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ALCOHOL, DRUGS AND CRIME

Vera's Second Interim Report On New York State's Interagency Initiative

Douglas W. Young
Mark N. Usdane

VERA INSTITUTE OF JUSTICE
377 BROADWAY
NEW YORK, NEW YORK 10013

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DOUGLAS W. YOUNG
Project Director
Alcohol, Drugs and Crime Project

MARK N. USDANE
Associate Director
Vera Institute of Justice

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Chapter One

Introduction

This is Vera's second interim report on New York State's alcohol, drugs and crime initiative. Almost two years ago, then Chairman of the Assembly Codes Committee (now Speaker of the Assembly) Melvin Miller introduced legislation to establish a pilot continuum of alcohol and drug abuse services to reach offenders from the time they entered the State prison system through the difficult post-release period. Proposing a partnership of State criminal justice and mental hygiene agencies, the original budget bill provided resources for the State Department of Correctional Services (DOCS) and the State Divisions of Parole, Substance Abuse Services (DSAS), and Alcoholism and Alcohol Abuse (DAAA) to enhance existing services and create new ones. Additionally, funds were allocated for the Vera Institute of Justice, to support and monitor implementation of the State initiative and design an evaluation to test the impacts of these services. The legislative initiative aimed to provide purpose, coherence and leadership to the State's programmatic efforts to address a key criminal justice and crime control issue -- the relationship between alcohol, drug abuse and crime.

The original special allocation by the legislature in the FY 87 State budget (and renewed in the SFY 88 Executive Budget) is grounded in the hypothesis that criminal recidivism among alcohol and drug-abusing ex-offenders can best be reduced by stopping abuse through participation in effective, comprehensive treatment -- in an array of services that includes in-prison programs, pre-release planning (including assessment of post-release needs), appropriate referral to community-based treatment, and follow-up of those treatment referrals (including further linkage to needed services). The initiative specifically addressed the present gaps in this treatment continuum, building on the best of what is already in place.

The initiative's designers envisioned a service continuum for chemically dependent offenders beginning with their identification at DOCS classification and then continuing with transfer to a prison facility where treatment would be provided. Following successful completion of treatment and near the end of their incarceration period, participating inmates would be prepared for release at a new alcohol/drug abuse pilot program (at the Lincoln Correctional Facility in Manhattan); here, treatment would continue and post-release treatment needs would be assessed and the participants would be referred to appropriate community-based post-release treatment programs. A paramount goal of the effort was to forge long-sought but unrealized collaborations among DOCS, Parole, DSAS and DAAA. These relationships were viewed as prerequisites to the development of post-release treatment services that are responsive to parolees' special needs.

Vera's record of the activities set in motion by the legislative initiative during its initial term is contained in our first interim report, published a year ago. We opened that report with a reservation that bears repeating now: Despite the encouragement and cooperation of all parties, understanding and describing an interagency State initiative from the outside is not easy. While our initial report tended to highlight matters that appeared then as causes for concern, we were on balance encouraged by the work undertaken during the effort's first nine months. Now approaching two years into the initiative, we continue to hold that view, and mean to convey it in this second interim report.

The initiative's second term has seen a strenuous effort to implement the project, meaning that the character of the exercise has been fundamentally unlike its first twelve months, which were devoted to planning and design. The action in the past twelve months has been at the operational level: DOCS brought the pilot Alcohol and Substance Abuse Treatment program (ASAT) on line at Lincoln, and Parole put its Access program to work, creating bridges between in-prison and post-release treatment. At this workaday level, policy issues from a "central office" perspective become a lot less important than how managers and staff conduct business on the line. Unresolved issues surfaced in last year's report as abstract concerns about how things should proceed; this year's record cites comparatively concrete shortcomings as practitioners struggled to bring innovative concepts to life. Similarly, the good news this year is different; our general enthusiasm about the project's prospects has been replaced by admiration for the many individuals in the trenches, trying to make the service end of this pilot project work.

Our appreciation for the persistence of these individuals leads us to underscore what our report is, and what it is not. Our effort to record these complex activities is not a report card. Rather, we seek to use this record as another source of technical assistance: a way for Vera to collect and express some of its ideas about the puzzles and obstacles that face personnel charged with demonstrating more efficient and just responses to the needs of alcohol and drug-abusing offenders.

Let us sketch the different angles from which we view the State initiative this year by citing some advances and unresolved tensions. A recurrent concern in both terms of the effort has been the establishment of the pre-release ASAT program. Last year, we were frequently warned about how hard it is to alter, however slightly, the pre-existing flow of inmates through the DOCS system. In response, one of the suggestions we made was that DOCS form an advisory group to the new Lincoln ASAT. We recommended that the group comprise individuals who run treatment programs at the facilities which were to feed inmates to the pilot program. We thought, at the time, that the pilot would be advantaged by counsel from these veterans of treatment efforts for prisoners; we also believed that these individuals needed to have some confidence, if not some ownership in the new program, if they were to identify and divert potential participants to it effectively. By charting the pilot ASAT's census, this

year's report underscores how difficult it was to get adequate numbers of appropriate candidates into Lincoln. That's a down side, and an illustration of how concrete most abstract issues became this year.

Our enthusiasm about Lincoln also takes a different shape this year. Last year, we were impressed with the early, detailed development of a day-to-day curriculum for the pilot ASAT; just as we finish this report, DOCS has passed line authority for the pilot ASAT to a coordinator who, we believe, is likely to imbue the new unit with the sort of vitality and personality associated with those ASAT programs that are held in high regard by inmates and corrections managers alike.

Another recurrent and unresolved question, described in both reports, is how to ground Access in the genuine interagency collaborations envisioned by the initiative's framers. Last year we described the lengthy and ultimately futile efforts to have DAAA play a direct service role by assigning two counselors to the Access team. This year, we comment on a marked imbalance in referrals to drug treatment over alcohol treatment resources. While our report details the many other forces at work here, it is possible that alcoholism treatment needs are not being assessed as completely as they should. With parole officers acting in the stead of DAAA-employed counselors, the clinically stronger, more experienced DSAS members of the Access team may understandably dominate discussions about the right referral resource for the Lincoln participants. Whatever the correct explanation of the referral imbalance may be, last year's relatively abstract consideration of DAAA's collaborative role was expressed this year in concrete operational outcomes.

Similarly, this year's welcome news about Access has moved from the abstract to the concrete. In our first report, we described the history of Access as an imaginative show of initiative by Parole and DSAS to develop needed services with few resources. This year, we have been impressed with some of the discharge planning for Lincoln inmates. In that planning, a true team of DOCS, Parole and DSAS representatives have frequently acted without the customary allegiance to role-specific responsiblities and boundaries, focusing instead on which agency is best positioned to accomplish necessary objectives. We believe these interactions reflect sufficient committment to permit the drug and alcohol experiment to disturb more comfortable, but less effective, institutional conventions.

There is mounting evidence that this venture to break the complicated drugs, alcohol and crime link is at a threshold where implementation activities on many fronts are beginning to fall into place. That it took a while, with a fair share of false starts and frustrations is not surprising. Recent events which, taken together, augur well for the pilot project's third term include DAAA's request to become the direct service partner in Access as originally specified, the achievement of full census at Lincoln, and staffing actions by DOCS to help the fledgling pilot ASAT gain a vital sense of purpose and identity.

The second interim report is organized in eight chapters. Operational activities by DOCS and Parole are described in Chapters Two and Three. These sections each open with a record of events and close with a section expressing Vera's more subjective recommendations and views. If the initiative's second term is the year of implementation, it is also the year in which research activities hit their stride. Chapter Four reviews the research design and methodology, and describes the research activities we've undertaken, where we're headed, and the kinds of data and products these efforts will yield for practitioners and policy makers. The final three chapters present some preliminary results of the research effort.

Chapter Two

The Lincoln Community Preparation Unit: Preparing the Alcohol and Drug Abusing Offender for Release

OPERATIONAL ISSUES

The original legislative measure authorizing the initiative called for the creation of a new "pre-release" ASAT, to be located at the Lincoln Correctional Facility in upper Manhattan. The program was specifically intended to take advantage of "the release milieu" -- inmates close to release, housed in the community to which they would be returning -- and to build on the men's ASAT participation in upstate institutions. The program unit was designed to be "residential," meaning that its participants would reside in a section of the facility apart from general population inmates. The legislative measure also authorized a relatively rich staffing pattern to provide extensive program opportunities for the participants.

Staffing and space. Staffing was authorized as follows: two GS19 ASAT Counselors; two GS14 Program Assistants; a full-time administrator responsible for on-site program supervision (a GS22 Senior Counselor); and a Stenographer. DOCS decided to create a 37-bed residential program unit, with the seventh floor of the Lincoln facility devoted exclusively to the pilot ASAT. Space for counselors' offices and program activities was initially identified on the seventh floor; the program supervisor's office was to be located on another floor of the facility, as was additional program space.

The unit, officially designated the Lincoln ASAT Community Preparation Unit (the "CPU," but frequently referred to as the "Lincoln ASAT"), became operational in May of 1987, with an initial contingent of five men. While staff counseling positions were approved for April 1, hiring delays ensued, with staff coming on board over the first quarter of the fiscal year. Early program staff included the two GS19 counselors and a GS14 counselor, with administrative support from the Lincoln Superintendent and DOCS regional program personnel. At the start, DOCS had trouble obtaining Civil Service authorization for the GS22 program supervisor. In early July an acting administrator was assigned to the program, splitting her time between Lincoln, where she typically spent two days per week, and another DOCS facility. A clerical support person was added soon thereafter. In September one of the two GS19 counseling positions was vacated; in December the second GS14 position, open since the program's inception, was filled.

In late January, DOCS named a new program supervisor (in the GS22 Senior Counselor line) to assume the position on a full-time basis. Officials anticipate this

individual reaching Lincoln by late February; in the interim, the regional ASAT program coordinator has assumed the program's supervision. Overall policy and administrative responsibility in DOCS for the pilot project is held at the Deputy Commissioner level. Instrumental in operational and programmatic issues are the central office unit directing Alcohol and Substance Abuse Programs, the Regional Coordinator for ASATs and the Superintendent of the Lincoln Correctional Facility.

As a residential unit, the Community Preparation ASAT is designed to occupy the seventh floor of the Lincoln Facility. As a result of difficulties in achieving and maintaining a full census, however, the Lincoln ASAT did not realize the status of a discrete, "residential" program until the end of the summer. When the ASAT census is less than capacity, other Lincoln inmates who are not program participants are necessarily housed on the ASAT unit. In part flowing from the same problem of low program census, space on the ASAT unit originally designated for staff offices, counseling and other program activities were reassigned due to other pressing needs at the Lincoln facility. ASAT staff initially operated with one small office on the unit, but were later permanently placed in an office on the third floor of Lincoln, along with Parole staff assigned to the project. A small office on the seventh floor is utilized by these counselors for individual sessions with inmates. Space for additional programming (group counseling, videos, films, etc.) is located on the ASAT unit with an additional group room utilized on the fourth floor, and the mess hall is available for family counseling.

Inmate Selection and Participation. DOCS originally established the following criteria for participation in the Lincoln Community Preparations ASAT: prior participation in an ASAT program for at least ninety days; at least twelve weeks remaining prior to release eligibility; and agreement to participate in all components of the pilot (ASAT programming, Parole's Access, and Vera's research). DOCS also agreed it would attempt to select inmates whose anticipated post-release residence was in Manhattan, the Bronx or Brooklyn, which are the boroughs served by the Access program.

Original "feeder facilities" selected by DOCS to provide inmates for the Lincoln program were the Mt. McGregor, Sing Sing/Tappan, and Woodbourne Correctional Facilities. Potential participants for the pilot program were to be identified by ASAT staff at the feeder sites four to five months prior to their eligibility for release (and before their Parole Board appearance). Inmates identified as pilot candidates would be informed of the Lincoln program, Parole's Access role, and Vera's research plans. If the inmate agreed to participate, he was to be transferred to Lincoln twelve to fourteen weeks prior to his eligible release date.

