 8 are in good condition and will house only the minimum-live-out offender population or the violation program if it continues to exist. Both units would require repairs and upgrades to continue serving the offenders. A new program and support building will need to be constructed adjacent to the housing building to allow the minimum-live-out compound to operate autonomously.

Housing Unit 9

Being the newest building on campus constructed in 2000, Housing Unit 9 does not require much repair or renovation. However, due to a construction defects, the building has water infiltration issues. This defect will need to be corrected. Also, work needs to be done on the exterior exit doors of the units to reduce air infiltration. They asked for a weather vestibule there.

Food Service, Laundry and Commissary

With the increase in the offender population, the campus will require more dietary and dining facilities. The existing kitchen and dining building will remain with alterations to the kitchen and conversion of the existing dining area for food production along with increased equipment to increase the production of meals. This would require relocating existing food storage to a new adjacent structure. This addition would then contain the relocated food storage, additional food storage as well as new dining areas for the offenders. The addition would also contain private dining areas for staff and guests. Also, contained in the addition, would be the new laundry facilities. As previously stated the current facilities would not meet the needs of the increased population. The new facility would have the capacities to service the future needs of the campus. The laundry is located adjacent to the Food Service building delivery area for ease of deliveries of detergent and cleaning supplies.

Existing Administration Building

Originally this building was designed as a school with classrooms and a gymnasium when opened in 1950. This building can easily be renovated to accommodate offender programs. Even though the building is in good condition and does not need many major repairs, new system upgrades such as heating and cooling, electrical and data/communication and handicap accessibility are required in order for the building to be used effectively for expanded and new programs. The building recently has had a roof replacement but the windows will need to be replaced to increase energy efficiency of the building envelope.

Central Plant/Utilities

The buildings of the current campus are supplied by one central physical plant through a series of underground tunnels. To supply the new buildings, the existing systems will need to be upgraded and additional mechanical systems installed along with modifications to the current tunnel system that will need to be extended along with new tunnels. To accommodate the upgrades and new mechanical systems the Central Plant Building will require an addition. With the increased demand, a larger electrical service will be required and the sanitary sewers evaluated for sufficient capacity as well as increased storm water runoff management.

ICIW – Master Plan Design Concept

The Iowa Correctional Institution for Women (ICIW) currently has a bed capacity of 443. Combined with women offenders from IMCC (70 beds) and MWU (92 beds), as well as ICIW operating bed count at 557, the February 2008 operational capacity for women offenders was projected to be 719. In order to accomplish the long-term planning objectives on the ICIW campus specifically, gender specific responsiveness to programs and services, reception, medical and mental health treatment needs, additional housing capacity, and improved administrative support it was determined that the campus would need to change orientation by expanding to the west. With the removal of Building Units 1, 2 and 5 future buildings will be organized around the expanded West Yard.

Approaching from the north, parking has been relocated between the existing Prison Industries Building on the northern end of campus, the Central Plant to the east, and the new Administration, Medical & Mental Health Housing, and Reception building(s) on the south. By reorienting the public components to the northern edge of campus, improved access to services and way-finding will occur. Additionally, it is recommended that a new Prison Industries Building be built west of the Unit 9 (Therapeutic Community Building) to reduce transportation of offenders and promote direct access to industry programs. The existing industries building will be converted to a central warehouse facility for the campus.

Utilities tunnels will need to be extended to connect new campus buildings and the perimeter fence will need to be extended to loop the facility. A new service court will be placed near the existing Food Service Building, which will be expanded and reconfigured to accommodate new dining space. The existing Administration Building built in 1950, will be converted to educational program space and, a new programs building will be built along the eastern edge of campus adjacent to the existing chapel.

Whenever possible new buildings on campus should be designed for energy efficiency and laid out for sustainable design principles. The master plan diagram layout is representational, building within each area, should be designed to promote efficiency while maintaining an intimate, non-institutional campus character that currently exists on the Mitchellville campus.

ICIW – Master Plan Cost Projection

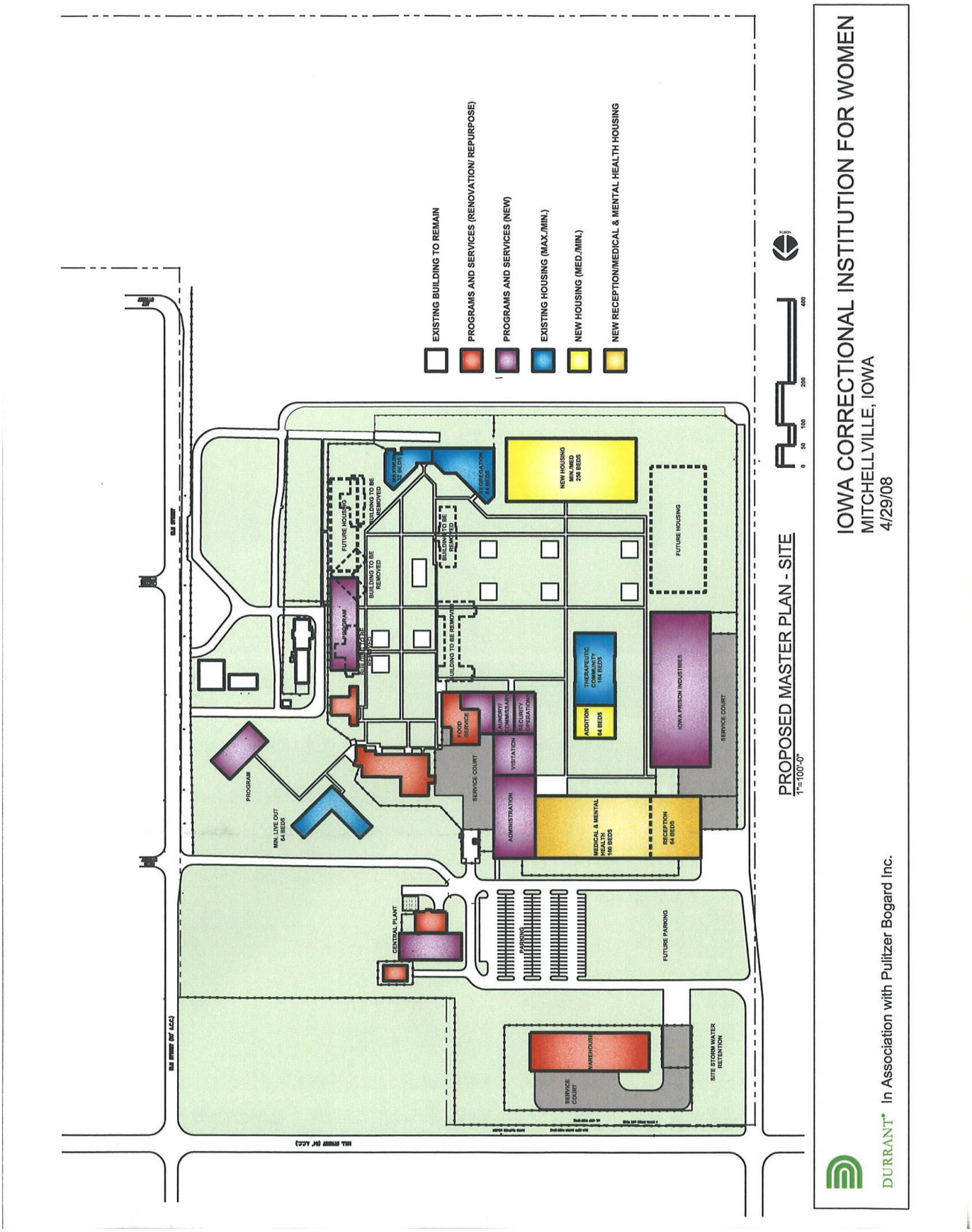
This cost projection, in concert with the ICIW Operating Principles and Macro Space Program, has been prepared to look at the long-term capacity and infrastructure needs at Mitchellville. Through the reorganization of the campus, the capacity at the end of this phase of work will be 888 beds. Infrastructure and campus layout will support an additional 320 beds bringing the projected long-range campus capacity to a potential of 1,208 beds. While it is hoped that in the near future, the various initiatives that IDOC is implementing will reduce the demand to add more bed capacity at ICIW, the master plan is designed to facilitate bed expansion. Without these initiatives, bed capacity on campus could reach a maximum potential of 1,484 beds in the year 2027.

The Estimate of Probable Cost has been calculated to reflect four major categories:

1. The cost of new square footage for proposed additions to existing buildings;
2. The cost of required improvements to existing buildings and/or demolition;
3. The cost for new building construction adjusted for,
   A. Fixed Equipment (Food Service, Laundry or, Fixed Detention)
   B. Site Work Allowance (Including Utility / Service Upgrades & Tunnel Extensions)
   C. Facility Gross Factor (for circulation)

Component Cost Breakdown:

1.	**Demolition –** Removal five buildings @ 50,050 SF=	$ 755,800
2.	**Facility Administration, Staff Support, Reception, Visitation, Security Operations, Medical & Mental Health Housing** @ 110,000 SF =	$26,650,000
3.	**Support Services –**	
	a. Food Service Renovation =	$ 310,000
	b. Food Service, Laundry, Commissary Addition @10,320 SF	$ 2,040,500
4.	**Housing Components –**	
	a. Units 6A, 6B, 7, 8, and 9 Renovation =	$ 973,500
	b. New Housing Units @ 65,500 SF= (Includes new program and support for MLO)	$18,530,000
5.	**Program and Services –**	
	a. New Buildings @ 15,850 SF=	$ 3,025,000
	b. Renovation of Administration Building =	$ 1,730,000
6.	**Building Infrastructure –**	
	a. New Warehouse @ 37,000 SF=	$ 3,000,000
	b. Power Plant Renovation =	$ 210,500
	c. Addition to Central Plant @ 9,570 SF=	$ 925,500
	d. Facility Gross Factor @ 21,600 SF=	$ 2,700,000
	e. Sitework Allowance	$ 1,827,500
	f. Fixed Equipment	$ 1,350,000
7.	**Soft Cost -**	$ 3,971,700
Total Project Costs for ICIW		**$ 68,000,000**


EXISTING BUILDING TO REMAIN
PROGRAMS AND SERVICES (RENOVATION/ REPURPOSE)
PROGRAMS AND SERVICES (NEW)
EXISTING HOUSING (MAX./MIN.)
NEW HOUSING (MED./MIN.)
NEW RECEPTION/MEDICAL & MENTAL HEALTH HOUSING
PROPOSED MASTER PLAN - SITE
1"=100'-0"
0 50 100 200 400
IOWA CORRECTIONAL INSTITUTION FOR WOMEN
MITCHELLVILLE, IOWA
4/29/08
DURRANT* In Association with Pulitzer Bogard Inc.
NEW HOUSING MIN./MED 256 BEDS
RECEPTION 64 BEDS
FUTURE HOUSING
BUILDING TO BE REMOVED
THERAPEUTIC COMMUNITY 104 BEDS
ADDITION 64 BEDS
IOWA PRISON INDUSTRIES
SERVICE COURT
MEDICAL & MENTAL HEALTH 160 BEDS
RECEPTION 64 BEDS
ADMINISTRATION
VISITATION
FOOD SERVICE
LAUNDRY
SECURITY OPERATIONS
PROGRAM
MIN. LIVE OUT 64 BEDS
CENTRAL PLANT
PARKING
FUTURE PARKING
WAREHOUSE
SITE STORM WATER RETENTION

Appendix A:
IDOC Focus Groups

IOWA DEPARTMENT OF CORRECTIONS FOCUS GROUPS November 27, 2007

Build Security Basics	CBC Beds	Classification	Education	Expand EBP	Mental Health – CBC
Scott Miller, Champion	**Gary Hinzman, Champion**	**Jeanette Bucklew, Champion**	**Robin Malmberg, Champion**	**Jim McKinney & Matt Gelvin, Champions**	**Gary Hinzman & Linda Murken, Champions**
Brett Taylor (ASP)	Al Hoff (1st)	Bob Johnson (NCCF)	Anne Gehle (ISP)	Bobby Smith (CCF)	Becky DeCarlo (5th)
Danny Manning (MPCF)	Bob Dvorsky (6th)	Chad Oeltjen (IMCC)	Brenda Cox (CCF)	Brad Hoenig (MPCF)	Bob Anderson (6th)
Dave Campbell (1st)	Cindy Engler (6th)	Darin Cox (5th)	Brenda Hampton (IMCC)	Craig Evans (2nd)	Jackie Paxton (4th)
Don Baker (NCCF)	Dan Craig (CO)	Jay Nelson (MPCF)	Jerry Bartruff (CO)	Dan Craig (CO)	Linn Hall (3rd)
Doug Bolton (ISP)	Diana Kellar (2nd)	Jeff Schultz (5th)	John Carroll (ICIW)	Darrell Moeller (ISP)	Malinda Lamb (6th)
Garry Seyb (MPCF)	Jeff Price (8th)	Jim McKinney (NCCF)	Judy Tomenga (5th)	Dennis DeBerg (1st)	Michele Haugen (2nd)
Greg Fitzpatrick (6th)	Jen Foltz (4th)	Jim Payne (CCF)	Melanie Steffens (6th)	Don Carroll (CCF)	Nathan Duccini (1st)
John Good (CCF)	Jessica Pierce (NCF)	Kathy Culbertson (ICIW)	Rick Bretthauer (FDCF)	Eleena Mitchell-Sadler (ICIW)	Ross Janes (1st)
Leah Noel (2nd)	Laura Sullivan (3rd)	Kim McIrvin (6th)		Gary Peitz (8th)	Sara Carter (1st)
Matt Thornton (ISP)	Mark Matkovich (7th)	Marcy Stroud (MPCF)		Janet Stange (NCCF)	Shawn LaRue (8th)
Mike Staton (FDCF)	Mike Brown (5th)	Mary Dick (FDCF)		Jennifer Reynoldson (5th)	
Randy Stroud (ISP)		Mike Kane (FDCF)		John Hill (1st)	
Shane Franklin (NCF)		Mike O'Reilly (ISP)		Katie Schumacher (1st)	
Steve Slough (CCF)		Ron Wyse (MPCF)		Michael Savala (CO)	
Tim Berger (FDCF)		Tracy Dietsch (ASP)		Michelle Dix (5th)	
Wesley Schilling (1st)		Tristin Potratz (FDCF)		Nettie Renshaw (FDCF)	
				Nicole Pizzini (6th)	
				Sally Kreamer (5th)	
				Scott Jones (5th)	
				Sonya Freeman (ISP)	
				Teri Jones (2nd)	
John Ault, Mentor Curt Smith, Communications	**Jeff Larson, Mentor Curt Smith, Communications**	**Jim Felker, Mentor Curt Smith, Communications**	**Jerry Burt, Mentor Curt Smith, Communications**	**Karen Herkelman, Mentor Curt Smith, Communications**	**Ken Kolthoff & James Wayne, Mentors Curt Smith, Communications**