DOCS sought to minimize the risk of pilot participants failing to win parole and being returned to upstate facilities after reaching Lincoln. With the program's focus on community preparation, selection criteria were aimed to increase assurance that

inmates would return to the community on completion of the Lincoln ASAT (though this could not be guaranteed). Priority was thus initially placed on Parole Board "reapps" or reappearance cases (inmates previously denied release and due for reconsideration), because, as a group, they were much more likely (roughly twice as likely) to be granted parole than were those being considered for the first time ("initials"). Men with conditional release dates (who are assured release at a particular time without regard to a Parole hearing), though very few in number, were also given priority over initials. After identifying these priority cases, initial applicants to the parole board who were judged as most likely to be granted parole were to be chosen.

From the start, DOCS ran into trouble identifying adequate numbers of qualified candidates for the Lincoln program. Counselors at the selected feeder sites reported problems in finding men for a minimum security facility because of the medium or maximum security status of their own facilities. Some attempts to increase the census resulted in participants at Lincoln who did not meet DOCS's own criteria. Among those inmates transferred to the program over the first few months of the effort, two participants had no prior ASAT experience and two had fewer than ten weeks' involvement. Three participants spoke little if any English, excluding them from effective participation before a Spanish speaking counselor was hired in December. At least three men had post-release residences outside of New York City -- areas not served by Parole's Access team. Procedural mix-ups also affected the program census; in November, three men were misclassified during transfer to Lincoln and served time with the Lincoln general population inmates for several weeks before being "found" and moved to the ASAT program for their remaining few weeks.

A significant step toward reaching and maintaining the target of 37 participants was taken in mid-June, with the selection of Otisville, Collins and Coxsackie Correctional Facilities as additional feeder sites. As shown in Table 2-A, the first two months of the program's operation saw only a trickle of participants; five had entered by the end of May and eight arrived in June. After June, the census more than doubled. The number of ASAT participants, however, only neared a capacity level during one month between May and December. After a peak of 35 in October, the census dropped discouragingly to 22. DOCS officials reported that this was due to a mis-communiciation between central office and feeder site staff. Central office thought the sites would be routinely providing men at this point, but the staffs were waiting to be told to identify additional candidates.

In total, 75 inmates entered the Lincoln Community Preparation Unit from the program's beginning in May through the first of this year. As shown on Table 2-A, Mt. McGregor sent the largest number of men (25) during this period, and Otisville, a site added in June, sent almost as many (22). Comparing these numbers with those sent by the Collins and Coxsackie facilities (both of which sent 3 men) illustrates the extreme variation in the numbers of men coming from each site. Of the 75 participants, 43 graduated from the program and were paroled by the end of December. Six

TABLE 2-A

Monthly Transfers of Lincoln Entrants by Feeder Site

	Mt.Mc-Gregor	Wood-bourne	Sing-Sing	Otis-ville	Col-lins	Cox-sackie	Monthly Total	Monthly Census*
May	3	2	-	-	-	-	5	5
June	5	1	-	2	-	-	8	12
July	8	-	1	2	1	-	12	24
August	1	1	1	7	1	1	12	30
September	4	6	1	1	-	-	12	29
October	3	-	3	4	-	1	11	35
November	-	1	-	1	-	-	3	22
December	1	2	3	5	1	-	12	24
TOTAL	25	13	9	22	3	3	75	

*Refers to the number of participants in the program at the end of that month.

men had been denied parole and returned to a facility upstate, one was transferred upstate on disciplinary charges, and another was returned on an immigration detainer; 24 inmates continued in the program as of January 1. November and December saw the highest parole (release) activity: a total of 26 (approximately half of the total paroled) left the Lincoln facility while, as noted above, a much lower number entered the program.

While not depicted on the table or in the program results described above, in mid-January DOCS again expanded to additional feeder sites, this time from 6 to 18. As a result, with the addition of seven new transfers on January 22 the program reached and exceeded the target capacity with 41 participants. DOCS administrators now indicate that several other candidates have been identified and "are in the pipeline," ready to fill program slots as they open.

PROGRAMMING FOR RELEASE TO THE COMMUNITY

Program Content. Successful attendance at an ASAT program in another correctional facility is a prerequisite for participation at Lincoln, as DOCS officials view the Community Preparation Unit curriculum as building upon and strengthening the effects of this prior treatment.[1] The Lincoln program was designed to provide a twelve-week cycle of drug and alcohol treatment within the community preparation milieu. Like other "residential" DOCS programs, Lincoln participants were to be active in programming throughout the day and evening. The Lincoln curriculum consists of weekly "themes," each focusing on one of the Twelve Steps of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Inspired by The Twelve Steps, additional weekly themes addressed in group meetings range from "honesty and self-control" to "family and faith." Merging the approaches of DOCS's model programs at Mt. McGregor, Woodbourne and Sing Sing/Tappan, the Lincoln unit was designed to blend psychological content and counseling with educational approaches. Films, audio tapes, lectures and seminars were planned to address such topics as health issues associated with drug and alcohol abuse (e.g., drug pharmacology, fetal alcohol syndrome and AIDS); participants were expected to do homework assignments to promote the internalizing of this material.

Self-help support groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) were to be an integral part of the program, particularly in linking inmates to support in the community prior to release, and encouraging continued

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[1] Descriptions of the original three feeder facilities (Mt. McGregor, Sing Sing/Tappan and Woodbourne) and an account of the evolution of drug and alcohol programming in DOCS can be found in the appendix of Vera's first interim report on this initiative (February, 1987). DOCS's ASAT Program Manual, written by Patrick Manucci, includes much valuable detail on the Woodbourne model.

involvement after release. The Lincoln pilot was designed to stress active involvement of the inmate's family in the recovery process, to be promoted through weekly Al-Anon meetings and family counseling sessions facilitated by an ASAT counselor. These activities were to be conducted on weekday evenings and weekends to make family involvement easier.

Pre-release services available to the general inmate population at Lincoln were also to be incorporated into programming for the ASAT participants. Such services include vocational assistance through the South Forty Corporation, which provides vocational counseling, job-readiness workshops, resume development and job referral. Other pre-release services available to Lincoln inmates include the use of the facility's library, which maintains a collection of resource materials, and the educational department which offers G.E.D. preparation and basic skills instruction. Original plans called for these services to be incorporated into the pilot program near the end of a man's twelve-week stay.

As was the case with the Lincoln program census, implementing these programming plans has been a gradual process. The program began in May with individual counseling only; in June, as the ASAT population slowly increased, group activities began. By the end of the year, program participants were typically attending one or two group counseling sessions per day, an AA/NA group each evening, and individual counseling twice a week. Family counseling is currently offered three evenings a week; each of the ASAT counselors works an evening one day a week and rotates on Sundays to accomodate this program component. Up to this point, however, less than half the men have participated in family counseling sessions.

Self-help groups are facilitated by community members who come to Lincoln six evenings a week. Al-Anon meets every other Monday, AA and NA three days a week. There is a Spanish AA group on Monday evenings, and Cocaine Anonymous on Sundays. All participants are exposed to films, videos and lectures pertaining to drug and alcohol abuse; these materials repeat those offered in other ASAT programs. One outside speaker was brought in to conduct an educational seminar on AIDS for ASAT particpants.

Although no effort has yet been made to make participation in South Forty's vocational services part of the ASAT routine, most ASAT inmates have voluntarily availed themselves of those services. Formal involvement in the facility's pre-release services is currently limited to an orientation provided to ASAT participants conducted by South Forty personnel, the library and education department staff, and representatives of Parole. Approval for the institution of a G.E.D. program at Lincoln (for all Lincoln inmates) was recently obtained; ASAT staff expects to incorporate this welcome option into future programming.

THE INMATES' VIEWS: LINCOLN PROCESS RESULTS

Vera's "process" interview is conducted with all inmates in the Lincoln ASAT program from five to ten days before they are scheduled to leave Lincoln. The process questionnaire is a relatively informal interview designed to obtain the inmates' subjective views of the Lincoln program, and the Access referral process. The interview is conducted after the participant has been in the program for two to three months and has had some contact with his Access counselor to make post-release treatment plans. The information presented here is taken from the 37 process interviews conducted before December 15. In this section, process results specific to the Lincoln program are discussed; the Parole/Access section includes results pertaining to that component of the pilot effort.

Inmates were first questioned about the information they were given before deciding to transfer to the Lincoln ASAT program. Most of the men (28) said they had been told about Lincoln's program either by their previous ASAT counselor or a Lincoln ASAT counselor who came to the facility to recruit participants. In most cases, inmates reported that little specific information was given. When asked whether the Lincoln ASAT program subsequently confirmed what they had been told or expected, only eight said "yes," six answered "somewhat," and 22 said "no."

Participants were also asked to describe their reasons for electing to attend the program at Lincoln. In the interview, the most common responses were ranked as being "very important" or "somewhat important" to the inmate in his decision to attend. Most of the men reported that getting additional treatment for their drug or alcohol problems was very important (16 gave this answer) or somewhat important (10). Being closer to home and family was the next most commonly cited reason for choosing to attend; 19 of the men thought this was very important, and 5 said it was somewhat important to them. Eighteen men indicated that they thought attending would be very (16) or somewhat important (2) in terms of increasing their chances of making parole. Ten reported they went primarily because it was recommended by a former counsellor or corrections facility official and nine men noted that they heard Lincoln had an especially good program. No other single reason was given by more than 10% of the men. Taken together, these responses suggested that most of the men were motivated for reasons consistent with the goals of the Community Preparation ASAT. Significantly, however, nearly one-third of the men did not provide any reasons that could be regarded as positive, or indicative of an "appropriate" motivation for participation.

When asked what they had gained from, or thought was good about the Lincoln program, the inmates' responses suggested a similar mix of positive and negative views. The most common positive remark, given by 16 of the 37 men, was that they "had learned a lot more" about their substance abuse problem and that the repeated program material was helpful in reinforcing their desire to stay straight or sober.

"It's the information you get, and that makes the difference," said one inmate. "I now know that I can't get high, even once." Eight men also cited the AA and NA group sessions, run by community members and outside speakers, as a positive feature. "Here, people are from the city," which makes it easier to identify with their experiences, according to one participant. A range of other responses, none cited by more than four of the men, was also given. About one-fifth (8 of 37) of the men said they had not gotten anything out of their participation and could not cite a good feature of the program.

ASAT participants were also asked what they didn't like about the program -- what made it less effective. There were two most common responses, provided by 11 of the 37 men. One of these was that there was not enough to do in the program. This assessment typically included the comment that there was too much reliance on films and videos, and that those that were used were outdated and uninteresting. Several participants also mentioned that the movies focused on alcoholism rather than discussing addiction in general. Many of these men suggested that additional group and one-to-one counseling would remedy the lags in the program. "What is worst is that we generally see films and videos instead of speaking with the guys or the counselors," remarked one participant. "I find them [the films and videos] less helpful in getting guys to open up," said another. Eleven respondents also indicated their belief that the program counselors lacked the appropriate skills and/or experience with inmates and addiction. Another common criticism, offered by nine of the men was that there was no opportunity for input by program participants. These men felt that they were not listened to, and that the program was not responsive to inmate concerns.

Not surprisingly, judgments about what were the best and worst elements of the program reflected these men's prior ASAT experience. Previous participants of the Otisville and Sing Sing/Tappan ASATs inmates tended to cite the more extensive educational programming, and the liberal use of films, videos and tapes as important positives. Inmates from Mt. McGregor, accustomed to a more intensive, inmate-run program, were consistently opposed to the wide use of videos and tapes, believing it detracted from time spent in useful group sessions.

In sum, Lincoln participants were generally positive about the educational efforts of the program staff, but were relatively critical of their efforts (or lack of efforts) to get the participants involved or stimulated. Twenty-five of the 37 inmates said that the staff's ability to educate about alcohol and drugs was "very good" or "good," and 22 gave this positive rating when asked if the staff had helped motivate them to continue in treatment. When asked about the counselors' ability to stimulate communication in group meetings, however, the most common response, provided by 11 of the men, was neutral (a '3' on the 1 to 5 point response scale); additionally, 10 of them gave the staff "bad" or "very bad" ratings in this regard. Opinions were split on their ability to get people involved in the program; 17 gave the staff good or very good evaluations, while the same number responded in the neutral to very bad range.

Ratings of the program's efforts to get them in touch with their families, and to get the family involved in treatment were also varied. Of those men who felt they could assess the program in this regard, most felt positive about it. Twenty-one men rated the program as good or very good at getting them in touch with their families, while seven gave neutral to negative assessments. In terms of getting the family to help the man deal with his drinking or drug problem, 16 men rated the program positively. On both questions, however, a significant number of men (8 men on the "getting in touch" question and 11 on the "getting involved" question) felt they could not judge because they had no such contact. Finally, these mixed feelings were perhaps most evidenced by inmates' responses to the question of whether their Lincoln ASAT involvement might contribute to their staying straight or sober: ten stated it was very helpful, eight were neutral, and eight said it was "of no use at all."

COMMENTS AND RECOMMENDATIONS

Program Administration and Staffing. Without an on-site program supervisor for the first two months, program start-up problems were immediately apparent. Problems arose in communication with and support from Lincoln staff, and inefficiencies in staff utilization were evident; there was no family involvement, and the program lacked cohesiveness and direction. These difficulties were partially addressed in July by the addition of a part-time supervisor, but making a permanent appointment to this vital position is necessary if the program is to develop into an effective transitional service for men re-entering the community.[2]

Support for the ASAT program from the Lincoln administration has been good. The Superintendent has been a source of support and positive influence; he maintains regular communication with ASAT staff, and has helped resolve difficulties when they have arisen, and negotiated in support of the ASAT program. DOCS central office has also maintained its support of the program and intervened when necessary, especially when, on occasion, Vera has asked for help. With the relative absence of direct, on-site leadership, however, the lines of authority over the program need to be more clearly defined. Ideally, in our view, it would be most useful for the Regional Coordinator of ASATs to have direct authority to supervise the pilot project and its on-site leader, serving as a liaison between the ASAT supervisor and Lincoln's Superintendent. Staff accountability and direction, immediate attention to problems (or potential problems), and developing ties with the community are important areas in which the ASAT program would be advantaged by a single, clearly responsible leader.

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[2] As noted above, within days of this writing, DOCS officals have indicated a new full-time appointment has been made and that this person should be in place by late February. In the meantime and through any transition period, the Regional ASAT Coordinator has been given responsibility for the program; as a result, we anticipate considerable programmatic advances in the Lincoln ASAT over the next few months.

Although funded for four counselor positions, only three have been filled; there remains a vacancy in one of the ASAT Counselor (GS19) positions. One of the advantages Lincoln was to have over other DOCS ASAT programs was a lower counselor to inmate ratio (approximately 1 counselor to every 9 inmates), fostering more frequent and substantive contact between counselors and program participants, particularly through individual counseling, which is minimal or nonexistent in most other ASAT programs. Just as the inmate census has fluctuated, so has the number of counselors on staff -- from two to three. At one point in November, only one Counselor and one Counselor Assistant staffed the program. This shorthandedness was in part relieved in early December when a third counselor was brought on board. Apart from short-staffing, the program suffered in its first seven months without a Spanish-speaking counselor, despite more than one-third of the participants being Hispanic, and some of them speaking little English. Staff inability to communicate with these inmates made their participation in the pilot program questionable. Fortunately, this critical need for a bi-lingual staff person was filled with the December counselor hiring.

Problems in establishing space for ASAT staff and programming was another factor in slow program start-up. Other pressing priorities and general overcrowding in the DOCS system were cited as reasons for reassignment of program space originally designated for the ASAT. Ideally, offices for ASAT counselors would be on the seventh floor where the ASAT inmates are housed; this placement would promote the more intimate involvement of staff on the ASAT unit and make them more accessible to the inmates. Accomodations also need to be made for more family involvement. Al-Anon meetings for inmates' families were to be an integral part of family involvement in the program. Lack of adequate space for these and other family meetings has been cited by the program supervisor as a problem in realizing this program component. We recognize the difficulties that Lincoln administration has in assigning program space, given the system overcrowding and the demands from quarters other than the Community Preparation program. It seems to us, however, that the pilot program must in effect take possession of the seventh floor if it is to work well and gain a crucial sense of identity and character.

Census Issues. From the start DOCS has had difficulty in identifying, selecting and ensuring that appropriate inmates reach the Lincoln pilot. Although DOCS planners anticipated the Lincoln ASAT program's start-up in February, the first inmates did not arrive until three months later. The slow arrival of inmates negatively affected programming, in that ASAT inmates were housed with other inmates at Lincoln for the first three months of the program. That mixing of populations resulted in conflicts between the inmates and difficulties in utilizing the limited space on the unit for ASAT activities (e.g., the TV room could not be used for group meetings, as the non-ASAT inmates on the floor insisted on their right to watch television).

Other problems in the selection of appropriate candidates were noted above: some men are returning to communities outside of the boroughs that are served by

Parole's Access pilot; some had little or no prior ASAT experience; some didn't speak the same language that the counselors spoke. In some cases it appeared that, in an understandable push to get men transferred to the program, Parole staff at upstate facilities had less than adequate opportunities to review cases and prepare paperwork. After some of these problems became evident, ASAT planners began working more closely with classification and movement staff in DOCS's central office, and met with personnel at some of the feeder facilities to communicate modifications and subtleties in selection criteria. The Alcohol/Drug Abuse Interagency Steering Committee meeting held in Albany in December focused on the census and selection issues (they were also discussed in the July committee meeting), with all reaching agreement that, at minimum, additional feeder sites were necessary.

Perhaps the subsequent (and very recent) expansion to 18 sites will provide the necessary numbers; perhaps also the training meeting for ASAT feeder facility staff scheduled for late January will help. These are steps in the right direction, but much more is necessary if the ASAT program at Lincoln is to thrive. As stated a year ago in Vera's first interim report on this project, we believe that a sense of ownership in the pilot by its constituent and feeder programs is necessary; without faith in the Community Preparation Unit, it is doubtful that the ASAT feeder staffs will exhibit the agility and energy required to continue identifying and providing good candidates for Lincoln.

Program content. Lacking in the Lincoln program is an identity which comes from strong leadership, purpose, continuity and cohesiveness. The influx of non-ASAT inmates on the ASAT unit from time to time (resulting from the low ASAT census) has inhibited efforts to develop such an identity. Participants cannot feel a "part" of something that keeps changing -- going from the "ASAT unit" to ASAT inmates on a unit. Just as the Woodbourne and Mt. McGregor programs appear to have their own "personalities," the Community Preparation pilot at Lincoln needs to develop one.

Implementation of AA and NA groups have become an important, positive part of the programming for inmates in the pilot. The Al-Anon meetings for inmates' families, however, have not materialized. Family counseling has been slow in evolving; most view this as a vital piece of community preparation, perhaps particularly important for alcohol and drug abusing individuals. A logistical issue was apparently resolved by moving the sessions from the visiting hall to the more private mess hall, but participation of inmates' families remains poor. The inmate makes the choice as to whether he wants family members to come in for counseling. When inmates and their families do agree to family counseling, there are sometimes cancellations or no-shows. Between an inmate's initial reluctance to include family members and broken appointments, this kind of plan can easily fail to materialize without determined and persistent efforts to make it succeed. We think ASAT staff must take a more assertive effort to engage inmates' families in the pre-release and recovery process. Consistency

and purpose are integral to establishing this program component; from the beginning of the man's stay in the pilot the ASAT counselor should reach out to involve both the participant and his family in understanding that "addiction is a family disease."

The proposed pilot was also to stress the integration of community-based programs while inmates are still at Lincoln. Although involvement by outside AA and NA leaders has been strong and welcome, other agencies, particularly community-based treatment programs and those which provide services to ex-offenders need to be solicited and integrated into the pilot curriculum. As noted in the next chapter, DOCS and Parole both need to contribute, and work together on the involvement of community-based services. As outlined in the original program plans, guest speakers can be utilized to conduct seminars and lectures on issues like reintegration into the community, drugs and alcohol, abstinence, or vocational issues. Similarly, pre-release services at Lincoln need to be made a formal part of the pilot. Inmates who participate in services offered in the facility by South Forty say they find it helpful, but too many pilot particpants simply elect not to obtain vocational assistance. Vera staff have recommended the use of a case management system (to be utilized by both DOCS and Parole's Access staff) and developed and offered a written program plan which would organize and document each client's pre-and-post release needs. Setting aside traditional agency boundaries, DOCS and Parole must merge their efforts to assure that pilot participants are familiar with (and appropriately connected to) the service delivery system in the communities to which they will return.

Chapter Three

Parole's Access Program: Pre-Release Linkage and Post-Release Case Management

OPERATIONAL ISSUES

In 1986, counselors from the State Division of Substance Abuse Services (DSAS) began working with officers and parolees in the Manhattan Parole office to provide assessment and referral services for parolees in need of treatment for drug abuse. The State initiative authorized two significant expansions of this small, experimental program called Access. In cooperation with the State Division of Alcoholism and Alcohol Abuse (DAAA), the service was to be extended to individuals with alcohol problems. Second, additional Access counselors were authorized to work with the Lincoln pilot participants, to link these men to community-based treatment before leaving Lincoln, and to follow them post-release to assure their continued involvement in treatment. In many ways, this service was to be the most innovative component of the continuum of services envisioned by the initiative: While in-prison and community-based programs are commonplace, these services have not been bridged through the proactive efforts of parole officers, community providers and case managers.

Staffing and "the Two Accesses." As originally proposed, the staff included a program coordinator, two counselors who specialize in drug treatment (DSAS employees subcontracted by Parole), two counselors specializing in alcoholism treatment (subcontracted DAAA employees), and a clerical support person. Parole planned to divide this staff into two "teams," each to include a drug and alcoholism counselor, both supervised by the Access Program Coordinator. Parole officials further planned to expand borough-based Access services in Parole's Manhattan (which serves parolees residing in Manhattan, Brooklyn and Staten Island) and Bronx district offices. In these offices, Access would work with the general parolee population; parole officers (POs) would send parolees to Access for help with drug and alcohol assessment and referral. The plans called for each of the two staff teams to be responsible for a particular district office. This same staff would split their time between "the two Accesses": the Lincoln ASAT Access program and the district office service.

On implementation, Parole's Access program was staffed according to plan with a Program Coordinator, two drug counselors provided by DSAS, and two alcoholism counselors. The two alcoholism counselors, however, were not staff provided by DAAA. DAAA's director insisted that assigning the Division's own counselors to the project was inconsistent with agency policy (a detailed account of this rationale is in Vera's February, 1987 Interim Report). To fill the alcoholism counseling positions,

Parole decided to recruit two parole officers from the Division's own ranks.[1] These alcoholism counselors/POs eventually joined the Access effort several months after the drug counselors had begun operating out of the Parole district offices.

The DSAS counselors began work on the project in December, 1986, familiarizing themselves with the district parole offices and developing ties with community-based treatment sites to be used in the Access effort. By mid-January they were working with general population parolees in these offices. The two parole officers acting as Access alcoholism counselors were hired in April and began a five-week training period, with the assistance of the DAAA staff person assigned to the effort. In addition to visiting treatment sites, the new counselors were trained in interviewing and counseling skills. In May, the staff "teams" were in place in the Manhattan and Bronx offices, and in June, Access counselors began work with the fledgling ASAT pilot at Lincoln.