Mental Health – Inst	Quality Assurance	Re Entry	Sex Offender	Substance Abuse	Women Offenders
Dr. Bruce Sieleni, Champion	**Sally Kreamer, Champion**	**Jerry Bartruff, Champion**	**Ron Mullen, Champion**	**Joel McAnulty, Champion**	**Diann Wilder Tomlinson, Champion**
Amy Wearmouth (ICIW)	Amy Scott (NCF)	Angela Morris (7th)	Amanda Milligan (2nd)	Art Schut (MECCA)	Angie Morris (7th)
Beth Pepples (NCCF)	Brian Foster (FDCF)	Art Rabon (5th)	Angella Roller (ISP)	Bob Schneider (ISP)	Bobbie Peters (6th)
Betty Brown (CO)	Craig Evans (2nd)	Bob Anderson (6th)	Dan Roach (ISP)	Carla Evans (2nd)	Cathy Davis (2nd)
Brenda Miller (ICIW)	Darin Cox (5th)	Candace Collins (ISP)	Gail Huckins (MPCF)	Carrie Carson (IMCC)	Cheryl Meyer (1st)
Danielle Malaise (ICIW)	Denise Cooper (1st)	Darin Cox (5th)	Jason Smith (DHS)	Dustin Lutgen (FDCF)	Chris Gesie (IMCC)
Deb Murphy (IMCC)	Jean Kuehl (6th)	Darlene Baugh (FDCF)	Jennifer Guild (5th)	Gail Juvik (6th)	Dan Craig (CO)
Deb Murray (CCF)	Jenifer Swihart (ICIW)	Diana Kellar (2nd)	Jennifer Kimbrough (5th)	Jack Adams (FDCF)	Deb Murphy (IMCC)
Dwayne Prull (IMCC)	Jerry Kuncl (5th)	Doug Bolton (ISP)	Jerry Bartruff (CO)	James Watson (NCCF)	Kathy Nesteby (DHR)
Greg Ort (IMCC)	Joe Poisel (8th)	Jeff Panknen (NCF)	Kathy Khommanyvong (FDCF)	Jerry Kuncl (5th)	Kris Weitzell (CO)
Heather Brueck (ISP)	Laura Scheffert James (IMCC)	John Mays (NCF)	Larry Brimeyer (CO)	Jill Dursky (NCF)	Lisa Hansen (5th)
Janice Berry (NCF)	Lorie Woodard (5th)	Johnny Hill (1st)	Michelle Waddle (MPCF)	Katrina Carter-Larson (NCF)	Marcy Stroud (MPCF)
Jerry Bartruff (CO)	Mike Foehring (CCF)	Kelli Collins (IMCC)	Randy Cole (6th)	Larry Lipscomb (NCF)	Michelle Dix (5th)
Jim Varland (FDCF)	Teama McGregor (ICIW)	Linda Bellinghausen (NCCF)	Ron Mullen (8th)	Marlana Lalli (5th)	Pam Taylor (4th)
Joan Greiman (ICIW)	Todd Ensminger (ISP)	Roger Baysden (IPI)	Sean Crawford (MPCF)	Ray Stigge (MPCF)	Patti Wachtendorf (ICIW)
John Van Ness (NCCF)	Waylyn McCulloh (7th)	Ron Wyse (MPCF)	Steve Naeve (2nd)	Roxanne Phillips (CCF)	Peggy Urtz (5th)
Josefina Hizon (Dr.) (MPCF)		Sally Kreamer (5th)	Sundi Simpson (8th)	Scott Jones (5th)	Rachel Scott (DHR)
Julie Hackenmiller (MPCF)		Stacey Bochart (FDCF)	Tim McClimon (7th)	Sheryl Lockwood (CO)	
Leanne Eichinger		Teresa O'Tool (NCCF)	Todd Ensiminger (ISP)	Stacy Bochart (FDCF)	
Lowell Brandt (IMCC)			Tony Tatman, Dr. (5th)		
Mary Hildebrandt (CCF)			Wendy Lyons (1st)		
Mike Brown (Offender					

Mental Health – Inst	Quality Assurance	Re Entry	Sex Offender	Substance Abuse	Women Offenders
Services)					
Nancy Simon (Iowa Protection & Advocacy)					
Pat Millin (ICIW)					
Randy Stroud (ISP)					
Renee Sneitzer (IMCC)					
Shawn Howard (CCF)					
William Schettler (ASP)					
Dr. Black, Mentor Curt Smith, Communications	**Lowell Brandt, Mentor Curt Smith, Communications**	**Cornell Smith, Mentor Curt Smith, Communications**	**Anne Brown, Mentor Curt Smith, Communications**	**Robin Bagby, Mentor Curt Smith, Communications**	**Sheryl Lockwood, Mentor Curt Smith, Communications**

Appendix B: Phase I Recommendations

Excerpt from Chapter 6, Phase I Report

Recommendations: Short and Long Term

A. Short Term Recommendations

Short-term recommendations are those that can be implemented during the next twelve to eighteen months or by the end of Fiscal Year 2008. The time frame for short-term recommendations was provided by Executive Staff of IDOC. Priorities for short-term recommendations were also determined with input from the IDOC Executive Staff during workshops and meetings.

An abbreviated list of the short-term recommendations is available in the Roadmap that accompanies this report.

1. Treatment

The short-term recommendations to IDOC and the legislature that follow are related to the previously identified special offender populations with treatment needs for substance abuse, mental illness, sex offenses, medical treatment for chronic and terminal illness due to aging, and gender-responsive services for women. In addition, reentry and prison industry opportunities for each of the five special populations were assessed and recommendations for each are included.

Substance Abuse Treatment:

The short–term recommendations to be implemented by end of Fiscal Year 2008 include:

- **Substance Abuse Treatment Assessment**

  Develop a plan to fill substance abuse assessment positions at IMCC; the plan may include step-up hiring over time.

- **Substance Abuse Treatment Continuum**

  Develop policies and a plan to adopt SAMHSA's evidence-based model: Co-occurring Disorders Integrated Dual Diagnosis Treatment Program for offenders with mental illness.

- **Substance Abuse Treatment Capacity**

  Determine whether additional short term and relapse prevention programming would require additional staffing or reassignment of current staffing.

  Study whether some mandated substance abuse treatment, especially short-term, for offender populations could be provided in CBC settings instead of institutions.

Complete a treatment and program staffing analysis to determine the level of staffing that would be required to meet demand for services.

Develop a plan to expand evidence-based program driven substance abuse treatment programs that meet the demand for and level of treatment required by the offender population.

Study both institution and community-based substance abusing offenders regarding access to, involvement in, and level of prior substance abuse treatment while in the community.

Study whether the faith-based Inner Change program at Newton (that was ruled unconstitutional based on separation of church and state) could and should be transformed into an evidence-based substance abuse therapeutic community that serves 100-150 additional eligible offenders throughout the system, consistent with appropriate assessments of risk and need.

Mental Health Treatment

The short–term recommendations to be implemented by end of Fiscal Year 2008 include:

- **Culture re: Mental Illness**

Develop training programs that explain the biology of mental illness for all IDOC line, treatment and management staff that addresses updated views of mental illness and recovery. This training should be included in both pre-service and annual training. Annual updates should include evaluation and outcome research in community and correction mental health care.

Implement the recently developed and updated mental health training for security staff.

- **Mental Health Assessment**

Continue to recruit psychiatrists to be involved in providing initial psychiatric assessments.

- **Mental Health Treatment Continuum**

Develop plan to increase access to acute care beds for both male and female offenders.

Develop and implement policies, procedures and training for judicial review for involuntary medication.

Determine appropriate use of designated mental health beds, including those proposed at IMCC, and develop a full continuum of beds that meet required level of care to be provided in each designated institution**.**

- **Mental Health Treatment Capacity**

Complete a staffing analysis to determine appropriate numbers per discipline of mental health professionals per facility location

Develop plan to increase appropriate disciplines and levels of professional mental health care across the continuum of care (acute to outpatient).

- **Mental Health Treatment Continuity in Community**

Conduct a complete study to determine numbers of CBC offenders in need of or receiving mental health care.

Conduct further study to determine the number of offenders in prison who serve longer sentences or "max out" because beds are unavailable in CBC system.

Conduct study to determine number of prisoners with mental illness who do not have access to reentry programs or release with community supports in place.

Conduct a complete study to determine the impact of adding nursing and social workers on psychologist workload across the continuum of care.

- **Mental Health Management Capacity**

Plan for the ability to meet systemic mental health management demands.

Sex Offender Treatment

The short–term recommendations to be implemented by end of Fiscal Year 2008 include:

- Identify if there is a more effective evidence-based Sex Offender Treatment Assessment Instrument that will assist IDOC in meeting its vision of matching appropriate treatment to need and custody level.

- Monitor outcome evaluations of programs that other correctional systems have implemented that have decreased intensive sex offender treatment from 16-36 months to 12 months.

- Determine the numbers of prisoners who "max out" because they are unable to complete sex offender treatment programs with special emphasis on offenders who have mental retardation and other developmental disorders, mental illness, and brain-injuries.

- Complete the treatment and program staffing analysis to determine required numbers of treatment and counseling staff to meet the current and projected treatment needs and demands of sex offenders.

- Develop a plan to add sex offender treatment personnel who are able to meet the current and projected treatment needs of sex offenders.

Medical Treatment for Aging Population

The short–term recommendations to be implemented by end of Fiscal Year 2008 include:

- Fill IDOC Nurse Administrator position to provide system-wide clinical and management oversight of nursing services.
- Fill currently vacant nursing positions to meet current minimum staffing requirements.
- Perform a detailed staffing analysis to determine the required medical/nursing positions per institution.
- Plan for a system-wide approach to recruit and train nurses for new positions at IMCC; hire and train all staff required to open the IMCC facility.
- Study how to expand keep-on-person (KOP) meds for offenders close to release.
- Complete the centralized pharmacy services study to determine whether it would be the cost effective.

Gender Responsive Treatment for Female Offenders

The short–term recommendations to be implemented by end of Fiscal Year 2008 include:

- Seek technical assistance that is available from federal agencies such as the National Institute of Corrections for further information and guidelines for planning and developing evidence-based gender-responsive services.
- Create opportunities to communicate with the legislature and courts about the special needs of women and the beneficial outcomes from gender-responsive treatment and programs.

Reentry

The short–term recommendations to be implemented by end of Fiscal Year 2008 include:

- Conduct a needs assessment to determine additional resources necessary to enhance capacity of applicable institutions to provide evidence-based reentry programs.
- Build further collaboration between institutions and the CBCs around Reentry Release Planning for incarcerated offenders.

IPI and Vocational Programs

The short–term recommendations to be implemented by end of Fiscal Year 2008 include:

- Complete the systemic staffing study to determine the level of personnel required for vocational training programs and increased IPI opportunities in the institutions

2. Classification

Resolution of the classification issues faced by the Department requires more comprehensive assessment and modifications than any immediate or short-term strategies might offer. However, there a couple of immediate steps that the Department could pursue to ensure improve the reliability and validity of its classification system.

Streamline and standardize the classification process. The current classification system is cumbersome and facility-specific rather than a departmental, comprehensive system.

Provide formal training on the classification system. A comprehensive training should be provided as soon as possible. An undated classification manual that specifies the operational definitions for each of the risks, custody override criteria, and classification procedures should be distributed to each staff member. This training should include reliability testing with actual DOC offenders to ensure that the rules and procedures are understood and applied correctly. Classification-related training should also be incorporated in the curriculum for all new employees. As needed, in-service classes should be provided to clarify questions or to modify the policies and procedures.

Develop and Implement Ongoing Auditing and Monitoring Process. Policies and procedures for ongoing audits and monitoring of the classification system are needed to ensure that the system is implemented and conducted consistently across all DOC facilities. Equally important is the development of automated management reports and agency performance measures related to the classification system.

3. Facilities and Operations

3.1 Institutions

- **Operations**

The short-term recommendations to IDOC and the legislature that follow are related to the previously identified operational issues that support the capacity to provide treatment services to the special offender populations that have treatment needs for substance abuse, mental illness, sex offenses, medical treatment for chronic and terminal illness due to aging, and gender-responsive services for women. The operational issues that were assessed include staffing, training and development, and ICON and performance measures.

An abbreviated list of the short-term recommendations is available in the Roadmap that accompanies this report.

Systemic Staffing Study

The short–term recommendations to be implemented by end of Fiscal Year 2008 include:

1) IDOC must either complete their independent staffing study or actively participate in independent staffing analysis by providing all requested information related to study and making staff available to for interviews and survey

2) IDOC needs to coordinate with DAS to revise job descriptions as needed. In addition, the table of organization should be revised in conjunction with staffing plan

3) If the internal staffing study is not validate, the legislature should fund an independent staffing study for security and non-security positions at IDOC institutions and CBCs.

4) IDOC needs to develop strategies to strengthen partnerships with National Guard and Reserves to address military leave issues.

Training and Development

The short–term recommendations to be implemented by end of Fiscal Year 2008 include:

1) Appropriate and fund pre-service, in-service and specialized training for staff in conjunction with needs identified from independent staffing analysis, strategic plan and IDOC training budget request.

ICON and Performance Measurements

The short–term recommendations to be implemented by end of Fiscal Year 2008 include:

1) Fund ICON reconfigurations, modifications and beta testing.

2) Fund validation and reliability studies for classification instruments to enhance IDOC performance measurement capabilities relative to offender risk.

3) IDOC-Develop additional key performance indicators to evaluate and monitor quality at the institutions.

- **Infrastructure**

Iowa Correctional Institution for Women

A significant focus for this study emerged, whereby as an initial systemic step in the overall plan to 'Build on Basics' correctional programs and initiatives, a pilot plan will be put in place focused on Gender-Specific Issues for Women Offenders. This effort to centralize programs and services will properly overcome crowding concerns, as well as, create a springboard to interface with the Community Based Corrections system.

The number of female offenders is expected to exceed capacity by 30.0% by mid-year 2007. By mid-year 2016, the female population is expected to exceed current capacity by 72%.

- We recommend replacement of the older housing unit buildings that are not conducive to sound correctional supervision and programming. Specifically, Building 5 should be removed.

- Relocate The Mount Pleasant Women's Unit (MPWU), a 100-bed Special Needs Unit for females, to ICIW.

- Relocate the Reception and Classification processing components for women from IMCC to ICIW. This change will further amplifying the need for immediate planning and design of a comprehensive correctional system and facilities for females. An initial target should focus on a Reception Center to accommodate 60 to 100 offenders, which is sized for long-term growth. Also, the center should include a health services component.

- We recommend a phased approach to growth at ICIW. The first phase sized at 320 beds to offset outdated buildings, relocate MPWU, and accommodate for overcrowding. In addition, Phase 2, at 192-beds should accommodate future growth.

- To accommodate for the increase number of offenders at the facility, we recommend increasing the capacity of food service and laundry services.

- Relocate shift supervisors closer to Central Control.

- Remodel Central Control. Provide toilet facilities for officers.

- Update security system.

- Repair water penetration in Building #9.

- Correct Life Safety Issues in Buildings 1, 2, 3, and 4.

ISP: Building a New Facility

Option One – Construction of a New Maximum Security Institution

This option considers the construction of a new institution on a different site, most likely at the farm. The new institution would contain, not only the housing units, and support service buildings including a physical plant, a treatment and program space, an industries building and other support services components. The cost estimates are inclusive of fixed equipment needed to operate the institution, as well as, allowances for site development.

The existing CCU building, the John Bennett Unit would continue to operate. These units will receive laundry and food services from the new facilities.

Using the Newton and Fort Dodge Correctional Facility as an introductory model for the types of campus components needed, we have projected the costs into a maximum-security environment.

- New Housing Units
    - Estimated Construction Cost - $98,700,000
- Physical Plant, Treatment Support Space and Support Services
    - Estimated Construction Cost - $21,000,000
- Industries Building
    - Estimated Construction Cost - $4,000,000
- Perimeter Security Fence
    - Estimated Construction Cost - $6,750,000
- Since the existing prison would be vacated most of the *Major Maintenance Projects* will not be required.
    - Fuel tank replacement
    - Septic system repair at Farm 3
    - Maintenance items to the John Bennett Unit, Farm 1 and Farm 3
    - Remodel dorm in Farm 1
- Life Safety issues to be corrected
    - At the John Bennett Unit, increase egress capacity from the Dormitories by adding two new egress stairs.
        - Estimated Construction Cost - $150,000
    - At Farm 1 and 3, provide second exit from the second floor.
        - Estimated Construction Cost - $100,000

Total cost for **ISP Option One =$130,700,000**

Newton Correctional Facility

The main Newton facility is one of the newest, therefore, the facilities has few major maintenance items. However, the Correctional Release Center is in need of renovation.
As part of the systemic study, Durrant recommended adding bed capacity to this facility to reduce for the current overcrowding within the system and to accommodate for the anticipated growth. Following is Durrant's recommendations for infrastructure related items.