In addition to these staff, a new position was created at Lincoln for an Institutional Parole Officer (IPO) for the pilot project. The IPO is primarily responsible for preparing the program participants for their Parole Board appearances, and handling the paperwork for these appearances and for transferring the case to the appropriate field office upon release. He also conducts initial interviews with pilot participants, which include a preliminary assessment of drug and alcohol history. Other staff who, according to Parole officials, have played a critical role in the project are Access clerical personnel. With the original allocation including only one clerical position, these officials have pushed for and been able to obtain central office support for an additional clerical staff in each of the Bronx and Manhattan district offices. These three clerical personnel handle arrangements (appointments and paperwork) between field parole officers and Access counselors, and much of the follow-up paperwork for Lincoln-Access participants.

There has been some staff turnover during the first six months of the project. In early June, the Access Coordinator was "bumped" from the job by Civil Service list, and a new Coordinator had to be identified and appointed. In August, the Access counselor serving parolees with alcohol problems in the Manhattan office took a leave of absence, leaving that position vacant until a new appointment was made in late September. Additionally, the IPO handling the pilot participants at Lincoln moved into another position and a new IPO was brought on board in August.

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[1] As noted previously, in addition to providing counseling staff for Access, DAAA (along with DSAS) was to work with Parole on a broader effort to provide training and technical assistance (TA) to field parole officers and community-based providers in support of the initiative. In the absence of the provision of DAAA counselors, Parole asked and DAAA agreed to extend the duties of the DAAA training/TA staff to include more specific training and assistance to the Access alcoholism counselors hired by Parole.

LINKAGE TO COMMUNITY-BASED TREATMENT

Pre-release activities. Initial plans called for Access counselors to interact regularly with Lincoln ASAT staff to discuss individual participants and their progress in the ASAT program. They were also to meet individually with the participant to assess his drug or alcohol treatment needs and identify community-based resources likely to meet those needs. After determining an appropriate post-release treatment referral (which includes fair assurance that the program will accept the man when he shows for treatment), the Access counselor was to inform and actively engage the Lincoln participant regarding the referral decision. Original plans called for the man's field parole officer, who would supervise the parolee upon his release, to be involved in the referral decision and to meet with the participant and the counselor at Lincoln, before the man's release.

In late June, Access started to work with the Lincoln ASAT participants; the first program participants were paroled in early August. Parole's Access staff spend one day per week (Thursdays) at the Lincoln facility handling pilot cases. Thursday mornings are usually spent speaking informally with ASAT staff, reviewing inmates' folders, and meeting individually with ASAT participants to assess their treatment needs or discuss post-release referral arrangements. In the afternoon, the Access-ASAT team meeting is typically held, along with additional assessment and referral sessions. Access also tries to arrange the meeting between the participant, his field PO and the counselor on Thursdays; on a few occasions, these are held on another day of the week, due to the field PO's schedule. Additionally, along with DOCS and Vera staff, Access personnel participate in orientation meetings for new pilot participants; depending upon the flow of inmates into the program, these sessions are held every two to three weeks.

The weekly Access-ASAT team meetings include the Access Program Coordinator, Access counselors and the IPO, and ASAT counselors (Vera staff attend as observers). (For a brief time, due to DOCS's short-staffing, these meetings were held twice a month; Access has always encouraged that they be held on a weekly basis, and they have been held as such for the last several months.) At the team meeting, pilot participants pending release are discussed and program and parole information is exchanged: ASAT staff report on the inmate's degree of participation in program activities; the extent of family involvement and supports; the inmate's view of his drug and/or alcohol problem; and his assessed amenability to treatment upon release. The IPO gives an overview of the man's parole conditions (if the inmate has met with the Board prior to the team meeting), the status of his "community prep" (his field PO's investigation of his post-release plans) and any previous history the inmate has with Parole, if applicable. If the Access counselor has met with the inmate before the meeting, his or her impressions of the man's treatment needs and tentative plans for post-release treatment are presented. Information about the man's involvement in ASAT activities at Lincoln is incorporated by the Access counselors in their assessment and referral decision-making.

Near the end of a participant's stay, the Access Program Coordinator sets up a meeting at Lincoln between the Access counselor, the inmate, and the field parole officer who will be supervising the case upon release. The inmate's employment, residence, other special problems (e.g., medical or psychiatric concerns) and post-release treatment plans are discussed as well as any additional parole conditions he must adhere to. Whether or not these meetings at Lincoln with the field PO occur depend on the availability and cooperation of the individual parole officers.

In basic terms, the assessment and referral roles outlined for the Access counselors have been implemented as planned. For the first several months of Access' involvement at Lincoln, the counselor typically met with each participant twice; in the first session, the man's treatment needs were identified, and in the second, he was told the name and location of the program to which he was being referred. More recently, Access administrators have encouraged the counselors to meet participants on a more frequent basis; usually at least three meetings are now held, including an introductory session. A more extensive review of the man's treatment history and needs is also conducted. This additional involvement appeared called for, given earlier problems with the timing and brevity of Access interventions. Evidence of these problems was elicited in Vera's interviews with participants; based on interviews done through mid-December, about half of the men had not been informed of their treatment referral within five to ten days before their release. Several of the pilot participants also reported that their second meeting (when they were given information on the post-release referral) was very brief, and did not permit much inmate input.

The amount of field parole officer involvement in the pre-release meetings has been notably less than that originally proposed. As of mid-December, about half of the men had gotten to see their PO before leaving Lincoln. Parole officials attribute this lack of involvement to several factors. First, a few of the Lincoln inmates had plans to go to boroughs out of the Access "catchment area;" understandably, no attempts were made to get POs from Long Island or Staten Island to visit these men pre-release. Additionally, for the few men who were sent to Lincoln for unusually short stays, there was no opportunity to arrange for such a meeting. Most commonly, however, when the pre-release meeting with the field PO didn't occur, it was because the PO missed the Lincoln appointment or simply wouldn't cooperate in arranging for one. In these cases, lack of cooperation was attributed to a specific priority that conflicted with the Lincoln meeting (e.g., a violation hearing or an absconder search), or a more general sense that the PO's field work is more important, and would be sacrificed by taking time to go to Lincoln.

Anticipating this kind of resistance, Access administrators have tried to promote involvement, and have developed procedures to encourage the PO to cooperate. After agreeing to an appointment at Lincoln, a letter is sent to the field PO and his or

her supervisors (a Senior PO and an Area Supervisor), noting the scheduled appointment with the named participant. A second letter is also sent to the PO (and supervisors), with a record of whether the PO actually followed through with the appointment. Finally, according to the Access Coordinator, if the PO conference is not held, the counselors attempt to reach the PO via telephone to discuss the referral plans.

Referral Plans. The most critical pre-release component of the Access program has been realized: post-release treatment referrals have been given to virtually all Lincoln participants. By the end of December, Access counselors had completed assessments of 41 inmates who had completed the Lincoln ASAT and received a release date (this number excludes the few men who had been denied parole or who were planning to reside out of state). Referral data, as reported to Vera by Access, are shown in Table 3-A, broken down by treatment modality. Of the 41 cases evaluated, Access had referred 31 participants to programs for drug abuse treatment, 4 to programs for alcohol abuse, and 4 for poly-abuse treatment. Two men had not yet received a specific referral upon release; Access planned to refer one man within a week or so of his leaving Lincoln, and the second was judged by both the Parole Board and the field parole officer as not needing a post-release referral (despite Access counselors' urgings to the contrary).

TABLE 3-A

ACCESS REFERRALS BY TREATMENT MODALITY
(through December, 1987)

Number referred	Drug Program	Alcohol Program	Poly-Abuse Program	TOTAL
Outpatient	27	4	4	35
Inpatient/ residential	4	-	-	4
TOTAL	31	4	4	39

An imbalance between drug and alcohol-related referrals is obvious in these totals. Parole officials indicate that this is consistent with the assessments made by Access counselors (and, they report, with the information reported in DOCS files), to the effect that very few men show evidence of alcohol problems. When specific referral sites are considered, it is clear that the Access counselors focus their referrals on a few select treatment providers, although as many as fifteen different programs were utilized for Lincoln participants. Of the 27 cases referred to outpatient drug programs, 12 were referred to Reality House and 6 to Kings County Polydrug Clinic. All four sent to a residential drug program were sent to Project Create.[2] Access staff indicate that those programs used repeatedly are chosen for one or more of the following reasons: the program has shown some commitment to helping with Access placements; it is especially responsive to this client population; and/or it provides the follow-up information required by Access in a relatively timely and reliable manner.

Post-release case management. Access counselors are also responsible for providing post-release follow-up services to the Lincoln participants. According to Access' original plans (detailed in the program's "Operating Procedures-Lincoln C.F. Pre-Release," dated February, 1987), within five days after a referred participant's initial appointment date with the treatment provider, a call would be made to the the provider to determine if the man showed and was accepted by the program. The participant's field PO was also to be apprised of the results of this follow-up call at this time. The field PO could then act further on the case as necessary, including referring the parolee back to the Access counselor for a new treatment referral. Further follow-up was intended through monthly telephone contact with the treatment agency and quarterly written progress reports, requested from the treatment provider and monitored by Access and then transferred to the field parole officer.

Based on reports from the Access Coordinator and counselors, Access was attempting to follow cases as planned, although they acknowledged problems: in many cases the five-day deadline is not met, and the communication between the Access counselor and the PO is slower and less dependable than originally specified. Access staff attribute some of this to difficulties in getting consistent and reliable follow-up information from the community-based referral sites. In addition, given the previously noted problems with field PO involvement at Lincoln, it is not surprising that some POs are slow to refer a man back to Access when the original referral doesn't work; getting the PO involved from the start appears to be a key to post-release follow through.

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[2] The four alcohol treatment referrals were made to Cumberland Alcoholism Treatment Program, Enter Alcoholism Services and Long Island College Hospital, with two referrals made to the latter. Other referrals for drug abuse treatment were to Enter Drug Program, Roosevelt Counseling Center, LUCHA, the Alpha School, A-Way Out and Queens Hospital Drug Program. Referrals for poly-abuse problems were made to the Nassau County Department of Drug and Alcohol Addiction, Town of Babylon Drug and Alcohol Abuse Services, Queens Outreach Drug and Alcohol Program and the Camelot Counseling Center.

As a means of seeking an independent assessment of the effectiveness of Access post-release follow-up and, indeed, the efficacy of the combined DOCS/Parole pilot efforts, Vera solicits case follow-up information from programs used as Access referrals. We also ask pilot participants and their field parole officers about referrals and referral outcomes during post-release follow-up interviews. These treatment follow-up results, available as of late January on 29 pilot subjects, are detailed in Chapter 8. In sum, these preliminary results suggest the need to improve post-release case management. Ten of the 29 men were actively attending programs; 19 had either never showed up at the program to which they had been referred, or left the program early (typically showing once for an intake interview and then never returning). Our data further indicate that Access re-referred only about half of this no show/left early group who could have been re-referred (i.e., not counting men who absconded, or were violated or rearrested). Access administrators largely attribute this to the failure of field POs to encourage these parolees to return to Access for additional referrals.[3]

THE INMATES' VIEWS: ACCESS PROCESS RESULTS

Lincoln ASAT participants were asked to assess the Access referral procedure in the same "process" interview described in the earlier chapter. Conducted five to ten days before the inmate's release date, the interview included questions about their knowledge of their post-release treatment referral, and whether they thought their interactions with the Access counselors and field parole officers had been helpful. This information is based on responses obtained through late November; this sample includes slightly fewer inmates (32 vs. 37) than that used for the ASAT process results.

Inmates were first asked what program they were going to after their release. Just less than half of the men (15 of 32) could specify the particular program to which they were going, although all but four of them could identify the selected treatment modality (in most cases reflecting a knowledge of their Board-mandated

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[3] Other, less formal post-release information reinforced the view that Access has not managed follow-up to the extent originally envisioned. This was evident when we first began receiving information from treatment programs (in November) which, in some cases, was discrepant with information we had previously received informally from Access. In these cases, it appeared to us that the Access counselor hadn't made the scheduled follow-up contact with the program, and not having heard (from the man's PO or the program) that the parolee didn't show or left early, the counselor presumed the man was still attending. When we talked to Access administrators about these discrepancies, they reported that the programs themselves could be responsible for providing discrepant information. According to these officials, on occasion a program would report to Access that a man was attending treatment, and then a week or two later report that the man had never showed for treatment; they particularly noted that some drug programs had problems providing consistent and reliable follow-up information.

conditions and/or a discussion with an Access counselor). Nearly half of the participants anticipated going to an outpatient drug program, six to NA (Narcotics Anonymous), and four to an outpatient substance abuse program. Three men thought they were going to an outpatient alcohol abuse program or AA, and the remaining men either didn't know where they were going or said they'd go "wherever Parole tells me." When asked whether they were satisfied with these post-release treatment plans, most of them (20 out of 29 who felt they could judge this) answered affirmatively; seven said they were "somewhat" satisfied, and two were displeased.

The participants' opinions regarding the degree to which they found Access helpful echoed the equivocal responses offered about the Lincoln ASAT program. Consistently, about half the men had positive impressions, but a significant number found Access of little value, or felt they had not had enough interaction with Access (within one to one and a half weeks of release) to judge its effectiveness. Sixteen of 32 respondents, for example, said Access counselors were "very helpful" in terms of understanding their problems and treatment needs, while 5 described them as "somewhat helpful," 7 said they were "not helpful at all," and 4 couldn't judge. Comparable ratings from inmates were evident in responses to other questions. With regard to Access staff describing post-release treatment options, 14 said they were very helpful, 8 said they were not helpful, and the same number said they were somewhat helpful. This mixed reaction to the program is perhaps best reflected in judgments concerning Access' role in arranging for a post-release treatment referral: 12 said Access was very helpful, while 11 said they were not helpful at all; only 2 men gave the "somewhat helpful" response, while 7 said they knew too little about Access' role in this regard to offer an opinion.

Not surprisingly, judgments about the value of meeting their assigned field PO as part of Access' pre-release services could not be made by most of the participants, as 22 men said they had either not met with their PO, or could not offer an opinion about his or her helpfulness because their meeting was too brief. Nevertheless, of the ten participants who felt they could offer an opinion in this regard, seven found the meeting very helpful and positive. Moreover, Vera interviewers consistently noted positive comments about the potential importance of a pre-release visit with the PO, especially in conjunction with a treatment referral. A typical comment expressed in this regard was, "it's a good idea to know who you'll be dealing with and to straighten things out early."

DSAS AND DAAA ROLES, AND THE PROVIDER TASK FORCE

As noted previously, DSAS has worked closely with Parole from the beginning of the Access effort (DSAS's historical involvement in Access is detailed in Vera's first Interim Report). In addition to providing two experienced DSAS-employed counselors to the program (and maintaining some supervisory responsibility for these positions),

DSAS officials have consistently offered assistance to the counselors, and supported Parole in its efforts to improve the provision of drug services for parolees. DSAS has particularly focused on the Access services provided in the Parole district offices; the DSAS counselors maintain their own records of activities in these offices (assessment interviews conducted with parolees, referrals made, etc.), which are in turn compiled and summarized in monthly reports produced by a central New York City DSAS office.

On an as-needed basis, DSAS central office staff has provided training and other direct assistance to the Access counselors, and occasionally observed team meetings at Lincoln. A similar, but more involved role has been played by the full-time DAAA staff person assigned to the project. This individual spent considerable time with the PO/alcoholism counselors when they joined the project, training them and providing technical assistance in developing contacts with the alcoholism treatment community in the city. In the form of consultation on special cases (such as "revolving door" clients) and on more general problems (such as poor program feedback), he continues to provide technical assistance to the Access program as needed.

Near the beginning of the 1987 calender year, when it became evident that DAAA would not be providing counselors to the project, Vera initiated contacts with the Bureau of Alcoholism Services of the New York City Department of Mental Health in an effort to fill the inevitable institutional gap between Access alcoholism counselors and community-based providers. Officials from the City Bureau, along with regional DAAA and Parole representatives quickly assumed the lead on this effort, and created a Parole Project Task Force, comprised of representatives of each of these agencies (as well as DOCS and Vera) and some seven local alcohol treatment providers.

The central goal of the Task Force was to generate commitments on the part of the providers to accept parolees from the pilot project, and to make the referral process responsive and ultimately effective. Since April 1987, Task Force meetings have been held monthly, but in September were changed to bi-monthly. For the first few months, this group met in anticipation of the opening of the Lincoln pilot and discussed potential issues of concern; initially there was worry that the programs would be overwhelmed with referrals from the pilot. As the Lincoln program got underway and participants completed and were paroled to the community, the concern of the Task Force members became one of a lack of referrals from the Lincoln pilot. (To maintain the providers' interest, it was further agreed to open the set-aside capacity of these programs to the general parolee population; still very few referrals emerged.)

In the Task Force meetings referral procedures had been reviewed and agreed upon, a system of communication between Access staff and the treatment providers had been determined, and treatment providers were eager to begin receiving the men from the Lincoln pilot. By the end of December however, only four men from the Lincoln pilot had been referred to any of the seven providers on the Task Force for

post-release treatment. Not surprisingly, recent meetings have addressed the question of why it has taken so long to generate graduates of the Lincoln program, and secondly, whether or not there has been insufficient identification of alcohol (and poly-abuse) problems in the Lincoln group.

Responding to the understandable frustration expressed by the Task Force members, and the need to maintain their interest and support, in January of this year Parole directed its Manhattan district office to implement a procedure where all parolees with special conditions of alcohol treatment be automatically referred to Access (by their supervising field PO). Access counselors have also been encouraged to use bi-monthly lists of parolees returning to New York City with alcohol treatment conditions (generated by Parole's Office of Policy Analysis and Information) as a means of outreach, approaching POs supervising these cases, and suggesting that they refer them to Access for assistance. These resourceful efforts on the part of Parole should boost referrals to the alcoholism providers, and thus maintain their involvement in the post-release effort.

COMMENTS AND RECOMMENDATIONS

Access-ASAT Team Meetings and Pre-release Planning. Vera staff has observed most of the ASAT-Access team meetings at Lincoln. Most of the meetings last the full hour and a half, though some have been quite brief, depending upon other work demands at Lincoln and the ASAT census at that time. We have seen the meetings evolve into admirable examples of the two agencies working together as a genuine team. The Access Program Coordinator has been particularly effective in keeping these meetings "on task," and in managing and recording decisions made on individual cases. The meetings show little evidence of "turf" battles; both Parole and ASAT staff seem to understand what they can best contribute to the effort, and we applaud this work.

In sharing information and insights on each participant, however, it appears to us that frequently there has been too little input from the inmate himself. There is usually mention of the man's receptiveness to post-release treatment, but not much indication that the issue was discussed thoroughly with him. In our view there are also too many pilot participants who report they are not informed of their post-release treatment plans until their last days before release. Inmates are anxious enough in the week or two before release; this anxiety would be reduced -- and referrals would be more likely implemented -- if all participants knew where they were going for treatment before this late date.

Parole officials have correctly noted that a few of the Lincoln men have arrived too late (and stay in the program for too short a period before release) for adequate Access involvement. For the most part though, resolving these concerns seems simply

to be a matter of making an extra effort to work more closely with the Lincoln participants. In this regard we welcome Access' recent efforts to increase the number and quality of scheduled meetings between Access counselors and participants; taking the time to make a comprehensive assessment, and getting the inmate to understand and at least preliminarily commit to post-release referral plans seem essential to making Access work.

Low Referral Rates for Alcohol and Poly-abuse Treatment. Another issue which may require further attention is the identification of alcohol problems. As noted previously, as of late December, Access had made four referrals for alcoholism treatment, four for poly-abuse, and the balance (thirty-one) to drug treatment programs. Access staff indicate these referrals reflect what the inmates tell them, which usually includes denial of alcohol problems.[4] Nevertheless, these referral rates are at considerable variance with drug and alcohol assessment data gathered by Vera on the pilot participants (detailed in Chapter 7), which indicate that, while very few pilot participants had an alcohol-only problem, as many as fifty percent of the men were judged poly-abusers, with a recent history of both drug and alcohol problems.

Further analysis of data on these pilot subjects suggested that the high number of referrals to drug programs may simply be a reflection of the special conditions of parole set (by the Parole Board) for these men; 70% of the pilot subjects had drug treatment-specific conditions, and 78% of them were given drug treatment referrals from Access. While following the condition may be regarded as proper (or even necessary[5]) procedure, the discrepancy between Access' referral rates and Vera's assessments of the participants' substance abuse problems suggests the need to probe further if the pilot is to achieve the best match between parolees and post-release programs. In this regard we anticipate seeing an increase in alcohol and poly-abuse referrals with Access' recent addition of a more experienced alcoholism counselor and the other alcoholism counselor's growing familiarity with these cases. Similarly, Parole's efforts to increase alcoholism provider involvement by formalizing referrals to Access for general population parolees with alcohol treatment conditions is viewed with promise.

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[4] Access administrators also note that there is little documentation of these men's alcohol problems in DOCS case files. In contrast to the more salient references to drug use (and offenses) typically found in these files, we have also observed this to be true. However, DOCS does provide MAST scores on most of these individuals, and these scores should be part of the Access case review. As discussed more fully below and in Chapter 7, use of these scores would in fact reveal that more than half of the pilot group has been identified as having alcohol problems.

[5] Data we have collected so far indicate that this is not necessary, as individual parole officers (and presumably Access) have considerable latitude in interpreting and enforcing special conditions of parole set by the Board. On the basis of these preliminary results we would assume that Access is not required to make a drug treatment-only referral for a man with a condition of "drug treatment," and could send such a man to a poly-abuse (or probably even an alcohol) treatment program.

Field Parole Officer Involvement. Pre-release meetings between participants and their field parole officers are not occurring for large numbers of the inmates. This leaves open the potential for the supervising PO -- who will be seeing the parolee on a weekly basis for several months -- to have little investment in the monitoring and enforcement of the referral. Access planners and the Coordinator appear to have devoted considerable energy in attempting to deal with this anticipated problem, including developing a system for reminding the PO and his or her supervisors of the Lincoln meeting, along with a follow-up reminder. We can only encourage that these commendable efforts be redoubled, and hope that, with time and support from central office staff, POs will recognize the value of these meetings.

We would also recommend renewed efforts in getting parole officers involved post-release. Access must assertively follow through with its original plans to inform the field PO of the parolee's referral status, and take the lead in communicating with the PO, and strongly encourage the officer to enforce special treatment conditions by monitoring attendence and re-referring to Access and to community-based providers. The high proportion of Access pilot participants who do not show or stay in treatment is disappointing, but perhaps not surprising. In anticipation of this attrition, aggressive follow-up with the treatment provider, the field PO, and if necessary the parolee are essential if Access is to make a difference.

Community Agency Involvement and Broadening Pre-release Needs Assessment. An innovative component of the initiative was to be the participants' involvement with community treatment programs prior to their release. A year ago, when DOCS determined it would be unable to arrange for inmates to leave the facility to visit community-based programs, Parole officials indicated they would investigate the possibility of bringing providers into Lincoln to meet with ASAT participants. While Parole spent some time exploring this with no success (staff shortages at some community programs were cited as an obstacle), we know of no recent efforts in this regard by either agency. Nevertheless, we continue to believe that face-to-face contact could significantly improve chances for parolees to reach post-release treatment; the idea is worth more pursuit by all parties.