- We recommend the construction of 400 bed housing unit at the facility.
- Renovate the Correctional Release Center including electrical upgrades
- Replace hot water loop around the main facility

Anamosa State Penitentiary

The Anamosa facility has served the State of Iowa well over its' long life and continues to play an important role in the overall effectiveness of the prison system. In order to remain effective, the facility is in need of updating. The cell houses are no longer conducive to sound correctional supervision and programming.

Clarinda Correctional Facility

The Clarinda Correctional Facility is relatively new. The facility is in good condition except for the showers and the roof edge design issue. The showers in all of the housing units are showing considerable deterioration. Finishes are not adhering properly to the substrate causing the concrete and concrete masonry to be exposed to constant moisture. Prolong exposure to moisture accelerates the deterioration of the substrate.

The improper design of the roof edge is allowing water to penetrate the exterior precast concrete wall panels. Water has stained the exterior face as well as migrated into the interior. Revising the roof edge detail should correct the problem.

The 750 bed facility is located in the Clarinda Treatment Complex which contains the State Mental Health Institute (DHS), Waubonsie Mental Health Center, Clarinda Academy, Hope Hall (old CCF, unoccupied) and CCF Lodge (DOC). The facility's meals are prepared in the kitchen of the Institute and delivered via panel trucks through a sallyport. As a result, the offenders housed in of the facility do not have an opportunity to work in the food service, since it is outside the security perimeter.
The CCF Lodge (DOC) houses minimum custody, work release offenders. Currently only two floors of the three-story building are being utilized.

Along with routine maintenance, Durrant has the following recommendations for infrastructure related items:

- Correct flashing at the roof edge to prevent water from penetrating the building. Clean wall panels. Prepare and paint inside of wall panels.
- Provide proper drainage away from building. Especially on the north side by the gymnasium.
- Repair showers in housing units.
- Consider adding a kitchen to the facility
- Renovate Lodge to allow for the housing of more offenders. Renovation to include new finishes, remodel of toilet/shower facilities, new windows, ADA accessibility, and correction of life safety items
- Determine use for Hope Hall

Fort Dodge Correctional Facility

The Fort Dodge facility is one of the newest facilities. Because of the age the facility does not have many major maintenance items. The only items are the hot water loop and the boiler piping. The boiler piping is deteriorating due to the hardness of the local water. A water treatment system has been installed to reduce the hardness. Along with routine maintenance, Durrant has the following recommendations for infrastructure related items:

- Replace water piping as it fails

Mount Pleasant Correctional Facility

The Mount Pleasant facility is a former Mental Health Hospital adapted to be used for correctional purposes. The buildings are old but are in relative good condition. The major maintenance issues for the most part are limited to the mechanical, electrical and security systems. Following are Durrant's recommendation for infrastructure related items.

- Update electrical system. Current system is not adequate to provide electrical services to the facility.
- Update heating system to a more efficient system including cooling capabilities.
- Replace windows throughout the facility. The efficiency of the new windows will pay for themselves in saved energy cost.
- Install high mast lighting in prison yard.
- Provide accessibility for person with disabilities to dining. Currently, all offenders need to transverse a steep ramp to get to the dining hall.
- Relocate women to ICIW.

- Upgrade security system including communications, cameras and door controls.

Iowa Medical and Classification Center

The IMCC facility is relatively new. Currently, a new Special Needs Unit is under construction. Following are Durrant's recommendation for infrastructure related items.

- Repair roofing on older buildings
- Replace windows in older buildings

North Central Correctional Facility

The Rockwell City facility is a mixture of old and new buildings. The facility is in need of an update to continue to operate effectively. Following is Durrant's recommendations for infrastructure related items.

- Construct new kitchen/dining room
- Repair the exterior of Building D
- Remodel and expanded Central Control
- Replace windows in Buildings A, B, and C and the Administration Building
- Wire emergency generator to serve the entire facility
- Repair steam tunnels and lines
- Replace damaged sidewalks

- **Bedspace Utilization**

The development of a valid and reliable risk classification instrument (when designed and successfully implemented) may indicate major re-distributions of offenders among facilities commensurate with the risks they pose. Until the future instrument is validated, we are limited in our ability to recommend re-use of facilities and their housing units. The first step toward accepted and efficient bed utilization is that development.

3.2 Community Based Corrections

This section of the report presents preliminary recommendations with regard to maximizing the benefits to the state from the best possible use of community-based correctional centers under the jurisdiction of each of the eight judicial districts. These preliminary short-term recommendations will be supplemented as part of the work proposed in Phase 2 of the Iowa Department of Corrections Master Plan.[112] *Similarly,*

[112] The Legislature is currently considering a request from the Department of Corrections for funding Phase 2 work.

the conclusions drawn and recommendations made will be reexamined and modified based on analysis of not yet available data and information, as well a complete analysis of how best to integrate the Department of Corrections' resources (both existing and proposed) with the resources in each of the independent eight judicial district's Departments of Correctional Services.

- **Operations**

Improving community corrections outcomes and increasing its capacity will not only have an immediate impact on institutional bed utilization but it will also have a potential impact on future institutional bed space and improve public safety by way of reducing recidivism. Therefore optimizing the potential of community corrections by increasing funding for capacity expansion and additional programming can have far reaching benefits throughout the system and be cost effective in the long term.

The following are our initial community corrections short-term recommendations. These are recommendations that could be implemented as immediately without the need for legislation or budgetary action by the legislature in order to implement.

1. **Determine the 'right' mix of residents (overall).**

   We found examples of offenders who could not work due to their health or offense type being sent to work release facilities and wasting bed space. By properly defining and assigning the right mix of population types to each of the district's facilities based on the need and programming available will help prevent misuses of bed space with inappropriate referrals or offenders who just can't benefit from the resources available in the area. This is an issue that is will require working with the judiciary, the DOC and Parole Board in a statewide systems approach to the problem. Districts have done what they can do to this point however perhaps the impact of this study will move decision makers to better understand the impact of their decisions and be more appropriate in their referral decisions.

2. **Increase support for mental health/medical services in the community to support the continuum of care.**

   The need for additional mental health services, dual diagnosis services (substance abuse and mental illness) and funding for medications was expressed in every district. Iowa Department of Human Services reports that the largest State mental health institution in 2005 held just 90 persons. On June 30, 2005 Iowa prison system held 2,902 mentally ill offenders. The Clinical Care Unit at the Iowa State Penitentiary is therefore the largest mental health facility in the state holding 143 offenders in 2005.

   In 2005 31 percent of male inmates and 60 percent of female inmates in Iowa institutions were mentally ill per psychiatric diagnosis.113 Similarly, that same year 26 percent of male parolees and 55 percent of female parolees were mentally ill.[114] This is a national trend and issue and must be addressed to avoid huge expansion of

[113] Population Growth, Iowa DOC Report to the Board of Corrections, July 2006, 15.
[114] Ibid., 15.

institutional capacity in the future. This issue is being addressed in the 6th District where they building a mental health center to serve approximately 20 mentally ill residents in community corrections residential setting in Cedar Rapids. Both the 1st and 6th districts have been doing the equivalent of a mental health court, even though the courts only get involved at the end of the process. Other current comprehensive programs that address mental health needs as one component in community corrections include: the first judicial district's day program and reentry court program, the fifth judicial district's Going Home: KEYS Reentry Program; and the third judicial district's mental health court. Dual diagnosis interventions are available in five out of the eight judicial districts, the largest being the Waterloo Dual Diagnosis Program.[115] During FY2005, a total of 252 offenders were served in dual diagnosis interventions statewide. The Department clearly understands the need for mental health treatment and expressed its commitment to it in the 2006 Mental Health Report to the Board of Corrections. It is simply a matter of obtaining and developing the necessary fiscal and program resources across the State to facilitate successful re-entry by this population.

3. Restore funding for substance abuse and education programming to 2002 levels.

Almost every district reported losing most of their treatment and education programming staff in the 2002 budget cuts and only a few of those positions have been restored. Nationally, 80% of offenders have substance abuse issues. Drug crimes are the most common crime among new admissions and have increased from 316 in FY 95 to 1,057 in FY 05.116 This staggering statistic dictates that community corrections must adequately addresses this need before offenders are released back into the community. Treating offenders for their addictions will improve public safety and reduce crime and recidivism. Not treating them will ensure that the revolving door continues to spin. In funding additional treatment it is critical that the proper type and length of treatment be provided and that a continuum of services exists so treatment dollars are wisely spent. Some education funding has been restored. According to the Department's 2006 - 2007 Strategic Plan, the greatest need among community corrections offenders is alcohol and drug treatment. The report states that 4,376 (67%) of offenders in community corrections need of substance abuse treatment surpassing the next highest need (emotional and personal support) at only 15%.

4. Educate the legislature on the impact of not fully funding staff raises and increasing cost of benefits.

Districts reported that when the legislature increases staff salaries, that they often do not raise the funding to support those raises. The result is that the district must cut other spending in order to pay for increased staff salaries. These cuts usually come from the one area that is possible to cut and that is programs.

115 Mental Health, Report to the Board of Corrections, Iowa Department of Corrections, April 2006. p12.

116 Ibid., 5.

5. **Share best practices across between the Judicial Districts and between community and institutional corrections.**

   The Districts operate independently via Performance of Service contracts with the DOC. Each District has a Board of Directors that oversees its operation. Although this is effective in ensuring that each district provides services relevant to its region, the autonomy that results may sometimes hamper sharing of successes and programming ideas. The unique relationship the CBCs have with the DOC may sometimes hamper the integration of best practices and innovation from occurring across the institutional and community systems. There is much talent among the judicial districts but it may not always get meshed with the DOC. Much that the districts do could apply to the DOC. The offender reentry case management system is one example where something is being implemented across both DOC and CBC systems.
   Sharing best practices between districts should also be encouraged. For example, in 1989 the 6th District developed an automated Matrix to calculate various assessment scores and risk and recommend placements, sanctions, etc. Some districts have reportedly tested it against their current placements and found they would need to make modifications to achieve the type of placements they want due to their correctional philosophy. Although we were not charged with evaluating its effectiveness, it appeared to be a useful tool that could be used statewide to provide more consistent placements and eventually could be tied in with ICON and we were surprised that other districts were not utilizing it or a customized version of it.

6. **Hire clerical staff or paraprofessionals to do PSI reports and data entry work.**

   Some districts reported losing clerical staff in the 2002 cuts resulting in parole officers spending more time taking supervision time away from parole officers.

7. **Develop programs for the older and ill residents being sent to the CBCs.**

   Districts reported that they are seeing more older and ill offenders coming into their facilities. Twenty years ago 4 percent of the DOC population was 51 or older; today 8 percent are in this age group. Today 49 percent of DOC population is between 31 and 50, up from 31 percent during the same period.[117] The aging of the offender population is a national trend. Districts should develop programs to meet the needs of this older population and have the resources to accommodate their need for additional medical care. (Not sure what they can do specifically). This population is creating challenges for probation supervision as well and making it even harder to properly handle the already heavy caseloads.

8. **Maintain awareness and use of Evidence Based Practices (EBP) through training.**

   Iowa is committed to the use of EBP however there should be a statewide funded infrastructure to provide training and education both internally and externally. Tight budgets often result in cuts to programming and training. Iowa DOC should maintain

[117] Population Growth, Iowa DOC Report to the Board of Corrections, July 2006, 14.

a strong commitment to staff training in the use of EBP. One way to achieve this would be to fund one trainer for each judicial district. The interaction with offenders and programming and supervision provided in the CBCs can be the difference between a successful and an unsuccessful reentry. It is therefore critical that staff be armed with all the tools available.

9. **Involve the Faith Community and Volunteers.**

   There are examples all over the State of the faith community serving offenders in the CBCs. This effort should continue and expand to bring the formal and informal support systems together to improve the chances of successful reentry by providing a mini-support system. It is important however that the resources be available to properly screen, place and manage volunteers providing services and support to offenders to prevent further harm.

10. **Control or reduce the number of sex offenders in the CBCs.**

    There is an ever increasing number of sex offenders returning to the community and they are taking up more and more beds in the CBCs. Although there is a Sex Offender Program that provides treatment through group counseling and education combined with intensive supervision to offenders who commit sex crimes, it is not desirable to place them in co-gender facilities or in work release beds if they are not able to work. In co-gender CBCs these sex offenders are in and around female offenders. Staff interviewed indicated that some of the sex offenders in their facilities were not able to find work due to the nature of their crimes and were wasting a bed that could be used by other offenders. Many of these referrals are coming directly from the courts however an effort should be made to educate the judges and other referral sources on a statewide basis to the problems created by this practice. In may even be more economical for the state to develop one or more residential sex offender facilities that can focus more resources on a concentrated population.

- **Infrastructure**

The CBC facilities are an integral and critical part of the correctional system. CBC provides an alternative to incarcerating non-violent offenders in the overcrowded institutions. In addition, the facilities provide an avenue for re-entry into society.

- Several CBC Facilities currently house more residents than what the facility was designed. We recommend providing new beds to reduce overcrowding. The Department of Corrections' expansion plan has targeted facilities at Ottumwa, Sioux City and Waterloo for additions.

- Also, the Department of Corrections' expansion plan has indicated the construction a new facility for the 5th District.

- Except for Davenport, the current facilities are in relatively good condition. Maintenance and improvements of these facilities should be on going.

- Since most of the buildings are between 15 to 20 years old, the HVAC systems no longer function properly and are need of replacement. Also, as a result of the age, the shower/toilet facilities are in need of renovating.

- We recommend constructing a new facility to replace the one at 1330 W. 3rd Street in Davenport. The current facility is not conducive to sound correctional supervision and programming. In addition, it has several life safety issues that affect the welfare of the residents.

- Following is recommendations for individual facilities

    - Ames, the facility is in need of receiving remedial attention over any other CBC facility.

        - Renovate shower facilities.

        - Redesign and replace current HVAC system

        - Construct new kitchen addition and remodel the existing kitchen

        - Construct new classroom Addition

    - Burlington
        - Redesign and replace current HVAC system

        - Construct new classroom addition to replace portable classroom

    - Cedar Rapids
        - Only minor maintenance items

    - Coralville
        - Construct new storage addition to building to replace garage and sheds.

        - Renovate toilet/shower facilities

        - Construct new classroom addition to building. Current classrooms are located in the lower level; requiring residents to go outside to get to them.

    - Council Bluffs (Women)
        - New facility

    - Council Bluffs (Men)
        - Redesign and replace current HVAC system

    - Davenport (605 Main)
        - Redesign and replace current HVAC system

- Replace roof
- Install new windows
- Provide new exterior exit stairs.
- Repair or replace room showers
- Correct life safety issues

- Des Moines (Women)
  - New facility
- Des Moines (Men)
  - Install elevator in programs building to allow for accessibility to all areas.
- Dubuque
  - Construct new classroom addition to replace current classroom in basement.
- Fort Dodge
  - New facility (under construction)
- Marshalltown
  - Redesign and replace current HVAC system
  - Remodel toilet/shower facilities
  - Construct new classroom addition
- Mason City
  - Redesign and replace current HVAC system
  - Install new walk-in cooler
- Ottumwa
  - Construct additional sleeping rooms
  - Construct new classroom addition to replace current portable classroom
- Sheldon
  - Redesign and replace current HVAC system
  - Remodel toilet/shower facilities
- Sioux City
  - Construct additional sleeping rooms
- Waterloo

- Construct additional sleeping rooms
- Replace waterline
- Replace windows in existing facility

- West Union
  - Redesign and replace current HVAC system
  - Replace roof

B. Long Term Recommendations

Long-term recommendations are those recommendations that can be implemented during Fiscal Year 2009 through Fiscal Year 2012. The time frame for long-term recommendations was provided by Executive Staff of IDOC. Priorities for long-term recommendations were also determined with input from the IDOC Executive Staff during workshops and meetings.

An abbreviated list of the long-term recommendations is available in the Roadmap that accompanies this report.

1. Treatment

The long-term recommendations to IDOC and the legislature that follow are related to the previously identified special offender populations with treatment needs for substance abuse, mental illness, sex offenses, medical treatment for chronic and terminal illness due to aging, and gender-responsive services for women. In addition, reentry and prison industry opportunities for each of the five special populations were assessed and recommendations for each are included.