In a more general sense, we recommend that Access work with the Lincoln ASAT staff to expand the programs' focus beyond traditional substance abuse services, to at least partially address the range of other post-release needs presented by the inmate. Once a man is released, parole officers rarely limit their concerns to one potential problem area; pilot inmates must be prepared to deal with an inseparable bundle of needs, including housing, employment, family and other social reintegration issues, and alcohol and drug abuse treatment. For example, both the ASAT and Access staffs have indicated that vocational issues are not their domain (Access views this as the responsibility of the field PO). Thus, in Access-ASAT team meetings, vocational matters are not typically noted, beyond mention of an anticipated

post-release job (which rarely materailizes). This is true despite the presence, for many inmates, of a South Forty vocational assessment already done on the inmate. As noted in the previous chapter, Vera has recommended a case management system that addresses vocational, as well as other kinds of basic needs assessment data; if such information were obtained and discussed in team meetings, counselors at both points of the envisioned continuum could more effectively serve the participants.

DAAA and DSAS Roles. As described earlier, DAAA opted not to have their staff serve as alcoholism counselors for the Access program, instead providing training and other technical assistance to the parole officers hired to provide alcohol-related services. Vera was (and remains) supportive of the original plan, which sought to exploit DAAA's statutory relationship with alcohol treatment providers to make such services readily available to pilot participants. Despite DAAA's efforts in training the POs to become counselors, this staff's lack of expertise with alcoholic offenders and particularly with providers further complicates the issue of the diagnosis and referral of offenders with alcohol problems. This was especially evident in the early months of the effort; the situation improved notably when Parole replaced one of the early placements with a PO who had a background in alcoholism counseling. Still, the contrast between these counselors and those from DSAS remains evident, as the drug counselors can use both personal and institutional relationships with providers to obtain treatment for Access clients.[6]

In Vera's view, the current arrangement could be improved with more active involvement of DAAA in particular (but not to the exclusion of DSAS) in staff supervision, case conferencing, and brokering with treatment providers. Indeed, the DAAA staff person assigned to the project has voiced a desire to be more involved in the Access effort, particularly as it concerns Lincoln participants. Parole administrators (and even to some extent DOCS's Lincoln ASAT staff) could better take advantage of this offer; participation in ASAT-Access team meetings, referral decision-making, post-release case management and general counselor-provider relations are all areas where DAAA could assist the Access effort.

Service Diffusion. Due in part to the slow start-up of the Lincoln ASAT program, Parole's expanded Access program continued to operate initially within the general parolee population through an already established network of parole officer referrals. The census at Lincoln was low in the beginning, and Access staff understandably spent one day a week at the Lincoln facility. As the census has gradually grown, however, Access has not tangibly increased its involvement with the Lincoln

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[6] In late January, Vera received word that DAAA, under new leadership, has expressed to Parole that it has reconsidered the direct service issue, and is now interested in providing DAAA counselers to the effort, as originally proposed. While it is as yet unclear how this will be presently implemented, Vera views this as a critically positive step.

pilot participants. We have noted and applaud recent efforts to use the counselors' one day a week at Lincoln more efficiently, with additional meetings set up between counselors and participants. Still, we question whether this one day provides sufficient opportunity to develop the firm link between parolee and program envisioned by the project's designers.

Similarly, while the post-release pilot caseload inevitably builds, the Access program, apparently due to broad responsibilities elsewhere, appears unable to monitor and manage Lincoln graduates in ways which clearly distinguish the pilot services from those offered to the general parolee population. Access administrators report that in recent months they have stressed the priority of the Lincoln participants to their counselors; this is commendable, but may be difficult to enforce, particularly with the drug counselors who have been working with the general parolee population for over a year now.

In sum, while Parole's aggressive commitment to provide services to the larger parolee population is understandable and indeed laudable, it can be viewed as occurring at the expense of the full experiment set forth in the State initiative: a test of the impacts of pre-release linkage and post-release case management. Noting the allocation of Access staff for the general parolee population, Vera expressed concern in its first Interim Report about this potential diffusion of services for (and interest in) the Lincoln pilot group. The evidence compiled since that time suggests that time constraints have hindered the amount and level of involvement Access devotes to this pilot group.

We have raised these issues with Parole and it acknowledges the problem of a shortage of resources and the disadvantages for Lincoln pilot participants. Parole is understandably reluctant to redistribute vital services away from the general parolee population to the pilot without additional resources (it has requested augmented Access staff for the next fiscal year). No one ought to be in a position of recommending a cut in services to the general parolee population; on the other hand, the fundamental hypothesis of the State initiative cannot be fairly and fully tested without the implementation of aggressive pre-release linkage and post-release case management services. In this regard, and in light of the Lincoln census reaching its goal, assigning two Access counselors (one for drug abuse and one for alcohol abuse cases) to deal exclusively with Lincoln pilot participants would be necessary for the program to be considered fully operational.

Chapter Four

The Research Plan: Design and Implementation

THE RESEARCH DESIGN

The design actually implemented in the second year of the initiative closely followed the preliminary plans specified in Vera's first interim report. The population studied included the pilot (or "experimental") group, composed of participants in the Lincoln ASAT and pre-release Access programs, and a comparison (or "control") group chosen from Lincoln's large Community Preparation - Open Date (C.P.O.D.) inmate population. This latter group was selected using a pre-established screening procedure, designed to generate a comparison sample that was similar (and therefore statistically comparable) to the pilot sample.

With the exception of some additional qualitative, process data collected on pilot participants during their stay at Lincoln, the same data are collected on both pilot and comparison subjects. These include drug and alcohol history information collected at a screening interview; extensive intake data obtained from DOCS files and in a face-to-face interview; follow-up information collected in interviews with subjects and their supervising parole officers at two and six months post-release; and arrest record data through twelve months post-release.

This design will afford an assessment of the central hypothesis of the State initiative: Offenders participating in the pilot services developed by DOCS, Parole and the other agencies will be less likely to commit crimes, abuse drugs and/or alcohol, and remain estranged from the community after their release. At the simplest level, these outcomes will be compared for men attending the new ASAT and Access programs, men attending other in-prison treatment, and men who receive no treatment.[1] Additionally, the wealth of data collected at intake and at follow-up points will be analyzed for descriptive purposes. These data will yield information on such factors as the prevalence of drug and alcohol problems in the DOCS population and their demographic correlates, participation in prison and community-based treatment programs, and the match between treatment needs and service availability, both pre- and post- release.

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[1] It is important to note that, because detailed individual data are being collected pre-release, the programs' effects can be studied while statistically controlling for other factors (besides program participation) that influence outcomes, such as age, criminal history, severity and type of prior substance abuse, treatment history, etc. This has generally not been the case with prior evaluations of programs for offenders, including DOCS's studies of the Woodbourne and Mt. McGregor ASAT programs.

RESEARCH METHODS AND INSTRUMENTATION

The Screening Interview. After several months of pilot testing instruments and procedures, Vera researchers began screening for comparison subjects in late April, 1987. Screening data are obtained on virtually all Lincoln C.P.O.D. inmates who meet pre-determined criteria.[2] C.P.O.D. inmates are those who have been granted parole and been given an "open date" (i.e., a tentative release date); they are transferred to Lincoln, and held -- five weeks on average -- prior to their release to the New York metropolitan area. Individuals in the C.P.O.D. pool are eligible for research screening if their post-release plans (as specified by Parole) include residence in the Bronx, Brooklyn or Manhattan, and if they have a release date at least seven days from the first Monday after their arrival at Lincoln.

Screening data are collected on potential comparison subjects during their first full week at Lincoln. After determining that a man is eligible (in terms of residence and release date), his DOCS file is investigated for any references to previous drug or alcohol involvement, and drug- or alcohol-related treatment. When available from the file, the results of a DOCS-administered Michigan Alcoholism Screening Test, or MAST score (Selzer, 1971), is recorded. The inmate then takes part in a 15-30 minute interview with Vera staff, in which he is informed of Vera's mission at Lincoln, and administered a series of research instruments measuring different dimensions of drug and alcohol history. He is also asked about his attendance in in-prison treatment programs during the current incarceration.

If an inmate does not wish to take part in all or part of the screening interview, he is thanked for his time and excused. Those who do complete the drug and alcohol measures are assessed by researchers with regard to a pre-set criteria for drug and alcohol history (detailed in the chapter on screening sample results). If they qualify for inclusion in the research population, they are informed further about the research goals and procedures, and asked to participate as a research subject. If the inmate agrees, he and the Vera researcher read and sign a formal consent form (shown in Appendix A) which contains an outline of the research and assurances as to the inmate's anonymity, the confidentiality of any research information obtained by Vera, and the subject's right to drop out of the study at any time. As is the case with all forms and instruments used by inmates in the study, a Spanish language version of this form is used when appropriate.

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[2] The only exception to this occurred in the latter part of 1987 and early 1988. On some weeks it was not possible for Vera staff to see all C.P.O.D. inmates entering the facility on that week (either because the weekly C.P.O.D. list was especially long, unusually large numbers of intake or follow-up interviews had to be administered, or the project was temporarily short-staffed). During these weeks, we randomly selected (before screening) a subset of the pool of eligible C.P.O.D. inmates for the research population.

Vera researchers follow essentially the same procedure when they first meet with Lincoln pilot participants to collect drug, alcohol and treatment history data; however, no Lincoln pilot participants are screened out of the study as a result of their scores on instruments used in this initial interview. With pilot subjects, this interview is used to familiarize the man with Vera staff, our research plans, and our role in the Lincoln ASAT. He is administered the same drug and alcohol measures, queried about prior treatment, and asked to sign the same consent form.[3]

Screening interview summary data are recorded by Vera staff on a screening log. As specified in the discussion below, respondents' scores on the various instruments are recorded, as well as the name and type of any drug or alcohol program they attended during the present incarceration. Chapter 5 presents results of analyses of data obtained in the screening interview.

Measures of Drug and Alcohol Abuse. In selecting and developing measures for the screening interview, we were keenly aware that self-reported drug and particularly alcohol use can be of questionable validity (e.g., Watson et al., 1984); the validity and reliability of those data obtained from criminal justice populations are especially suspect. Faced with this reality, procedures and questioning strategies were developed and tested to enhance the quality of the screening data. Interviews are always conducted in quiet, private areas of the prison (usually in an office assigned to Vera staff) under strict assurances of confidentiality and anonymity. A special effort is made to present Vera staff as unaffiliated with DOCS, Parole or other institutional personnel; inmates are told that the information collected by Vera is for research purposes only, and their answers can in no way affect their relationship or status with these official agencies. It is stressed to the inmates that dishonest answers would make the research less valuable, and that we would rather have them refuse to participate or to answer a question than to answer it inaccurately. Perhaps most importantly, a few months after our interviews had begun, researchers in the field received signals that the "inmate grapevine" had accepted these assurances, reinforcing the inmates' willingness to participate.

It is evident that, given the inherent difficulties in assessing self-reported substance abuse in this population, use of a single measure to identify drug or alcohol abuse is suspect with regard to validity and reliability. We therefore used a series of instruments to measure different dimensions of drinking and drug problems, and

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[3] Originally, DOCS said it would inform men at the feeder sites about Vera's research plans, and would obtain an assurance from the man that he would, by virtue of his status as a Lincoln participant, cooperate with Vera's research. DOCS had difficulties implementing this arrangement and, in a few cases, men came to Lincoln and refused to cooperate in the research (these were all men who were unhappy to be at Lincoln in the first place and refused Vera because it was one of the few matters of choice).

augmented self-report data with information available from the inmate's DOCS file. In introducing the instruments to the inmate, he is told to try to remember his drinking and drug use (and related behavior) in the one-year period prior to the current incarceration.[4] The interviewer asks the inmate to think about his life during this recent period, and to write the dates in question on a piece of paper. Inmates rarely have problems specifying and remembering this period quite clearly (perhaps because they have had considerable time to reflect upon it); it seemed apparent from our pilot testing that, while a few inmates might intentionally misrepresent their behavior during this period, these self-reports are not inaccurate due to problems with recall.