Substance Abuse Treatment

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

- **Assessment for Substance Abuse Treatment**

  Continue to fill substance abuse assessment positions at IMCC if a step-wise approach is used.

  Continue to monitor population growth and fund additional substance abuse assessment positions as required by data driven service demands.

- **Substance Abuse Treatment Continuum**

  Implement SAMHSA evidence-based treatment model: Co-occurring Disorders Integrated Dual Diagnosis Treatment Program for offenders with mental illness.

  Determine if a similar gender specific program exists for women offenders who have mental illnesses or if this treatment approach has been evaluated for outcomes for women with co-occurring disorders.

  Plan to provide this program by dually trained staff (a professional with both mental health and substance abuse training and expertise).

  Plan to implement this program in IDOC special needs units; consider piloting the program at the Clinical Care Unit at Ft. Madison.

- **Substance Abuse Treatment Capacity**

  Once the classification system has been updated and the number of offenders who fall within each custody classification has been clarified, IDOC should use the LSI-Rs of offenders in each classification to determine of level of substance abuse treatment needs. The levels of treatment required for each custody classification should be cross-matched against the current distribution of substance abuse services to determine if there is a need to adjust the substance abuse treatment program distribution.

  Develop a plan to expand evidence-based substance abuse treatment programs that meet the demand for and level of treatment required by offender population.

  Monitor the demand for all levels of substance abuse services on an at least an annual basis.

  Adjust the level of substance abuse treatment services distribution to meet the data driven demand for services.

  Fund additional treatment positions to meet the data driven demand for services.

Mental Health Treatment

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

- **Culture re: Mental Illness**

  Conduct annual training to update clinical staff re: current trends in community and correctional mental health care.

  Conduct annual reviews and update of mental health standard operating procedures and post orders to reflect change in culture and approach to managing offenders with mental illnesses.

- **Mental Health Assessment**

  Continue to recruit psychiatrists for initial assessments.

  Add additional psychologist assessment positions.

  Monitor increase in the offender population and track the need for additional assessment staff; evaluate on an annual basis.

- **Mental Health Treatment Continuum**

  Determine if legislative change to Iowa Code Section 904.201 is required regarding the use of hospital beds for non-prisoners or if needed changes can be accomplished by changing practices.

Ensure that there are sufficient numbers of mental health beds across the continuum of care to meet the increasing demand for mental health services.

Decrease the number of "civilian" patients and increase the capacity for acute care for prisoners.

More accurately track the level of mental health bed demand through ICON.

Adjust and repurpose beds as demand and the proposed new classification system requires.

Determine whether repurposing and focusing mental health services in one institution, particularly acute and partial hospitalization mental health care, would be more cost effective and would also improve the ability to recruit and retain psychiatrists.

Adjust clinical staffing for licensed hospital level care to be equal to staffing patterns in state psychiatric facilities.

- **Mental Health Treatment Capacity**

Fill nursing vacancies to meet minimum staffing requirements for psychiatric hospital level of care.

Develop additional academic relationships to provide training opportunities and build the potential pool of future clinical staff.

Develop new policies to plan for and adopt and implement SAMHSA's Recovery Model for treatment of mental illness across the continuum of mental health care.

Implement Recovery Model treatment programs.

Consider using mid-level psychiatrically trained NPs and PAs to extend psychiatric resources.

Add psychiatric nursing and social work positions to acute care, partial hospitalization, and special needs unit settings.

Use psychiatric RN positions to assist with telemedicine to free psychologists for treatment.

Fund additional required mental health positions in acute, partial hospitalization and special needs units commensurate with the defined level of care.

- **Mental Health Treatment Continuity to the Community**

  Develop a detailed plan for additional reentry opportunities for offenders with mental illness.

  Fund additional reentry opportunities/programs for offenders with mental illness.

- **Management Capacity**

  Fund and fill a quality assurance position for mental health (peer review, EBP, outcome evaluation).

  Determine additional mental health management position demands as part of a comprehensive workload analysis.

  Fund and fill regional mental health management positions.

Sex Offender Treatment

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

- **Sex Offender Treatment Continuum**

  Develop additional treatment program slots and /or programs to meet data driven demands for mandated treatment.

  Develop sex offender treatment programs for those who have mental illness and who are also sex offenders. Recommend identifying an evidence-based program that targets interaction of illness management and sex offending behaviors.

  Plan and develop consistent evidence-based (EBP) sex offender treatment programs across IDOC institutions and the CBC system.

- **Sex Offender Treatment Capacity**

  Monitor demand for services annually and adjust treatment programs to meet data driven demands for treatment services.

  Develop additional treatment program slots to meet the level of treatment program distribution demands for mandated treatment.

  Fund additional treatment program staff as the data driven service demands document the need.

Medical Treatment for Aging Population

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

- **Nursing/Medical Care Capacity**

Study how/if the use of a phlebotomist, unit coordinator, and clerical staff may expand nursing care of current positions which will provide additional nursing time to the aging population.

Fund additional medical/nursing and extender positions as the growth of the aging population requires.

- **Assisted Living (AL) and Terminal Care (TC) Capacity**

Clarify what level of medical/nursing care each institution can provide to aging and other offenders with medical and nursing care needs.

Develop criteria to place an offender in need of assisted living or terminal care for each institution.

Expand the trained offender worker program to assist with hospice, infirmary and assisted living care.

Monitor use of designated medical beds throughout the system.

Continue to monitor the demand for medical and nursing care services to meet the health care needs of the aging population on an annual basis.

Adjust staffing patterns to meet the level of health care services that data demonstrates is required.

Fund additional data driven positions requirements.

- **Centralized Pharmacy**

Study whether the use of extended medications would be cost effective and expand nursing care resources.

Complete the study of cost effectiveness of centralizing pharmacy services for IDOC.

Implement a plan for pharmacy services.

Monitor effectiveness and cost savings of a new centralized pharmacy, if implemented.

Monitor and adjust any new pharmaceutical plan and determine if additional positions are required.

Fund additional required positions.

Gender Responsive Treatment for Female Offenders

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

- IDOC should revise key policies that allow flexible, culturally and gender responsive rules. Security and supervision should be realistically consistent to meet the risks and needs of women.

- IDOC must increase the number of BFOQs at ICIW, provide incentives to attract female correctional officers from some of the male facilities, and aggressively recruit female correctional officers.

- Provide gender-specific training that will help staff be more effective in working with female offenders.

- Develop evidence-based programs that are creative, flexible, realistic and women-centered.

- Develop a balance between non-traditional training to expand economic, employment and social roles of women with those that can in a short time frame prepare women for work in the community to which they are returning.

- Ensure that the therapeutic community (STAR) meets programs and activities requirements as set forth in ACA First Edition Performance-Based Standards for Therapeutic Communities

- Develop evidence-based Re-entry programs in conjunction with CBC, the Parole Board and other government, private and community based programs.

Reentry Programs and Opportunities

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

Expand the current number and type of evidence-based (EBP) reentry programs offered by institutions and increase the number of participants.

Change the release and reentry program model to implement a system-wide tiered step down approach by releasing institutions.

Fund efforts to build capacity or sustain changes based on results, budget justifications and priorities for reentry programs using a step down approach.

Appropriate and fund additional staff necessary to ensure assessed individuals from special needs populations will receive opportunities to participate in tiered reentry programs prior to release.

IPI and Vocational Programs

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

Appropriate (i.e., set aside) and fund initiatives related to EBP vocational training program, including hiring of adequate vocational training personnel to the program for the target populations

Appropriate funding to extend basic educational opportunities (ABE and GED) for offenders as fundamental to successful vocational and work opportunities that extend to community reintegration.

Approve and fund to increase staff positions in industries, vocational training and other work programs based on the outcome of the independent staffing analysis and the initial classification validation study/

Appropriate and fund efforts to expand industries programs for eligible female offenders and special needs populations.

Appropriate and fund hiring of a Central Office volunteer coordinator to significantly expand the use of volunteers to reduce costs and consistent with evidence-based programming initiatives for correctional programming and services;

Amend statutes as necessary to achieve initiatives.

Implement vocational training programs and expand IPI.

Continue funding efforts to build capacity or sustain changes based on results, budget justifications and priorities for vocational training programs and IPI.

2. Classification

The issues and problems posed by the classification system have evolved over time. Consequently, their resolution and the development of a valid and reliable classification system will not occur through any one or all of the short-term strategies identified. It is also important to remember that the need to revalidate the classification system is not an indication that the current or original system was faulty or that the classification staff is performing poorly. Every three to five years, the objective classification systems should be subjected to a rigorous revalidation process to ensure that the instruments are valid and reliable for the current institutional populations and that the policies and procedures reflect the current laws and norms. Therefore, in addition to recommending short-term strategies, the following long-term strategies for strengthening and refining the classification policy and procedures are recommended:

- Revise and Update the external classification system. Because many of the concerns and barriers observed during this assessment were applicable to both the men and women offenders, a study to assess the validity of the classification system for the Department's offender populations is strongly recommended. The study should include separate samples/files for the male and female offenders to explore the question as to whether a gender-specific system is needed. This initiative would also provide the opportunity to:
    - Test alternative definitions to potentially improve the predictive power of the current custody risk factors and generate additional dynamic risk factors;
    - Develop separate initial and reclassification instruments;
    - Develop indices for rating the severity of criminal offenses and major and minor institutional infractions disciplinary;
    - Specify reasons and procedures for discretionary and mandatory overrides; and
    - Refine to the classification process.

The redesign process should, at a minimum, include the following tasks:

Task 1: Review of this classification assessment to ensure that all of the problems and/or questions associated with the risk factors, weight of the factors, policies, and procedures have been identified and to explore additional options for improving the system. This review requires input from classification supervisors, case managers, treatment, security, executive, research, mental health, medical, and information system staff.

Task 2: Assess the validity of current risk factors, custody scale, and classification procedures and test the predictive power of the suggested refinements to the current and new risk factors as derived from this assessment and the review of the system. This task will require statistical analyses of electronic files with criminal history, classification, and disciplinary data for the male and female offenders and special populations. In addition, in order to test some of the suggested modifications to the risk factors, manual data collection from the case files may be required.

Task 3: Revise and fine-tune the system. Based on the results of the statistical analyses and simulations, the classification instruments, manual, and policies should be updated.

Task 4: Document the revalidation process and results. A written report should be prepared documenting the presenting problems, statistical analyses, recommendations, and refinements. The current policies should be updated to reflect all modifications to the process.

Task 5: Implement the approved modifications to the classification system. The Department should develop a comprehensive time-task chart for training all classification staff, educating the non-classification staff, modifying the automated information system, and structuring the implementation of the approved changes to the system.

Task 6: Design and implement ongoing auditing and monitoring processes to track the classification process and ensure quality control of the system.

a. Assess the Department's internal classification goals and objectives and develop a formal system that will provide reliable and useful information for managing and placing offenders within a facility. Because intra-facility management of female and special need populations (sexual predators, sexually vulnerable, mental health, geriatric, administrative segregation, etc.) pose different sets of questions and problems from than those presented by general population offenders, specialized systems for these populations may need to developed. Thus, the Department must specify its internal classification goals for the general population as well as these special populations. Development of an internal classification system would require a validation study that includes each of these populations to ensure that the system provides an accurate assessment of their personality and behavioral patterns related to housing, program, and/or work assignments

To undertake either or both of these classification development efforts requires strong commitment by Executive and facility-administrative staff. They will require, in addition to intensive staff participation, resources to generate the data for developing and testing the risk factors, updating the classification module within ICON, revising departmental policies and procedures, and implementing the updated classification system.

3. Facilities and Operations

When the classification system is validated, a suitable and efficient bed utilization plan can be developed and implemented using frequency distributions of custody levels and estimates of special needs housing for the long run. That plan would also take into consideration the projected increase in male and female offenders, the physical condition of each facility and the housing units within them, as well operational, programming and staffing considerations.

Through that analysis, options can be developed, and recommendations made so that beds can be distributed appropriately in available and appropriate housing. If there is shortfall of beds for custody levels and special needs, plans can be made to provide additional, appropriate beds via capital improvements, expanded use of community resources, contracted correctional services, and/or other innovative approaches.

3.1 Institutions

- **Operations**

The long-term recommendations to IDOC and the legislature that follow are related to the previously identified operational issues that support the capacity to provide treatment services to the special offender populations that have treatment needs for substance abuse, mental illness, sex offenses, medical treatment for chronic and terminal illness due to aging, and gender-responsive services for women. The operational issues that were assessed include staffing, training and development, and ICON and performance measures.

An abbreviated list of the long-term recommendations is available in the Roadmap that accompanies this report.

Systemic Staffing Study

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

1) IDOC should implement approved changes to management controls for overtime identified in staffing plan.

2) It is important that the results of the IDOC staffing study are thoroughly reviewed to identify any proposed changes to statutes that would result from staffing study.

3) Develop a plan to continue funding that phased hiring of IDOC staff to meet minimum staffing goals.

4) Develop and fund recruitment strategies for increasing hiring of women and ethnic minorities at IDOC.

5) The legislature should review, approve and authorize hiring priorities based on hiring plan and budget.

6) The legislature should continue to appropriate needed Central Office staffing consistent with independent staffing analysis and plan.

7) It is imperative that the legislature understands that new EBP initiatives may require additional Central Office staff positions to perform that necessary program validation and outcome studies.

Staff Training

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

1) Continue funding efforts to build capacity or sustain changes based on results, budget justifications and priorities for staff training and development. To do so, the following is recommended:

   a) Use the systemic security and treatment/program staffing analysis to support identification of training needs.

   b) Review the current system-wide training plan and address legal risk management issues with counsel.

   c) Develop a plan to address training deficits that are identified in this report.

   d) Review IDOC training budget on an annual basis and adjust to meet current training needs.

   e) Ensure that all IDOC training addresses applicable evidence based practices and professional requirements of *ACA ACI 4th edition Standards and 2006 Standards Supplements.*

   f) Enhance performance measurements for training at the institutions.

   g) Appropriate and fund hiring training coordinators at institutions where vacancies exist.

   h) Appropriate and fund efforts by IDOC to seek block grants through federal government agencies to address gaps in training for staff working with special populations.

ICON and Performance Measurements

The long–term recommendations to be implemented by end of Fiscal Year 2012 include:

1) Authorize and fund Information Technology study to assess capacity and determine needs of institutions.

2) Continue funding efforts to build capacity or sustain changes based on results, budget justifications and priorities for ICON and data systems.

3) Fund training for institutional staff relative to modifications to ICON and other data system (particularly as it relates to the classification study outcomes).

4) Authorize and fund data warehousing, data mining and data mapping for IDOC.

5) Appropriate and fund quality assurance and monitoring component for IDOC data systems.

6) Implement continued ICON and Performance Measurement training for IDOC staff.

7) Implement use of additional key performance indicators for ICON.

8) Continue funding efforts to build capacity or sustain changes based on results, budget justifications and priorities for performance measurements.

9) Legislature-Appropriate and fund requests to expand grant writing resources related to provision of programs and services.

10) Appropriate and fund efforts by IDOC to partner with Regents and non regent institutions to conduct EBP outcome studies on reentry programs and recidivism.

11) Appropriate and fund evaluation of available technologies to enhance performance measurement and accountability for security rounds and movement control at IDOC institutions.

Infrastructure

The Anamosa facility has served the State of Iowa well over its' long life and continues to play an important role in the overall effectiveness of the prison system. In order to remain effective, the facility is in need of updating. The cell houses are no longer conducive to sound correctional supervision and programming.

- We recommend replacement of the older housing unit buildings by constructing 1000 beds of new housing units. The current housing will need to remain in use until new housing units are ready to receive offenders. As a result some of the existing buildings will be required to be demolished.

- Renovate old housing units building to contain support and program functions. This could include classrooms, hobby craft, counseling centers, meeting rooms and libraries.

Bedspace Utilization

When the classification system is validated, a suitable and efficient bed utilization plan can be developed and implemented using frequency distributions of custody levels and estimates of special needs housing for the long run. That plan would also take into consideration the projected increase in male and female offenders, the physical condition of each facility and the housing units within them, as well operational, programming and staffing considerations.

Through that analysis, options can be developed, and recommendations made so that beds can be distributed appropriately in available and appropriate housing. If there is shortfall of beds for custody levels and special needs, plans can be made to provide

additional, appropriate beds via capital improvements, expanded use of community resources, contracted correctional services, and/or other innovative approaches.

3.2. Community Based Corrections

This section of the report presents preliminary recommendations with regard to maximizing the benefits to the state from the best possible use of community-based correctional centers under the jurisdiction of each of the eight judicial districts. These preliminary long-term recommendations will be supplemented as part of the work proposed in Phase 2 of the Iowa Department of Corrections Master Plan.[118] Similarly, the conclusions drawn and recommendations made will be reexamined and modified based on analysis of not yet available data and information, as well a complete analysis of how best to integrate the Department of Corrections' resources (both existing and proposed) with the resources in each of the independent eight judicial district's Departments of Correctional Services.

1. **Create more female only CBC facilities.**

   Female offenders should not be housed in sight of males or near sex offenders. Management has done an admirable job of trying to separate them as much as possible however some facilities create enormous challenges. Some locations have no capacity for female offenders at all. For example, Johnson County has no female capacity and Johnson County female offenders are assigned to Cedar Rapids for work release. Fort Dodge and the Sheldon Residential Facilities also do not house women offenders. The women from those areas are housed in the Curt Forbes facility in Ames and the Sioux City facility respectively. Therefore, those women already have issues finding employment and addictions services upon release must start their job and treatment searches over when finally released form the CBCs.

   The State and Districts should look at creating separate residential facilities or a few centralized residential facilities specifically for women offenders. Separate facilities for female offenders would create a safer environment for the female offenders and could foster gender responsive and gender specific programming. Some of the co-gender facilities had female offenders housed in the same corridor where male offenders and male sex offenders are housed. In others, they are housed in an adjacent wing but within sight of male offenders and share dinning areas. To aggravate the issue of safety for these female offenders, based on staffing constraints, often there was but one residential staff person working on the off shifts and in some cases it was a male staff person. In light of PREA and the current trends towards gender specific programming it would be a prudent move to have separate facilities for the female offenders.

2. **Consider contracting for privately operated halfway houses for male and female offenders.**

   Contracting for more halfway houses or contracting for additional beds at existing halfway houses could provide for quick and economical expansion of capacity for both male and female offender services without incurring capital costs. Some of

[118] The Legislature is currently considering a request from the Department of Corrections for funding Phase 2 work.

those CBC's could be operated under contract with private not for profits and could be considerably smaller (10-15 bed) halfway houses.

3. Seek out alternative funding sources for programs and services.

Many programs provided through the CBCs are grant funded however with the national attention that re-entry and the debate in congress over the "Second Chance Act" there are many opportunities for grants and perhaps foundation funding to support specific programs or for underserved populations. Several districts admitted that they had not pursued possible grant funding as much as they had in the past due to the shortage of staff to do so. Judicial district staff should make every effort to identify and obtain funding for such programs to supplement the services provided. As example, a low income housing facility is being built in Cedar Rapids with foundation and federal grant funding.

4. Consider using additional supervision methods.

Alternate supervision methods could aid in easing the pressure probation officers feel with their heavy caseloads. By moving offenders who require less supervision to supervision such as a Self Supervised Probation done by judge or district for those requiring little supervision or a Monitory and Maintenance Program for offenders with a little higher risk. Offenders in this group could perhaps be supervised by lower level staff.

5. Review the practice of referring sex offenders to CBC facilities.

Several districts expressed concern over sex offenders who have been sent to their facilities but are unable to work outside the facility due to the nature of their crime. These offenders are taking up space that could be better utilized by other offenders. Some of these offenders would perhaps be better served in prison. Persons who are unable to work should not be placed in a residential work release setting. Educating those making such referrals may be required.

6. Communicate and educate the legislature on the impact of new legislation.

The legislature should be informed about the impact that regulations and legislation may have on institutional and community corrections. Sometimes there are unintended consequences to legislation and rule changes passed by legislatures. Some examples that have recently occurred include:

- The legislature recently created crime classes that did not exist before. One crime was a serious misdemeanor that carried 1 year in jail, but now is a class D felony on the third offense and carries prison time.
- OWI penalty enhancements have resulted in additional prison time. Prior to this change the courts went back 6 years for prior offenses but now go back 12 years. This has resulted in a higher number of second and third offenses thus creating a "new class" of offender who are eligible for prison and residential beds.

- The addition of precursor drugs to list of illegal drugs has resulted in additional incarcerations.

4. Put more staff in neighborhoods and high crime areas instead of at centers.

A key component to reentry is placing services closer to the neighborhoods where the offenders and their families live. This practice makes supervision easier and increases the likelihood that family members will become involved in reentry programs and be more understanding and supportive of the requirements the offender must meet.

Appendix C: Survey Instruments Mental Health – CBC Mental Health Services Needs and Availability

Paper Survey Instruments of CBC Offender Records

Client's Name:
ICON #:
County of Residence:

Does the client have a mental health issue? ☐ Yes ☐ No
Does the client have current substance abuse issues? ☐ Yes ☐ No

Diagnosis:
- ☐ Schizophrenia, Schizoaffective ☐ Bipolar
- ☐ Depression/Major Depression
- ☐ Post Traumatic Stress Disorder ☐ Eating Disorders (Anorexia, Bulimia)
- ☐ Dementia
- ☐ Brain Injury/Organic Disorder ☐ Borderline Personality Disorder
- ☐ Substance Abuse/Dependence Disorder
- ☐ Other: ☐ Psychosis/Psychotic Disorders

Diagnosed By: ☐ MD, DO, PAC ☐ LISW, LMSW, LMHC ☐ RNP

Date Diagnosed:

Involved in mental health treatment currently: ☐ Yes ☐ No

Receiving Social Security or Social Security Disability Benefits? ☐ Yes ☐ No

Past Treatment: ☐ Yes ☐ No

Current Supervision Status:
- ☐ Probation ☐ Parole
- ☐ Intensive ☐ High Normal ☐ Low Normal ☐ Minimal ☐ Low Risk
- ☐ Administrative

Current LSI score: Initial LSI score:

Current Supervision:
Violations: ☐ None ☐ technicals ☐ new arrests ☐ served contempt/jail time
☐ positive UA/BA's

Previous Supervision Status: ☐ Probation ☐ Parole When?
☐ Intensive ☐ High Normal ☐ Moderate ☐ Minimal

How did previous Supervision end?
☐ Successful ☐ Sanctions ☐ Contempt Time ☐ Revocation

Submit by Email | Print Form

Durrant Study Survey- County Mental Health Services

Community Based Corrections Ability to Obtain Mental Health Treatment for Offenders Under Community Supervision

Judicial District:

County:

Contact Information:

Name: Phone Number:

E-Mail:

Are offenders allowed access to county funding? If so, please check the offenders who can access county mental health funding.

- ☐ Probationers
- ☐ Work Releasees
- ☐ Parolees
- ☐ Residential Probationers

Does this county have a mental health services office or satellite that provides services for offenders under community corrections supervision?

- ☐ Yes
- ☐ No

If yes, please skip the rest of this page and answer the questions on page 2 and 3 of this survey.

If this county has no available mental health services for offenders under community corrections supervision, you have completed this survey.

Please send completed surveys to pbajrw@aol.com no later than January 25, 2008.

The following questions are about mental health services that are available for offenders under community supervision in this county. Please check the appropriate response on the scale based on the following indicators:

0 = Not Available
1 = Theoretically, but nearly impossible to access
2 = Difficult, but able to access
3 = Available but long waiting lists for services.
4 = Available most of the time
5 = Always available

Available Mental Health Services for Offenders in this County

Therapy/Treatment	0	1	2	3	4	5
Publicly Funded	☐	☐	☐	☐	☐	☐
Only If Insured	☐	☐	☐	☐	☐	☐
Corrections Funded	☐	☐	☐	☐	☐	☐

Comments re:

Medication Services	0	1	2	3	4	5
Publicly Funded Medications	☐	☐	☐	☐	☐	☐
Only If Insured	☐	☐	☐	☐	☐	☐
Corrections Funded	☐	☐	☐	☐	☐	☐

Comments:

Is there a Psychiatrist, Psychiatric Nurse Practitioner, or Psychiatric Physician's Assistant in this county who prescribes medications for offenders who are under community corrections supervision?

☐ Yes ☐ No

Please send completed surveys to pbajrw@aol.com no later than January 25, 2008.

If so, how long does it take to be seen by this prescriber? ☐

Co-occurring (MH/SA) Treatment

0	1	2	3	4	5
☐	☐	☐	☐	☐	☐

Who Provides the Treatment?

- ☐ Mental Health Agency/Provider
- ☐ Substance Abuse Agency/Provider
- ☐ Combination of MH + SA
- ☐ Corrections

The Co-occurring Treatment Provided Is:

- ☐ Integrated (using EBP Curricula/Treatment Program)
- ☐ Parallel (MH provides MH Treatment/ SA provides SA treatment)

Psychiatric Hospitalization

0	1	2	3	4	5
☐	☐	☐	☐	☐	☐

Does this county have a contract to provide hospitalization in the county?

☐ Yes ☐ No

If not, how many miles is the hospital located from the county? ☐

Do offenders under community supervision in this county have access to any of the following mental health services?

	Yes	No
Jail Diversion	☐	☐
Jail-Based Mental Health Services	☐	☐
Mental Health Courts	☐	☐
Mobile Crisis Response	☐	☐
Assertive Community Treatment	☐	☐

Please send completed surveys to pbajrw@aol.com no later than January 25, 2008.

(ACT) Team ☐ ☐

Other/Comments:

Does this County have available Trauma / Victim Services

	Yes	No	Unknown
Specific to Domestic Violence	☐	☐	☐
Specific to Sexual Assault	☐	☐	☐
Specific to Other Crime Victims	☐	☐	☐
Specific to Veteran Needs	☐	☐	☐

Any additional comments about obtaining mental health services for offenders under community supervision in this county:

Please send completed surveys to pbajrw@aol.com no later than January 25, 2008.

Submit by Email | Print Form

Judicial District Durrant Study Survey

Community Based Corrections Ability to Obtain Mental Health Treatment for Offenders Under Community Supervision

Judicial District:

Contact Information:

Name: Phone Number:

E-Mail:

Does this District have case managers and/or probation/parole officers who work specifically with offenders who have mental illnesses?

☐ Yes ☐ No

If yes, how many?

Is this number sufficient?

If not, please explain:

What strategies has your district implemented to improve access to mental health services?

Please send completed surveys to pbajrw@aol.com no later than January 25, 2008

Is specialized training available for those case managers/coordinators and probation/parole officers who supervise/work with offenders who have mental illnesses?

☐ Yes ☐ No

If yes, please describe:

If no, what training would you like to see implemented?

Additional comments related to mental health and related services for offenders who are under community supervision:

Please send completed surveys to pbajrw@aol.com no later than January 25, 2008

Appendix D:
Classification System Update

Validation and Redesign of the Iowa Department of Corrections Inmate Classification System:

Findings and Recommendations

Completed by:

Criminal Justice Institute, Inc.
Middletown, CT

March 28, 2008

I. Statement of Needs

Criminal Justice Institute, Inc. (CJI) undertook a comprehensive assessment and re-design of the Iowa Department of Corrections (IDOC) custody classification system. This component of the Master Plan was intended to address the problems with the classification system identified in the Durrant, et al, "State of Iowa Systematic Study of the State Corrections System."[119] As the current classification system problems were generated by subjective and outdated classification risk factors as well as unreliable classification processes,[120] we worked closely with IDOC staff to analyze current classification practices; develop practical, cost-effective solutions; draft new policies and develop preliminary classification factors and instruments; and provide feedback to findings and recommendations; and develop and execute implementation plans.

II. Assessment and Design Tasks

CJI staff, on behalf of Durrant with regard to the Iowa Corrections System Study Phase 2, completed the following tasks:

1. **Finalized Project Plan and Reviewed of System.** CJI worked closely with the IDOC Classification and Female Offender Focus Groups throughout this initiative to review the current classification assessment to ensure that all of the problems and/or questions associated with the classification risk factors, weight of the factors, policies, and procedures had been identified and to explore realistic options for improving the system. (See Appendix A for a listing of the members of the Focus Groups.) The focus groups' roles were to analyze current classification practices; develop practical, cost-effective solutions; draft new policies and develop preliminary classification factors and instruments; provide feedback to findings and recommendations; and develop and execute implementation plans.

2. **Develop Preliminary External Classification System for IDOC.** Based on the discussions of the focus groups and classification literature, preliminary gender-specific initial and reclassification custody assessment instruments, policies, and procedures were developed. The preliminary policies and instruments were presented to the focus groups for feedback to ensure the focus groups' discussions and suggestions were accurately reflected in the documents.

3. **Identify Data Requirements, Sources, and Samples.** Electronic data were requested from the IDOC automated information system regarding the inmates' demographic, classification, disciplinary history, criminal history, current charges, program needs, etc. CJI worked closely with IDOC research and information system staff to:
   - Identify the data required to assess the validity of the current system, test the preliminary risk factors, develop custody scales, assess any mandatory restrictors identified by the IDOC for the male and female inmate populations; and
   - Draw the samples required to validate the current instrument and test the preliminary initial and reclassification instruments and policies. Samples were stratified by assessment date, gender, and type of custody assessment.

4. **Analyze Data.** CJI conducted analyses by type of custody assessment and gender to assess the validity of the risk factors at the initial versus the reclassification assessment for male and female inmates. The following statistical analyses of the current and preliminary risk factors and the

[119] Durrant in association with Pulitzer-Bogard & Associates and Criminal Justice Institute (2007). "State of Iowa Systematic Study of the State Corrections System." Des Moines, IA: Durrant Group.
[120] For a complete listing of the strengths and barriers of the current IA custody classification system, see pages 24-25 of the report, "State of Iowa Systematic Study of the State Corrections System."

custody scales were completed and presented to the focus groups and IDOC executive staff:

- Frequency distribution of the demographic and offense characteristics of samples compared with the inmate populations;
- Frequency distribution and mean number of disciplinary reports for the initial and reclassification risk factors by gender;
- Computation of the rates of mandatory restrictors and discretionary overrides;
- Frequency distribution of the scored and recommended custody levels;
- Multiple regression and correlation coefficients among the risk factors, total score, scored custody level, and final custody;
- Analyses of variance of the custody scale cut points; and
- Graphs comparing the current and recommended custody distributions to demonstrate the impact of any changes**.**

5. **Present Findings and Recommendations**. With the completion of Tasks 1 - 4, CJI presented the findings and recommendations to the IDOC focus groups and executive staff. These presentations included a review of the methodology, comparison of the current versus the preliminary system, recommendations for improving IDOC classification system for the male and female inmates, and projected custody distributions by gender. As per IDOC feedback and questions from the IDOC, additional analyses were conducted and the classification instruments and procedures were revised.

6. **Develop New Classification Instruments, Manual, Polices, Procedures, and Implementation Plan.** CJI has provided guidance to the IDOC as it drafts new classification policies and manual. CJI will continue to work closely with the IDOC to ensure that the policies and procedures meet the needs of the Department while adhering to national standards. Furthermore, CJI will work with the IDOC to develop a feasible strategy for implementing the new classification system.

7. **Preparation of Phase-Two Final Report.** In addition to this summary of the classification initiative for the classification component of the IDOC Master Plan, CJI will produce a final report that summarizes all of the work completed during this phase of redesign and validation of the IDOC external classification system. CJI will document the presenting problems, statistical analyses, recommendations, and refinements to the IDOC classification system. This report will be written in non-technical language appropriate for distribution to administrative, facility-based officials, and classification supervisory and line staff. It will also provide baseline data for tracking the modifications to the system as well as for assessing their impact.