In addition to recording available drug, alcohol and treatment data from DOCS files for future analysis, interviewers use this information while administering the screening instruments. When necessary, a man who is denying or in some way misrepresenting an apparent history of abuse is reminded that the interviewer has looked at his file, and any evidence found in the file that indicated past problems is reviewed with him. In such cases, the inmate is encouraged by the interviewer to discuss the reasons for prior drug-related arrests, a high MAST score, notes by corrections counselors about a drug or alcohol problem, or reasons for his attendance in a treatment program. Important inconsistencies are resolved to the satisfaction of the interviewer before the screening process continues.

The first measure administered in the interview is the Substance Abuse Frequency Questionnaire (SAFQ), in which the inmate indicates on a 0 to 3 scale the frequency with which he used specific drugs. (The SAFQ and all other screening instruments can be found in Appendix B.) Based on a measure utilized in an earlier, large-scale federal study of drug treatment outcomes (Hubbard et al., 1984), the SAFQ scale is depicted on a 5x7-inch card held by the inmate, who is asked to indicate his level of use for each of several drugs named by the interviewer (0 = used once a month or less, 1 = used 1-3 times a month, 2 = used weekly or 1-2 times a week, and 3 = used daily or almost daily). If he scores a "2" or a "3" on any drug item, the man is also asked which drug he regards as his "primary problem" and if he had ever used drugs intravenously during the year previous to this incarceration.

The Alcohol Quantity/Frequency Questionnaire (Alc-QF) is administered next. Adapted from a more extensive index developed for the Rand studies (Polich et al., 1981), the Alc-QF provides a measure of the respondent's quantity (in ounces) and

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[4] Note that this restricted time period is in contrast to the MAST and other, more global measures of abuse which make no references to time (several MAST questions, for example, begin with the phrase "Have you ever..." such as "Have you ever attended a meeting of Alcoholics Anonymous?"). Obviously, indices utilizing restricted periods will identify fewer cases as having drinking or drug problems, but it will more accurately reflect the prevalence of problems just prior to the present incarceration. This type of measurement is preferable in the present research, which is designed to assess treatment effects on a current, existing problem.

frequency (number of drinking days over a typical 30 day period) of wine, beer and liquor consumption. By computer analysis, such responses can be used to estimate individuals' daily average alcohol intake, adjusted for differences in the "proof" or levels of alcohol concentration of different beverages. (As seen in Appendix B, the Alc-QF includes separate probes for three types of beverage alcohol, with respect to the number of bottles, cans, shots, etc., drunk on a typical day.)

The inmate is then administered the Adverse Consequences Questionnaire, which measures the extent to which (again, during the year prior to incarceration) he experienced difficulties -- such as getting into arguments or fights, missing work, having medical problems -- as a result of taking either drugs (ACQ-D) or alcohol (ACQ-A). Recognized as important symptoms of substance abuse problems, the items used in the present ACQ scale are common to those used in other scales (e.g., Polich et al., 1984; Mulford, 1977), but tailored for an inmate population. The scores on both the ACQ-A and ACQ-D can range from 0 (no consequences) to 9, depending upon the number and frequency of occurrence of particular problems. Related to the ACQ are two questions about the inmate's use of drugs and alcohol during his commission of crimes. Here the man is asked if he was drinking and/or high on drugs on the day that he committed the instant offense, and how often this occurred in general when he committed crimes (scored as 0 = never, 1 = sometimes, or 2 = frequently). These two items are summed for separate crime-alcohol and crime-drug scores, which range from 0 to 3.

The last instrument administered in the screening interview is the Alcohol Dependence Scale (ADS), a standardized measure of the alcohol dependence syndrome with proven reliability and validity (Skinner and Horn, 1984). Developed and normed over several years with large populations, the ADS measures the extent to which the respondent has experienced classical symptoms of the syndrome (e.g., loss of control over drinking, increased tolerance, withdrawal symptoms), and specifically "the extent to which the use of alcohol has progressed from psychological involvement to impaired control" (p. 5). As with other instruments, the inmate is asked to respond to each of the 25 items in the questionnaire in terms of the one-year period prior to the current incarceration. Scores on the individual items are totalled to obtain an overall ADS score ranging from 0 to 47.[5]

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[5] The ADS is similar to the MAST, but was developed with the more specific intention of measuring degree of dependence on alcohol. The MAST addresses a much broader range of signs and symptoms of alcohol problems, and is described and accepted as a screening instrument, where respondents can be roughly grouped as being "non-alcoholic," "suggestive of alcoholism," or "alcoholic." In this sense, the ADS is a more useful research instrument, since individual scores reflect actual, relative degrees of dependence (in statistical terms, the ADS can be regarded as "interval" or "ratio" level of measurement).

Responses on the screening instruments are recorded and analyzed in two different ways, initially to determine if the inmate qualifies as a potential comparison subject, and in more detail when a man is formally designated as a research subject. Preliminary scores on the Alc-QF and SAFQ are calculated in the screening interview. As specified in Chapter 5, the Alc-QF is scored dichotomously (excessive or not excessive alcohol consumption) and respondents are assigned a score of 0, 1 or 2 on the SAFQ. These scores are then used in combination with scores on the other scales to determine if the inmate qualifies as having a drug, alcohol or poly-abuse history sufficient to warrant his inclusion in the study.

His alcohol history is evaluated first. An inmate qualifies on the basis of an alcohol problem if he (a) meets the Alc-QF criteria of excessive use, or has a score of (b) 10 or more on the MAST (as recorded in his DOCS file), or (c) 10 or more on the ADS, or (d) 2 or more on the ACQ-A. If one of these criteria is not met, he is evaluated for a poly-abuse problem. Men qualify as poly-abusers if they score 6 or more on the ADS or MAST, or 1 on the ACQ-A, and a 1 on the SAFQ, or 1 on the ACQ-D. If the inmate does not meet either the alcohol or poly-abuse cut off for inclusion in the research, he is then assessed for drug abuse. Here, a man qualifies for the research if he scores a 2 on the SAFQ or a 2 or more on the ACQ-D. Some of the men meeting the drug criteria, however, are screened further using a random assignment procedure. The purpose of this procedure is to "oversample" alcohol and poly-abuse cases in the research population (and reduce the number of drug-only abusers), in order to achieve a better balance in the comparison group.[6]

The Research Sample: Intake Data Collection. Comparison group candidates who meet the above criteria and agree to participate further in the study are considered members of the research sample, along with all Lincoln pilot participants. As noted previously, with the exception of some additional process information gathered on pilot subjects, the same data are collected on comparison and pilot group members. At Lincoln, these data are recorded by Vera researchers on an Intake Data Collection Form (IDCF) which, when completed, is transferred to Vera's main site for checking and computer processing.

The IDCF is divided into three sections: a pre-prison section focusing on demographic and background information, and data pertaining to the inmate's life in the year prior to the present incarceration; prison information; and post-release plans. In addition to demographic information, the pre-prison section includes: residential

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[6] The procedure involves using a random number table to reject anywhere from 25% to 75% of the men qualifying as drug-only cases. The proportion rejected is determined on a weekly basis, in response to the size of the C.P.O.D. pool available that week (more are rejected if the pool is large). For the most part, the 25% level was used during the first 2 months of the data collection, and the 75% level has been used thereafter, except for the few weeks with unusually small C.P.O.D. pools.

history; familial information with some history; educational data; vocational history; income in prior year; some self-reported social/emotional information; physical and mental status and history; and community-based alcohol and drug treatment history. It is in this section of the IDCF that the alcohol and drug-related data collected at the screening are recorded for further analysis. Additional items about the association between the inmate's use of drugs and/or alcohol and crime are included here. The institutional section of the IDCF includes data pertaining to dates of incarceration and parole; parole conditions; prison disciplinary proceedings; and attendance in and self-reported satisfaction with prison programs (with additional detail on alcohol/drug programs). The following post-release plans are recorded in the last section: residential; vocational; financial support; social/familial; anticipated drinking and drug use, and the anticipated means of dealing with drinking and drug problems.

The Vera researcher first examines the inmate's DOCS file for IDCF information. For some items, this file serves as the principal source of data (e.g., for the prison information), but for the most part, file data are used as a basis for probing during the inmate interview (e.g., if there is a reference to familial drug or alcohol abuse), or as a double check on inmates' responses. The IDCF interview, which can take anywhere from 45 to 90 minutes, is scheduled in the last week prior to the inmate's release from Lincoln.

Follow-up Data Collection. All research subjects are told that we intend to interview them twice following their release from Lincoln, the first interview being two months after their release date.[7] In addition to this interview, an interview is done with the subject's field parole officer (PO) on approximately the same date. The field PO interview, which typically takes from 15 to 30 minutes, is conducted at the Parole office, or in some cases over the telephone. Before the inmate leaves Lincoln, considerable effort is put into arranging his participation in the two-month follow-up interview. The interview usually takes place at Vera's offices, but may be conducted in a private office at the Division of Parole. Subjects are given a "contact card" with Vera's address, phone number, and a suggested interview date before they leave the facility. They are also asked, on a confidential basis, to give researchers an address and number where they may be reached to arrange for the follow-up, should they lose the card. Information about when the research interview is scheduled is also supplied to the man's field PO, who is asked to pass this information on to the subject, and to

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[7] Originally, the second interview was to take place 12 months post-release. However, preliminary review of the two-month data suggested that there was less involvement by parolees in alcohol- and drug-related treatment than was anticipated. This appears to occur (if at all) sometime after the two-month date -- perhaps several months later. Waiting 12 months to reinterview these parolees would result, most likely, in loss of their "fresh" recollections pertaining to alcohol/drug use and treatment, and undoubtedly, attrition of the research population. We therefore decided to move the second follow-up interview up to six months post-release.

remind him to call Vera to arrange a visit if he wishes to take part in an interview. Follow-up phone calls to the PO and to the man's home are made when necessary. In some cases, we are informed that the parolee has absconded (and cannot be interviewed), or that he is at Rikers Island (or another facility) due to rearrest or a parole violation. In the latter situation, a Vera researcher goes to the facility, and the interview is conducted there. Some proportion of the research subjects state that they wish to be dropped from the study; those who simply never contact Vera for the follow-up remain part of the research.

The Follow-Up Data Collection Form (FU-DCF) focuses on events in the parolee's life since his release from Lincoln. Included in the interview are: residential information; familial, and some self-reported social/emotional information; vocational and income data; and measures of present drinking and drug use (similar to the intake screening). Much of the interview also concerns self-reported use of services in educational, vocational, medical, mental health, and alcohol and drug areas. In all cases, the man is asked to assess his needs in these areas, to describe the reasons he has (or has not) pursued relevant services, and to report on the outcomes of service use. Furthermore, he is asked about the role of his parole officer in each of these areas.

Field parole officers are asked similar questions about the subject's service use, and his or her role in assisting the parolee to obtain services. Additionally, they are queried regarding their enforcement of parole conditions, and any official actions taken concerning the subject. The PO interview ends with several open-ended questions that solicit the respondent's view of the accessibility and effectiveness of alcohol and drug treatment for the parolee population.

Arrest record information (New York State "rap sheets") is also collected at two points during the post-release follow-up. At the two-month period, the man's arrest history is recorded for analysis. Data on arrests prior to this last incarceration become part of the research intake data collected at Lincoln (as pre-release, or "predictor" data); arrests occurring during the two-month post-release period are recorded and analyzed as "outcomes." The research design calls for an examination of rap sheet data twelve months after release to assess longer-term outcomes.