III. Validation and Refinement of the IDOC Classification System

A. Methodology

The validation and refinement of the IDOC classification system required an assessment of the relationship between the current and revised risk factors and the inmates' overall institutional adjustment and violent institutional behaviors. The analyses were conducted separately for the initial versus reclassification samples and for the male and female inmate populations. This ensured that the revised scales and risk factors were valid for categorizing inmates into custody levels according to their threat to the security of the institution and the safety of staff, other inmates, and themselves.

The most powerful predictor of institutional risk is involvement in serious institutional misconduct. For the analyses of the risk factors and custody scales, the three primary indicators of risk were the total number of institutional infractions (overall behavior), the number of violent infractions (violent), and the percentage of cases (% bad) with an institutional infraction during the first twelve months of incarceration following the custody assessment.[121]

B. Validation Samples

As previously indicated, multiple data files were required for these analyses. Electronic demographic, current offense, prior criminal, escape, supervision, program/intervention, mental health, civil commitment, needs assessment, and custody assessment data were obtained from the IDOC Iowa Corrections Offender Network (ICON). The validation samples included:

- Initial classification – all initial classification assessments completed on the inmates admitted to the Iowa Medical and Classification Center between October 1, 2005 and September 30, 2006. The sample included 3,919 male inmates and 574 female inmates.

- Reclassification -- custody reassessments completed by IDOC institutional staff between October 1, 2005 and September 30, 2006 (if an inmate had multiple custody assessments, the first custody re-assessment during the sample window was included in the sample). This sample included 7,788 male inmates and 966 female inmates.

To estimate the impact of the changes to the classification system on the current IDOC population, demographic, current offense, prior criminal, escape, supervision, program/ intervention, needs assessment, and custody assessment data were obtained for the IDOC inmate populations as of November 1, 2007. This sample included 8,145 male inmates and 756 female inmates.

---

[121] A key task of the focus groups was to differentiate among IDOC institutional infractions according to the threat they posed to the safety and security of the institution. The Sub-committee identified four types of infractions: Predatory/Violence, Institutional Management, Non-Compliance (Control/Disruption of Facility), and Miscellaneous. The violent infractions included: killing; assault; kidnapping; extortion, blackmail, protections (strong-arming); rioting; arson; robbery; criminal conduct; fighting (class b); threats/ intimidation (class b); sexual misconduct (class b); unauthorized group/gang conduct; and attempt or complicity (class a). The inmates' overall behavior included the predatory/violence, institutional management, and non-compliance (control/disruption of facility) behaviors.

Provided in Appendix B are two tables with the demographic, current offense, prior offense, and institutional data of the inmates within the validation samples contrasted with those of the IDOC inmate population as of November 1, 2007. These data suggest that the initial and reclassification samples are representative of the current IDOC population. Therefore, inferences based on our findings and observations from the samples provide insight to the validity of the PSD classification systems and any recommended changes.

C. Validation Terminology

There are several terms that are used throughout this description of the validation and design of the IDOC classification system; these include:

- **Scored custody level** – the custody level suggested by the total number of points the inmate scored on the objective risk factors. For the current IDOC classification system, if the inmate's total score was between zero and five points, his/her scored custody level was minimum. If the total score was six to ten points, he/she was considered medium custody. If the inmate scored 11 or more points, his/her scored custody level was maximum custody.
- **Final custody level** – the custody level to which the inmate was assigned after IDOC mandatory restrictors regarding the placement of inmates and any applicable discretionary factors were considered. This is the custody level to which the offender was assigned following the custody assessment.
- **Reliability** – assessment of the consistency or agreement across staff regarding the inmate's score on the respective risk factors, applicability of any mandatory or discretionary override criteria, and final custody level.
- **Predictive Power** – as measured by correlation co-efficient, this assesses the strength of the relationship between the risk factor or custody scale and institutional predatory behavior and overall adjustment. Correlation analyses ask the question, for example, does the number of institutional infractions vary according to the severity of the offender's current offense?[122] Correlation co-efficients allow us to compare the strength or predictive power of the respective risk factors by gender and across time (at initial classification and at reclassification).
- **Valid Custody Scale** – indicates that the classification system accurately assesses the risk to institutional safety and security posed by the inmates and identifies distinct groups of inmates, i.e., the behavior of minimum custody inmates differs from medium custody inmates; the behavior of medium custody inmates differs from maximum, etc. It is measured by an analysis of variance (ANOVA).
- **Statistical significance** - For the validation of the current IDOC classification system and design of the new system, the minimal standard for statistical significance was $p < .05$. Throughout this document when reporting the statistical significance of a statistic, * denotes $p < .05$; ** denotes $p < .01$ and *** denotes $p < .001$.

IV. Findings from the Validation of the Current IDOC Classification System

[122] Correlations range between +1.0 and -1.0; a correlation of +1.0 indicates a perfect positive relationship between the two variables, i.e., for each unit of increase in the risk factor, there is an equal increase in the rate of institutional infractions. In contrast, a negative relationship suggests, for example, as the score for the risk factor increase, the rate of disciplinary infractions decreases.

A. Assessment of the Current Initial Classification Process for the Male Inmates

Provided in Table 1 are current initial classification risk factors along with the mean number of institutional infractions during the first year of incarceration among the male inmates. These data are useful in determining if the respective categories within each of the risk factors help to identify distinct categories or groups of inmates. Table 1 illustrates, for example, that the most serious charge for about a third of the male offenders (34%) was a person offense that involved death, personal injury, threat of harm, and/or use of a weapon. Among the male inmates incarcerated for these types of crimes, the average number of violent institutional infractions during the first 12 months of incarceration was .12 reports. In contrast, among the 628 (16%) male inmates incarcerated for an offense that involved threat of harm, property damage, but no weapon, the average number of violent institutional infractions was .10. These data suggest that male inmates incarcerated for an offense that involved death, personal injury, or threats of harm had similar rates of institutional misconduct, and that their behavior differed from male inmates incarcerated for crimes that did not involve death, personal injury, or threats of harm. These offenders, for example, had only .04 violent reports.

Provided in Table 1, in addition to the scored risk factors, are the rates of institutional infractions for the scored and final custody levels at initial classification. Table 1 also documents the number and behavior of male inmates for which the scored custody level was overridden. The most common override reason among the male inmates at initial classification was a "security" reason. These 207 inmates (5.3%) were considered a security risk due to pending charges, gang affiliation, recent adjustment/management problems, escape history, and/or protective needs. The administrative overrides (52, 1.3%) were due to IDOC policies that restrict offenders with specific characteristics, crimes, or sentences from minimum or even medium custody. At initial classification, the scored custody level was over-ridden for 7.9% of the male inmates.[123]

Table 2 provides the correlation coefficients for the relationship between the current risk factors at initial classification for the male and female inmates. Among the male inmates' current offense, length of sentence, record of violence, time served, time remaining, behavior and age, institutional adjustment, and last custody level were correlated with the number of violent infractions and overall institutional adjustment during the first 12 months of incarceration. The male inmate's total score, scored custody level, and final custody levels were statistically correlated with violent, overall and % bad behavior during the first 12 months of incarceration.

Further, as shown in Table 3, the analysis of variance indicates that the scored custody scale is valid for the male inmates at initial classification. For example, among the 1,801 male inmates who scored as minimum, the mean number of overall number of institutional reports during the first 12 months of incarceration was 1.27 reports. The variance among the minimum custody inmates was 1.15 to 1.41 reports, respectively. Among the male inmates who scored as medium, the mean number of overall number of institutional reports during the first 12 months was 2.25 reports. The variance or lower and upper boundaries for this custody level were 2.08 to 2.42 reports. Continuation of these analyses to consider the rates of violent behavior as well as consideration of the behavior of the male inmates, who scored as maximum custody,

[123] The generally accepted standard for overrides is 5 to 15%. Austin, James and Hardyman, Patricia (2004). "Objective Prison Classification: A Guide for Correctional Agencies. Washington, DC: National Institute of Corrections.

indicates that the scored custody scale identifies three statistically different groups of inmates.

However, analyses of variance for the final initial classification custody decisions indicate that with the application of the mandatory restrictors and staff discretion, the validity of the classification system diminished. The minimum and medium custody inmates are not well differentiated and the medium and maximum custody are not well differentiated. It was important to observe that the minimum and maximum custody male inmates differ with respect to rates of overall infractions and violence.

B. Assessment of the Current Initial Classification Process for the Female Inmates

Provided in Table 4 are current initial classification risk factors along with the mean number of institutional infractions during the first year of incarceration among the female inmates. Table 4 illustrates that the most serious charge for about a fifth of the women (18%) was a person offense that involved death, personal injury, threat of harm, and/or use of a weapon. Among the female inmates incarcerated for these types of crimes, the average number of violent institutional infractions during the first 12 months of incarceration was .14 reports. In contrast, among the 57 (10%) female inmates incarcerated for an offense that involved threat of harm, property damage, but no weapon, the average number of violent institutional infractions was .12. As observed for the male inmates, women incarcerated for an offense that involved death, personal injury, or threats of harm had similar rates of institutional misconduct, and their behavior differed from women incarcerated for crimes that did not involve death, personal injury, or threats of harm. These 413 offenders had an average of .07 violent reports.

In addition to the scored risk factors, provided in Table 4, are the rates of institutional infractions for the scored and final custody levels and override reasons at initial classification for the female inmates. At initial classification, 675 of the women (65%) scored as minimum custody, after consideration of the mandatory and discretionary override criteria, 61% of the women were placed in minimum custody. Among the women at initial classification, the most common override reason was for "security;" 19 (3.1%) of the women were considered security risk due to pending charges, gang affiliation, recent adjustment/management problems, escape history, and/or protective needs. At initial classification, the scored custody level was over-ridden for 3.3% of the female inmates.

As shown in Table 2, among the female inmates, the only current risk factor that was correlated with institutional violence was their record of violence. Their current offense severity, record of violence, number of prior disciplinary reports, behavior and age, and institutional adjustment were correlated with their overall institutional adjustment and % bad behavior during the first 12 months of incarceration. The female inmate's total score, scored custody level, and final custody levels were correlated with their overall adjustment and % bad during the first 12 months of incarceration. Only the scored custody level was statistically correlated with violence.

As is shown in Table 3, the analysis of variance of the initial classification custody scales indicated that neither the scored nor the final custody levels are valid for differentiating among the women's predatory behaviors or overall institutional adjustment. The data suggested that with respect to overall adjustment, the minimum custody female inmates differed from those labeled medium or maximum custody, but there were no statistical differences in the misconduct rates of the medium and

maximum custody female inmates. With respect to predatory behavior, there was no statistical difference between the minimum and medium custody female inmates. There were so few maximum custody females (8), that the statistical analyses were inconclusive. In sum, these analyses indicated that the current classification system is not valid for the female inmates at initial classification.

C. Validation of the Current IDOC Reclassification Process for the Male Inmates

Provided in Table 5 are current reclassification risk factors along with the mean number of institutional infractions during the 12 months following the custody re-assessment among the male inmates. Table 5 illustrates, for example, that the most serious charge for over half of the male offenders (55%) was a person offense that involved death, personal injury, threat of harm, and/or use of a weapon. Among the male inmates incarcerated for these types of crimes, the average number of violent institutional infractions during the first 12 months following the custody assessment was .10 reports. In contrast, among the 940 (12%) male inmates incarcerated for an offense that involved threat of harm, property damage, but no weapon, the average number of violent institutional infractions was .11. As observed for the initial classification assessments, these data suggest that male inmates incarcerated for an offense that involved death, personal injury, or threats of harm had similar rates of institutional misconduct, and their behavior differed from male inmates incarcerated for crimes that did not involve death, personal injury, or threats of harm. These 2,605 male offenders, for example, had only .04 violent reports.

Provided in Table 5, in addition to the scored risk factors, are the rates of institutional infractions for the scored and final custody levels at reclassification. Table 5 also documents the number and behavior of male inmates for which the scored custody level was overridden. The most common override reason among the male inmates at reclassification was a "security" reason. These 569 male inmates (7.3%) were considered a security risk due to pending charges, gang affiliation, recent adjustment/management problems, escape history, and/or protective needs. The administrative overrides (150, 1.9%) were due to IDOC policies that restrict offenders with specific characteristics, crimes, or sentences from minimum or even medium custody. At reclassification, the scored custody level was over-ridden for 15.5% of the male inmates.

Table 6 provides the correlation coefficients for the relationship between the current reclassification risk factors for the male and female inmates. At reclassification the male inmates' current offense, record of violence, time remaining, number of disciplinary reports, behavior and age, institutional adjustment, and last custody level were correlated with the number of violent infractions and overall institutional adjustment during the first 12 months of incarceration. In addition, the offender's escape history was correlated with his overall adjustment. The male inmate's total score, scored custody level, and final custody levels were statistically correlated with violent, overall and % bad behavior during the 12 months of incarceration following the custody re-assessment.

Further, as shown in Table 7, the analysis of variance indicated that the scored custody scale is valid for the male inmates at reclassification with respect to violent behavior and overall adjustment. For example, among the 2,986 male inmates who scored as minimum custody, the mean number of overall number of institutional reports during the 12 months of incarceration following the custody re-assessment was .78 reports. The variance among the minimum custody inmates was .71 to .85 reports, respectively. Among the male inmates who scored as medium, the mean number of overall number

of institutional reports during the 12 months of incarceration following the custody re-assessment was 1.94 reports. The variance or lower and upper boundaries for this custody level were 1.82 to 2.05 reports. Continuation of these analyses to consider the rates of violent behavior as well as consideration of the overall behavior of the male inmates, who scored as maximum custody, indicates that scored custody scale identifies three statistically distinct groups of inmates. However, the analyses of the final custody levels indicated that with respect to overall institutional adjustment and violent behaviors the validity of the system is diminished. Inmates assigned to minimum custody or medium-outs have similar rates of infractions, however the behavior of these inmates is statistically different from those assigned to medium custody. Maximum and medium custody male inmates are distinct groups with respect to their violent and overall adjustment. Thus, the final custody designations are valid for identifying non-violent, low risk inmates and placing them in less restrictive custody levels. However, the less restrictive custody levels---minimum-outs, minimum-live out, minimum, minimum secured and medium-outs---are not valid for the male inmates at reclassification. As the security and administrative overrides contribute to the blending of the custody levels for the male inmates, it would behoove for the IDOC to review and update their policies and override criteria to ensure the integrity of the classification system.

D. Assessment of the Current Reclassification Process for the Female Inmates

Provided in Table 8 are current reclassification risk factors along with the mean number of institutional infractions during the 12 months following the custody re-assessment for the female inmates. Table 8 documents that the most serious charge for less than a third of the women (30%) was a person offense that involved death, personal injury, threat of harm, and/or use of a weapon. Among the female inmates incarcerated for these types of crimes, the average number of violent institutional infractions during the 12 months following the custody re-assessment was .18 reports. In contrast, among the 98 (10%) female inmates incarcerated for an offense that involved threat of harm, property damage, but no weapon, the average number of violent institutional infractions was .09. The majority of the women (60%) were incarcerated for a crime that did not involve death, personal injury, or even threats of harm. Among these 576 women, the average number of reports was .05 violent reports and 1.02 overall reports. These data suggest that this risk factor is an important factor for predicting the women's institutional adjustment.

In addition to the scored risk factors, provided in Table 8, are the rates of institutional infractions for the scored and final custody levels and override reasons at reclassification for the female inmates. At reclassification, 558 of the women (58%) scored as minimum custody, after consideration of the mandatory and discretionary override criteria, 57% of the women were placed in one of the four minimum custody levels. At reclassification among the women, the most common override reason was for "treatment;" the scored custody level for 15 (1.6%) of the women was modified to place the woman in a treatment program. (Note this is not a measure of the number of IDOC women assigned to treatment program. As the majority of IDOC female inmates are housed at ICIW, a custody level modification is not required for most program/ treatment assignments.) At reclassification, the scored custody level was over-ridden for 3.1% of the female inmates.

As shown in Table 6, among the female inmates, the current risk factors that were correlated with institutional violence was their current offense, record of violence, time remaining, number of discipline reports, and institutional adjustment. Their current offense severity, record of violence, time remaining, number of prior disciplinary reports, behavior and age, institutional adjustment, and last custody level were correlated with their overall institutional adjustment and % bad behavior during the 12 months following the custody re-assessment. The women's total score, scored custody level, and final custody levels were correlated with their violence, overall adjustment and %bad during the 12 months following the custody re-assessment.

As is shown in Table 7, the analysis of variance of the reclassification custody levels indicated that the scored custody scale is valid for differentiating among the women's predatory behaviors and overall institutional adjustment. Similar to the reclassification findings for the male inmates, the final custody levels are **NOT** valid. The various minimum and medium-out custody levels are not well differentiated and the medium and maximum custody female inmates are not well differentiated. This problem is acerbated by the mixing of the custody levels for housing and programming at ICIW, generating additional risk to low-risk, potentially vulnerable women.

V. Re-Design of the IDOC Classification System

As previously indicated CJI worked closely with the IDOC Classification and Women Offender Focus Groups to identify preliminary gender-specific initial and reclassification custody risk factors, policies, and procedures for the new classification system. One of the first, and perhaps most important decisions made by the focus groups was to develop separate instruments for the initial versus the reclassification process. As the current IDOC system has a single instrument, with this change the focus groups hoped that the new system would facilitate the flow of inmates to appropriate custody levels according to the inmates' institutional adjustment and performance rather than static criminal history factors. The preliminary instruments and custody scales were presented to the focus groups to ensure their comments were accurately reflected, to build consensus as to which risk factors would be incorporated in the initial and reclassification instruments for the male and female inmates, and to select the custody scales/criteria for assigning inmates to a custody level. This required long hours of meetings and much patience with numerous statistics, the focus groups worked tenaciously to build systems that valid for the male and female inmates.

The focus groups identified nearly 50 preliminary risk factors and considered multiple custody scales for the initial and reclassification process for the male and female inmates to build a truly gender-specific, valid classification system for the IDOC. (A listing of the preliminary risk factors identified by the focus groups is provided in Appendix C.) This report will summarize the analyses of the predictive power of the risk factors and custody scales selected for the respective instruments for the male and female at initial and reclassification.

A. Design of the Initial Classification Instrument for the Male Inmates

The risk factors selected for the male initial classification instrument were:

- Current Offense based on offense type – violent, property, drug, public order, or other;
- Number of Violent Current Charges;

- Severity of Prior Felony and Aggravated Misdemeanor Convictions during last 10 calendar years;
- Time Remaining to Serve;
- Severity of Prior Disciplinary Reports during last three calendar years;
- Number of Prior Class A, B, and C Disciplinary Reports during last three calendar years;
- Current Age at assessment;
- Escape History during last five calendar years;
- Stability Factors - as measured thru LSI-R subscales related to employment, living arrangements, finances, family, peers, attitude, and emotions; and
- STG Membership.

The new classification instruments approved by the focus groups are included in Appendix D. These instruments illustrate the operational definitions and scoring of the new risk factors and provide the custody scale cut points. As shown in Table 2, each of the new risk factors, except for the history of escape factor, is statistically correlated with institutional violence and overall behavior among IDOC male inmates at initial classification. The correlations with institutional adjustment, i.e., predictive power, of the new risk factors and custody scales, represent an improvement over the current system.

To illustrate the differences between the current and new classification systems, the analyses of variance of the new custody scales for the male inmates at initial classification are provided in Table 3 along with the ANOVA for the current system. The new scored custody levels are valid with respect to the male inmates' overall adjustment during the first 12 months of incarceration; however, there appears to be some blending of the medium and maximum custody inmates with respect to violent behaviors. Perhaps the most important finding from these analyses was the validity of the final initial classification custody level; the new custody scale represented a substantial improvement over the current scale, even after the administrative and security restrictors were considered.

B. Design of the Initial Classification Instrument for the Female Inmates

The risk factors selected for the female initial classification instrument were:

- Current Offense based on offense type – violent, property, drug, public order, or other;
- Number of Current Violent Charges;
- Severity of Prior Felony and Aggravated Misdemeanor Convictions during last 10 calendar years;
- Severity of Prior Disciplinary Reports during last three calendar years;
- Number of Prior Class A, B, and C Disciplinary Reports during last three calendar years;
- Current Age at assessment;
- Escape History during last five calendar years;
- Stability Factors - as measured thru LSI-R subscales related to employment, living arrangements, finances, family, peers, attitude, and emotions; and
- STG Membership.

Although most of the risk factors on the female initial classification instrument consider the same types of behavior as considered for the males, the operational definitions and scores were modified to reflect the histories of the women. Time to serve was excluded as a scored risk for the women because it was negatively correlated with institutional adjustment, i.e., women with long sentences had fewer institutional reports than those with relatively short time periods to serve. The Women Offender's Focus Group opted to delete the item and control for time remaining to serve through the restrictions for work or program assignments outside of the security perimeter. Security threat group (STG) membership was not statistically correlated with institutional violence or overall adjustment among the female inmates, the Women's Focus Group opted to include the risk factor because the data suggest that women who are members of an STG have higher rates of institutional misconduct.[124] (The new female initial classification instrument is included in Appendix D.) As shown in Table 2, among the female inmates for the initial classification, the current offense, number of current violent convictions, severity of prior convictions, and current age were statistically correlated with institutional violence. Except for escape history and STG membership; all of the risk factors were correlated with overall adjustment during the first 12 months of incarceration. The correlations with violent behavior and institutional adjustment (i.e., predictive power) of the new risk factors and custody scales represent improvement over the current system for the women. Further, the data suggest that the new system predicts the women's behavior better than it does the men's behavior. For example, the correlation between overall adjustment for the women was r = .305 compared to r = .231 for the men.

The analyses of variance of the new custody scales for the female inmates at initial classification are provided in Table 3. The new scored custody levels are valid with respect to the female inmates' overall adjustment during the first 12 months of incarceration; however, there appears to be some blending of the medium and maximum custody inmates with respect to violent behaviors. This is primarily a function of the small number of women assigned to maximum custody (9, 1.8%). Perhaps the most important finding from these analyses was the validity of the final initial classification custody level. The new custody scale represented a substantial improvement over the current scale, even after the administrative and security restrictors were considered.

C. Design of the Reclassification Instrument for the Male Inmates

The risk factors selected for the male reclassification instrument were:

- Current Offense based on offense type – violent, property, drug, public order, or other;
- Number of Violent Current Charges;
- Severity of Prior Felony and Aggravated Misdemeanor Charges;
- Time to Serve;
- Severity of Prior Disciplinary Reports during last 12 months from assessment;
- Number of Prior Disciplinary Reports during last 12 months from assessment;
- Current Age;
- Escape History during last 5 calendar years from assessment;
- Program/Work Compliance; and

[124] We found, for example, that female STG members had on average, 2.33 misconduct reports compared to an average of 1.33 for non-members; 50% of the female STG members had one or more report compared to only 36% of the non-members. However at initial classification, due to the very small number of female STG members (6) these differences were not statistically significant.

- STG Membership.

The new reclassification instruments approved by the focus groups are included in Appendix D. These instruments illustrate the operational definitions and scoring of the new risk factors and provide the custody scale cut points. The reclassification risk factors were defined to reflect the inmates' behavior during the 12 months following the custody re-assessment. The static criminal history and offense risk were re-defined and re-weighted adjusted for the reclassification instrument, as it is important to place greater emphases at reclassification on the more recent inmate's institutional behavior and performance. This allows the offender to progress to a less restrictive custody level (or regress to a more restrictive one) according to risks posed to the institution.

As shown in Table 6, each of the new risk factors, except for the history of escape factor, is statistically correlated with institutional violence. All are correlated with overall behavior and % bad among IDOC male inmates at reclassification. The correlations with institutional adjustment, i.e., predictive power, of the new risk factors and custody scales, represent an improvement over the current system.

To illustrate the differences in the validity between the current and new classification systems, the analyses of variance of the new custody scales for the male inmates at reclassification are provided in Table 7 along with the ANOVA for the current system. The new scored custody levels are valid with respect to the male inmates' overall adjustment during 12 months following the custody re-assessment; however, there appears to be some blending of the medium and maximum custody inmates with respect to violent behaviors. Perhaps the most important finding from these analyses was the validity of the final reclassification custody level; the new custody scale represented a substantial improvement over the current scale, even after the security and administrative restrictors were considered. The new classification system identifies statistically distinct groups of minimum, medium, and maximum custody inmates with respect to their overall adjustment and violent behavior. Thus, it is a valid classification system.

D. Design of the Reclassification Instrument for the Female Inmates

The risk factors selected for the female reclassification instrument were:

- Current Offense based on offense type – violent, property, drug, public order, or other;
- Severity of Prior Felony and Aggravated Misdemeanor Charges;
- Time to Serve;
- Severity of Prior Disciplinary Reports during last 12 months from assessment;
- Number of Prior Disciplinary Reports during last 12 months from assessment;
- Current Age
- Escape History during last 5 calendar years from assessment;
- Program/Work Compliance; and
- STG Membership.

Although most of the risk factors on the female reclassification instrument consider the same types of behavior as considered for the males and for the female initial classification assessment, the operational definitions and scores were modified to reflect their predictive power at re-assessment. (The new female initial classification instrument is included in Appendix D.) As was done for the male reclassification instrument, the reclassification risk factors were tailored to reflect the women's behavior during the 12 months following the custody re-assessment and to place greater emphases on the women's most recent

institutional behavior and performance. This will allow the women to progress to the least restrictive custody level according to their risks posed to the institution. At reclassification, STG membership was statistically correlated with %bad ($r = .081$, $p < .05$) indicating that the factor helped to differentiate women who were likely to have one or more misconduct report. Therefore, the Women's Focus Group opted to include the risk factor.

As shown in Table 6, among the female inmates at reclassification, the current offense, severity of prior convictions, time to serve, severity and number of disciplinary reports, and current age were statistically correlated with institutional violence. Except for escape history and work/ program compliance, all of the risk factors were correlated with overall adjustment/% bad during the 12 months following the custody re-assessment. These data indicate that the new reclassification risk factors and custody scales represent an improvement over the current system for the women and that the new system predicts the women's behavior better than it does the men's behavior. For example, the correlation between overall adjustment for the women was $r = .305$ compared to $r = .235$ for the men.

The analyses of variance of the new custody scales for the female inmates at reclassification are provided in Table 7. The new scored and final custody levels are valid with respect to their inmates' overall adjustment and violence during the 12 months following the custody re-assessment, except there is some blending of the maximum and medium custody levels. This appears to be a function of the small number of women assigned to maximum custody (35, 3.6%). Both new scored and final custody levels are clearly better than the current custody system for women offenders. For example, the f statistic for the new final custody (a measure of the variation between the groups of inmates) is $f = 48.332$ ($p < .01$) compared to $f = 22.679$ ($p < .01$) for the current final custody level.

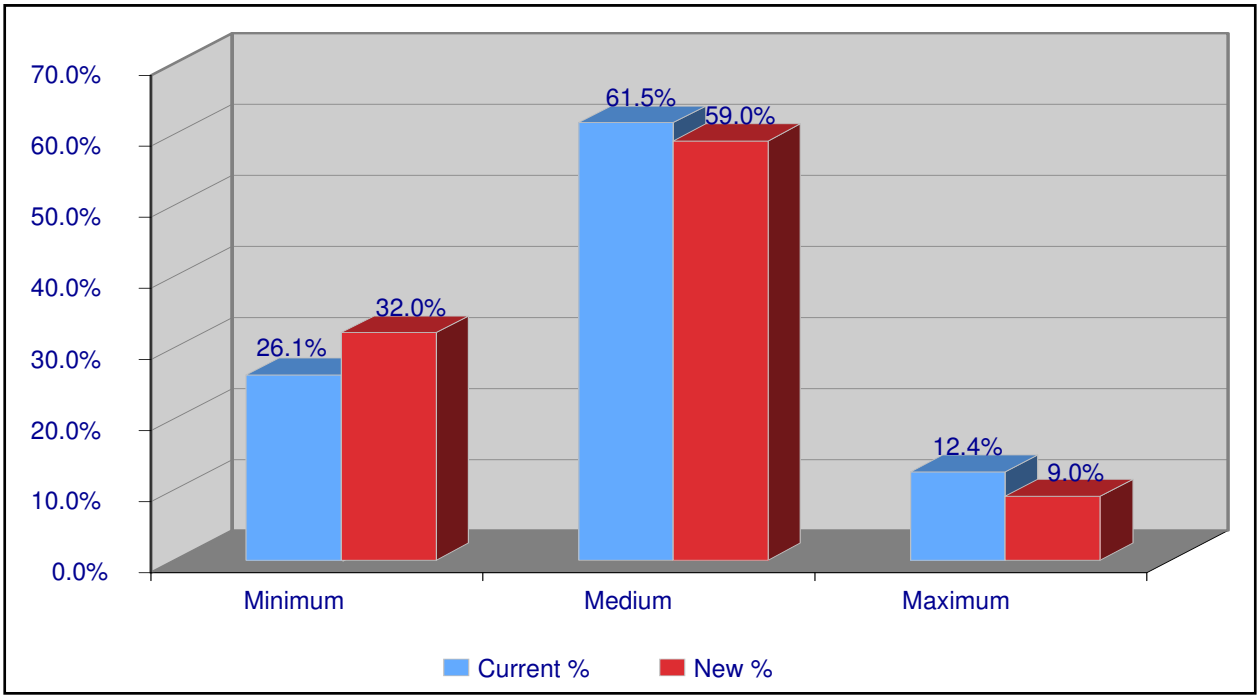
VI. Impact of the New Classification System on the IDOC Custody Distributions

Perhaps the most critical question for the master planning process posed for our analyses was the impact of the new classification system on the custody distribution of the IDOC inmate populations. As custody distribution influences institutional safety and security, the flow of inmates within and between institutions, assignment of inmates to programs and institutional jobs, use/mission of IDOC facilities, facility planning, budget and cost savings, and staffing. For these analyses, the new classification system as approved by the IDOC executive staff and the focus groups was applied to the IDOC inmate population as of November 1, 2007.

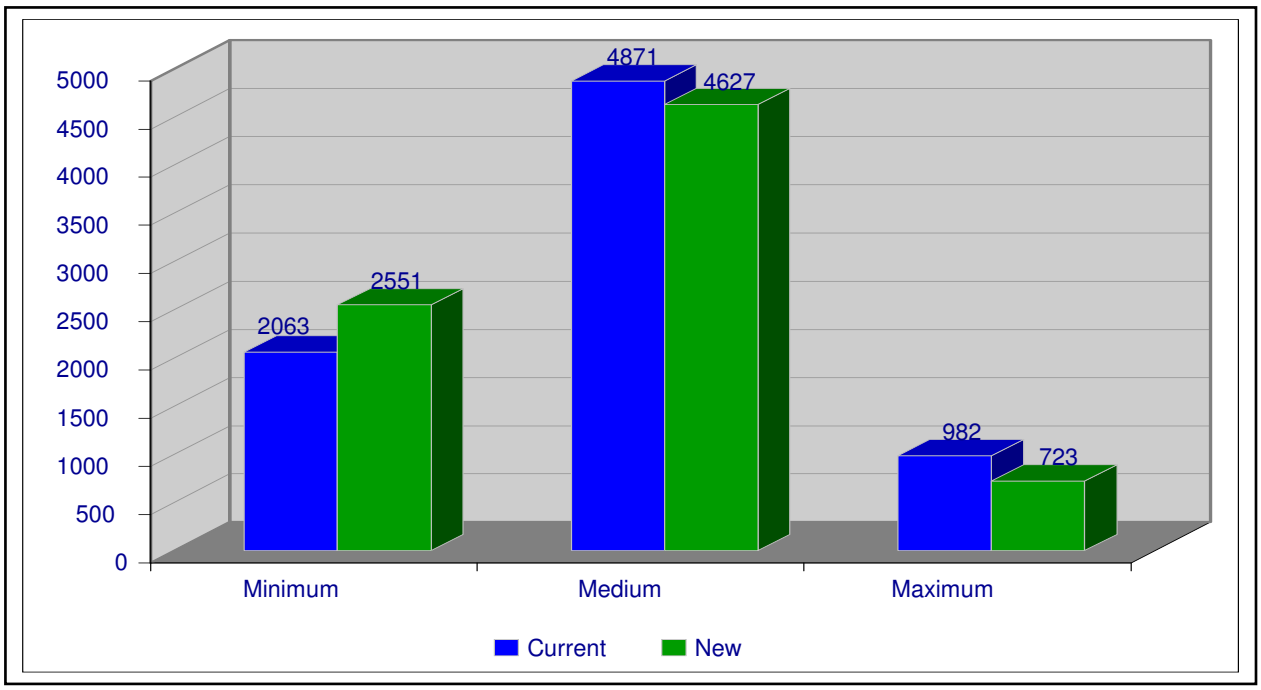
A. New Custody Distributions for the Male Inmates

Graph 1 illustrates the impact of the new classification system on the male inmate population. These data suggest that under new system, the new custody distribution will be: minimum 32%, medium, 59%, and maximum, 9%. As shown in Graph 2, the new system will decrease the number of male inmates assigned to maximum custody (New, 723 versus Current, 982) and to medium custody (New 4,627, versus Current, 4,871). However, there will be an increase in the number of men eligible for minimum custody (New, 2551 versus Current, 2,063).

Graph 1: New Versus the Current Custody Distribution – Percentage of Males as of 11/01/07



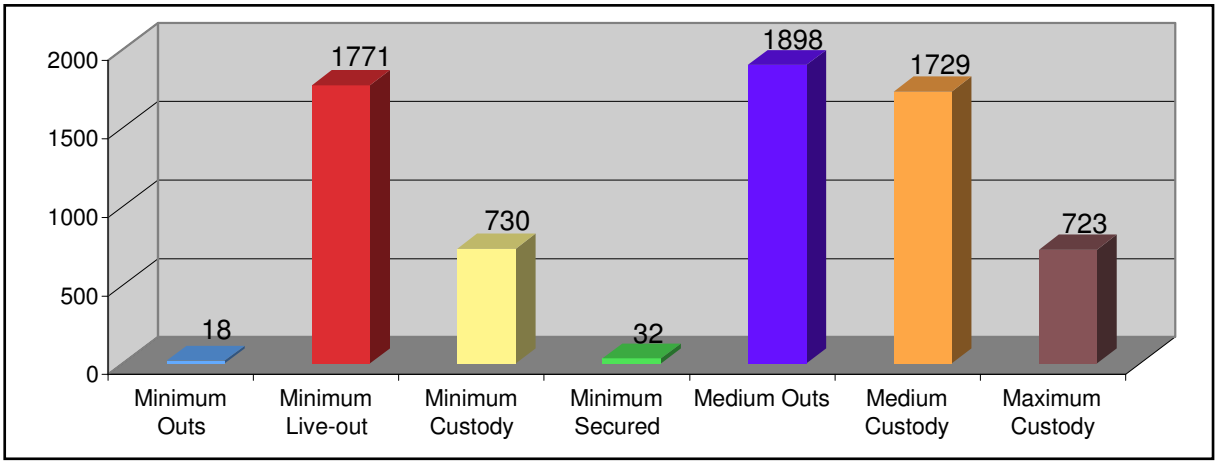
Graph 2: New Versus the Current Custody Distribution – Number of Males as of 11/01/07



Graph 3 illustrates the number of men who would be eligible for minimum-out and medium-out work/program assignments based on the IDOC objective policy criteria for these custody levels. It is important to note that the numbers provided in Graph 3 are estimates; the staff's discretion for these

decisions is critical to the actual placement of the inmate in minimum-out and medium-out work/program assignments.

Graph 3: New Custody Distribution with Work/Program Custody Levels – Males as of 11/01/07

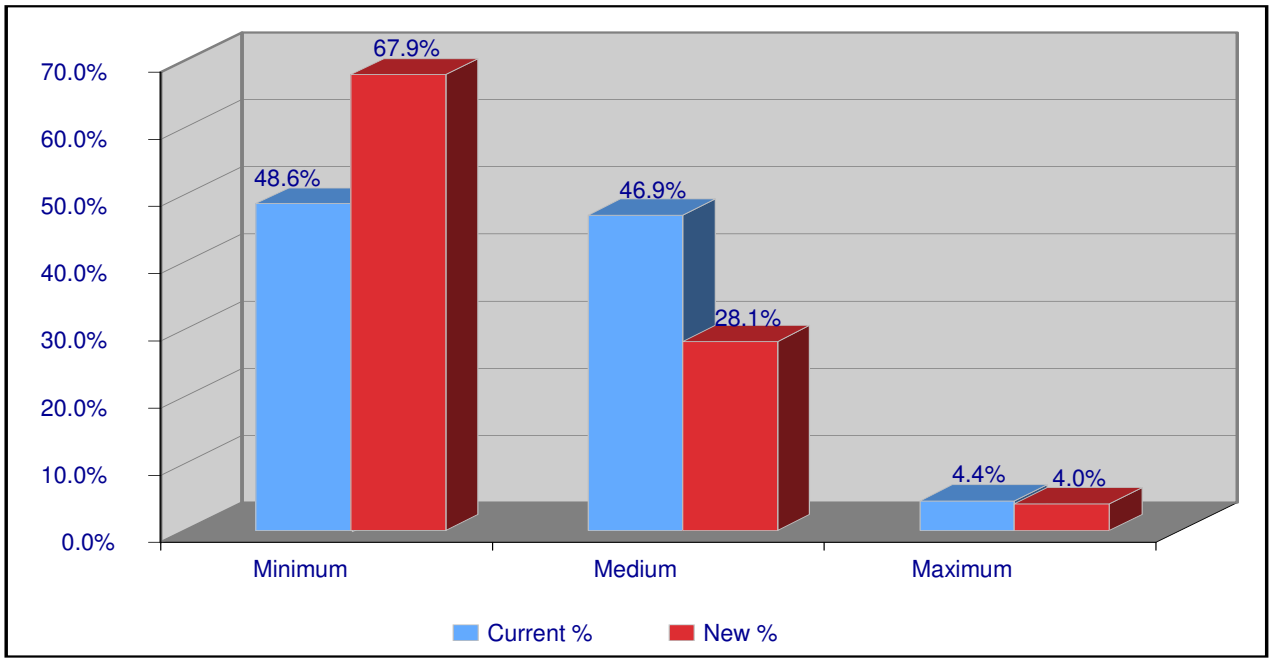


B. New Custody Distributions for the Female Inmates

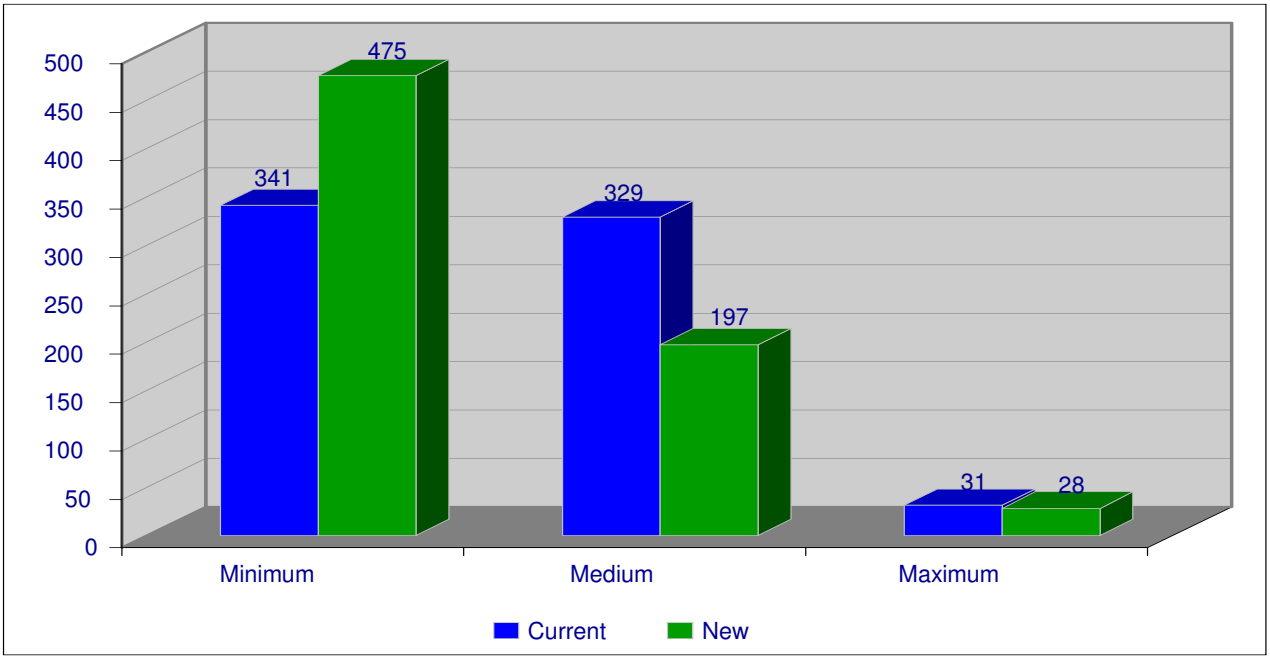
Graph 4 illustrates the impact of the new classification system on the female inmate population. These data suggest that under new system, the new custody distribution will be: minimum 68%, medium, 28%, and maximum, 4%. As shown in Graph 5, the new system will have little impact on the number of women assigned to maximum custody (New, 28 versus Current, 31), however there will be substantial increase in the number of women eligible for minimum custody (New, 475 versus Current, 341). With this increase in the number of female minimum custody inmates, the number of medium custody females will drop substantially (New, 197 versus Current, 329).

Graph 6 illustrates the number of women who would be eligible for minimum-out and medium-out work/program assignments based on the IDOC objective policy criteria for these custody levels. It is important to note that the numbers provided in Graph 6 are estimates; the staff's discretion for these decisions is critical to the actual placement of the inmate in minimum-out and medium-out work/program assignments.

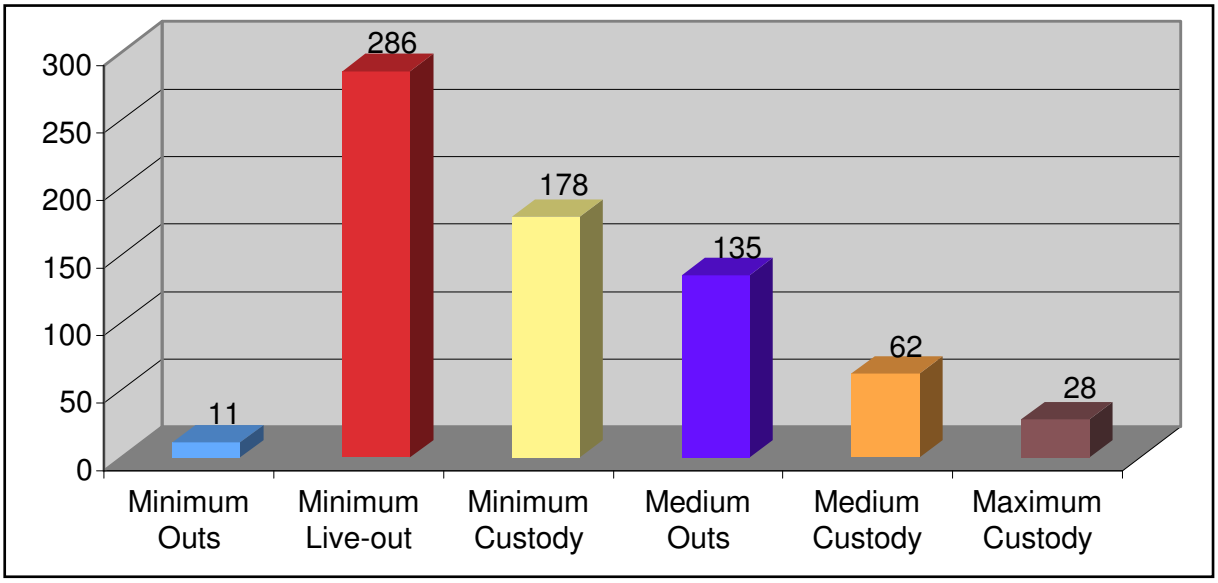
Graph 4: New Versus the Current Custody Distribution – Percentage of Females as of 11/01/07



Graph 5: New Versus the Current Custody Distribution – Number of Females as of 11/01/07



Graph 6: New Custody Distribution with Work/Program Custody Levels -- Females as of 11/01/07



VII. Summary and Next Steps

As indicated from the analyses described above, the data strongly indicated that the new gender-specific classification system is valid for the IA male and female inmate populations and will serve the Department well for identifying the risk an inmate poses to the security of the institution and safety of the staff, other inmates, and self. As always, there are additional steps to full implementation of the classification system. The following actions are recommended:

1. **Review the IDOC classification policies and procedures to identify which, if any, policies and procedures require revision for the new system to be fully implemented.**

2. **Review the mission of each IDOC facility, housing unit within the respective facilities, and use of community-based corrections beds (CBC) to determine the best fit for the inmate population with respect to safety, security, program, work, and services given the changes in the custody distributions.**

3. **Automate the new classification system as most of the new risk factors can be scored from the data available within ICON.** Development of software for scoring the risk factors, identifying the preliminary custody levels, identifying applicable mandatory restrictors, and auto-forwarding of the completed custody assessments to the appropriate staff for review, transfer, etc. will expedite the classification system.

4. **Provide on-going comprehensive training to IDOC case managers, security and facility administrators on the new classification policies, procedures, and revised instruments.** While comprehensive training is planned as part of the

implementation of the new classification system, on-going training and in-service meetings at which the classification procedures and scoring rules are reviewed are critical to ensure questions and problems are resolved quickly. All staff should be provided with a detailed classification manual that documents the operational definitions of the risk factors, misconduct rating scale, and the new custody scales and criteria. Mandatory training with reliability testing should be provided for all new staff prior to beginning their classification-related duties. Notice of changes to the system should be provided to the institutional administrative and security staff to ensure all are familiar with the revisions to the classification systems.

5. **Develop on-going and ad hoc reports for auditing and monitoring classification trends.** As the new classification system represents a substantial change for the Department, it will be important to diligently track the system to ensure full-implementation and to quickly work through any problems that may arise.

Classification	Women Offenders
Jeanette Bucklew, Champion	Diann Wilder Tomlinson, Champion
Bob Johnson (NCCF)	Angie Morris (7th)
Chad Oeltjen (IMCC)	Bobbie Peters (6th)
Darin Cox (5th)	Cathy Davis (2nd)
Jay Nelson (MPCF)	Cheryl Meyer (1st)
Jeff Schultz (5th)	Chris Gesie (IMCC)
Jim McKinney (NCCF)	Dan Craig (CO)
Jim Payne (CCF)	Deb Murphy (IMCC)
Kathy Culbertson (ICIW)	Kathy Nesteby (DHR)
Kim McIrvin (6th)	Kris Weitzell (CO)
Marcy Stroud (MPCF)	Lisa Hansen (5th)
Mary Dick (FDCF)	Marcy Stroud (MPCF)
Mike Kane (FDCF)	Michelle Dix (5th)
Mike O'Reilly (ISP)	Pam Taylor (4th)
Ron Wyse (MPCF)	Patti Wachtendorf (ICIW)
Tracy Dietsch (ASP)	Peggy Urtz (5th)
Tristin Potratz (FDCF)	Rachel Scott (DHR)
Jim Felker, Mentor	Sheryl Lockwood, Mentor
Curt Smith, Communications	Curt Smith, Communications