GENERAL ANALYSIS PLAN

The first step in the analysis will be to perform frequency distributions for descriptive purposes. Results of these analyses on data currently available are presented in this report. Further descriptive tests will focus on bivariate analyses, using crosstabs and correlational methods where appropriate. Next, individual data elements will be statistically "reduced" into composite indices, for purposes of using these indices for multivariate analyses. For example, a socioeconomic index composed of education, employment, and income variables will be created; similarly, the

myriad of drug and alcohol measures will be analyzed and ultimately combined into composite variables representing severity of alcohol and drug problems, pre-incarceration treatment history, etc. Other composite variables to be created and used as independent (or "predictor") variables in subsequent analyses will include prior familial and residential stability; psychological and physical well-being indices; and extent and severity of criminal history.

The same approach will be used for aggregating the dependent, or outcome measures. Indices that represent community reintegration, such as familial, residential, educational and vocational involvement, as well as post-release measures of employment and income will be created. The alcohol and drug information will also be reduced, creating single measures of drug and alcohol problem relapse and involvement in treatment. The rap sheet information will be subject to the same procedure, to assess criminal recidivism. The final analytic step will be a multivariate examination of the central hypothesis; that is, whether the treatment programs have an independent impact on the outcome measures, controlling for important independent variables. The primary technique here will be multiple regression.

Results Presented in This Report. Presented in this report are the results of the preliminary frequency distributions, available on a range of data collected at research intake and follow-up. Chapter Five concerns results obtained in the screening interview done with C.P.O.D. inmates at Lincoln. Because the data collected at screening (drug, alcohol and prison treatment history) are available on both those who are selected for the research (as comparison subjects) and those who are screened out, these results pertain to the largest and most representative group of DOCS inmates studied in this research. In this report this larger pool will be referred to as the "screening sample," which includes both inmates rejected at screening and those in the "research sample" (composed of pilot and comparison subjects). Additional chapters concern the latter sample. Chapters Six and Seven present descriptive results of data collected at intake; Chapter Seven specifically concerns drug and alcohol-related data obtained during intake at Lincoln. Preliminary follow-up results, available here on only a small number of comparison subjects are presented in Chapter Eight. This chapter also includes results on a selected subset of follow-up outcomes for a small group of pilot participants.

LIMITATIONS OF THE STUDY

As noted previously, the design and methodology employed in the research is intended to yield statistically sound conclusions regarding the effectiveness of the pilot efforts and other treatment modalities for State prison inmates returning to New York City. Assuming research intake at Lincoln continues as planned (see the schedule below), it will be possible to compare the effects of the pilot effort to those of alternative treatments (in the aggregate) and to "no treatment," controlling for nu-

merous variables that also influence post-release outcomes. The extent to which specific other in-prison and community-based services (e.g., a particular upstate ASAT or a specific drug program in New York City) can be assessed by this research will depend upon the number of men participating in the research who attend each of those services. Given a sufficient sample size, analyses will be done to investigate the impacts of other programs individually; however, we do not expect that there will be adequate numbers of subjects in these analyses to provide the statistical controls to be used in the main analysis presented above.

In this regard it should also be noted that it will not be statistically possible to examine separately the impact of the Lincoln ASAT as compared to the Parole Access efforts at Lincoln. This is because all Lincoln pilot participants receive both "treatments." In the comparison group there will be men who attended other ASAT programs (and received no Access services), as well as men who went only to the Access program run in Parole offices for the general parolee population. Again, if the number of men who have obtained these different combinations of services is sufficient, analyses will be done to assess the effectiveness of these different programs operating independently.

A more general limitation of the present research concerns the representativeness of the Lincoln samples (both pilot and comparison). Although the outcomes of these groups can be compared to each other, we are less sure if results from these two study groups can be generalized to the larger population of all DOCS inmates returning to New York City. Conversations with DOCS officials indicate that the Lincoln C.P.O.D. population (the subject pool for the comparison group) is likely to be representative; indeed, the intake site was chosen for this reason. It is not clear, however, that the pilot participants at Lincoln are typical of all DOCS inmates who attend treatment. Until a statistical assessment of this issue is conducted (it is planned for fall, 1988), we cannot assume the study's results can be generalized to the larger population as a whole.

STUDY TIMETABLE

Research objectives for the 1988 fiscal year centered on implementing the research design, through data collection and monitoring activities, and conducting preliminary analyses of results. The data collection timeline shown below provides an overview of current activities, and places them within the longer-term context of the State initiative. Each of the four data collection activities (intake, follow-ups at 2 and 6 months, and rap sheet data at 12 months post-release) are shown, with different schedules for the comparison and pilot groups. This difference arises from the delay in participants reaching the Lincoln program, and from the need to collect data on the pilot group for a longer period.

At the dates indicated for termination of intake activities (July 1988 for comparisons and April 1989 for pilots), our goals are to have screened at least 600 men, and from this group, to complete intake on approximately 450 research subjects, including at least 150 in the pilot group and 300 in the comparison group. Post-release follow-up is attempted with all of the research subjects, and with their supervising field parole officers. Project goals in this regard are to sustain no more than a 33% attrition rate on subjects available for interviews (i.e., not counting absconders, reincarcerated subjects, etc.) and a 10% attrition rate on field parole officers at the two-month point, and 50% attrition on subjects and 20% attrition of FPOs at the six-month interview.

As shown in the timeline, with the exception of 12-month follow-up data, all data collection on comparison subjects will be completed in FY '89. Intake on pilot participants will continue until the end of the fiscal year, and follow-up of these subjects will go into FY '90. Research activities completed in the current fiscal year are detailed below, and throughout the rest of this report. Ongoing data collection tasks notwithstanding, analyses, interpretation of results, and report writing activities will peak in the fall and winter of 1988 and early '89; the focus of these activities will be the substantive database collected by the fall of 1988. This database will consist of the complete two-month follow-up information on comparison subjects, and about half of the pilot subjects' two-month data; using it, we will be able to assess several major research hypotheses, and include these findings in Vera's third interim report, scheduled for February 1989. With data collection activities winding down, most of fiscal year 1990 will center on final data analyses and report writing; a final report is anticipated for the summer of 1990.

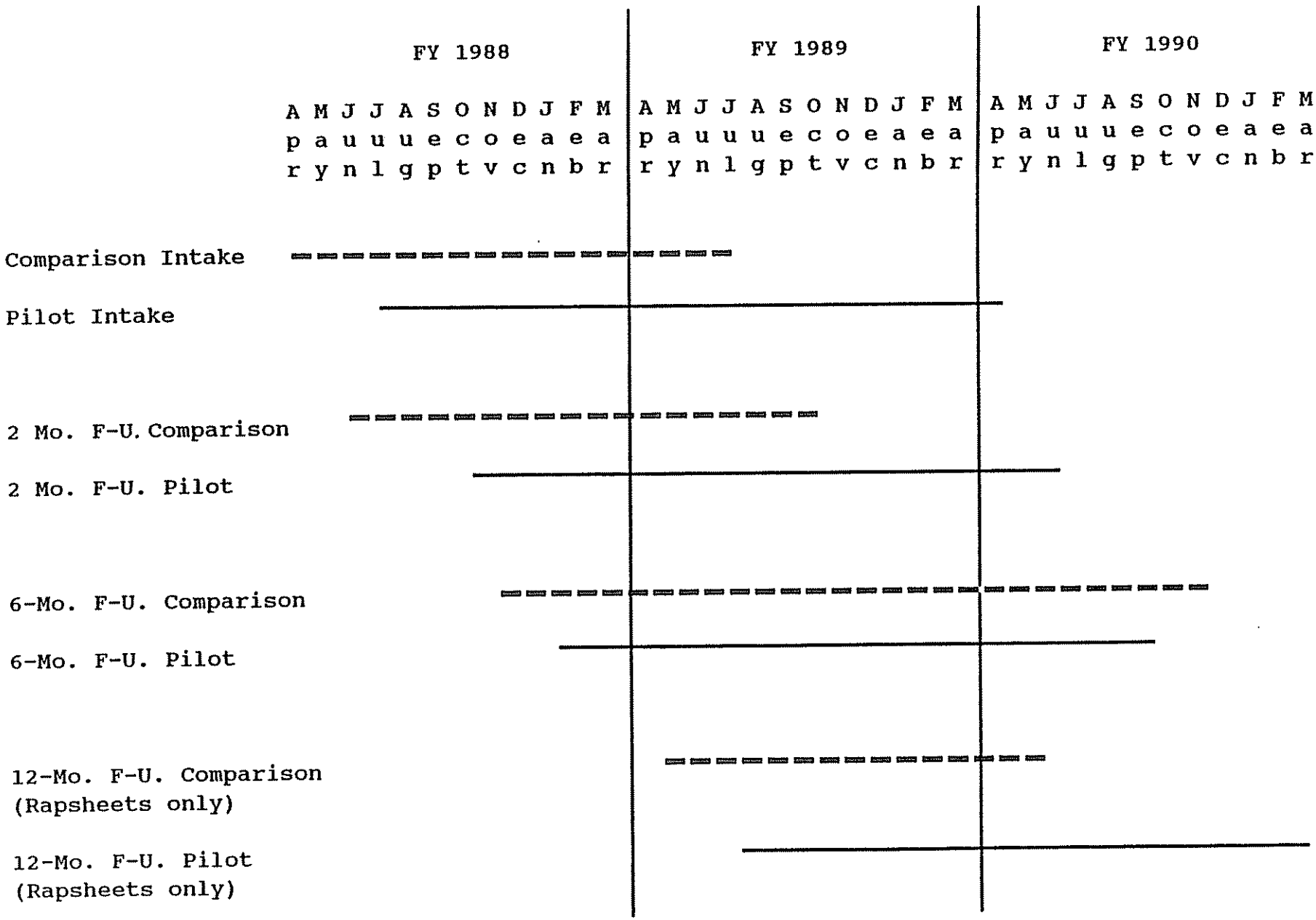
Fiscal Year '88 Activities. By mid-January, 1988, Vera was on or ahead of schedule with regard to all data collection activities, with the exception of 6-month follow-ups on comparison subjects. Specifically, by this date screening data had been obtained on 455 inmates; research intake had been completed on 203 comparison subjects and 51 pilot subjects; and two-month follow-ups were done on 93 comparisons, 14 pilots and 137 parole officers. Slightly short of our goal of 27, 19 six-month follow-up interviews had been completed with comparison subjects (no pilot subjects are scheduled before March, 1988); 45 parole officers had been interviewed for the six-month point.

Preliminary analyses of data collected during the first several months of the current year were conducted during the latter half of FY '88; the results of these analyses are described in subsequent chapters of this report. Again, project goals were met with regard to the number of cases that were available for analysis for the present report. The results of an analysis of data collected during the screening interview, currently available for 455 inmates, is presented in the next chapter of this report. Findings from data collected on the extensive intake and two-month follow-up interview forms (each of which include over 350 variables and require considerable

computer processing time) are then discussed. These include preliminary intake results on a sample of 114 men, and two-month follow-up findings for 34 subjects. More limited follow-up findings, taken from an ongoing log of post-release data, are also discussed for a sample of 173 men.

Additional qualitative research activities undertaken in the current year included the collection of in-depth process information about the workings of the pilot programs; they centered on structured interviews with all participants, and narrative records of researchers' observations of program activities. These activities were done simultaneously with the technical assistance duties described in the earlier chapters of this report. Visits to ASAT sites, community-based treatment providers, parole offices, etc., are useful to project staff both as a means to improve program performance, and as a descriptive base for the research.

DATA COLLECTION TIME LINE



Chapter Five

Screening Sample Results

Information collected in the screening interview includes multiple measures of recent drug and alcohol abuse history, and a record of in-prison treatment participation. Obtained on a sample of several hundred men passing through the Lincoln facility prior to their release, results of these interviews should be viewed not only in conjunction with the specific goals of this study, but more generally as a valuable, descriptive profile of a significant offender population: State inmates/parolees returning to New York City. As of January 15, Vera staff had met with 485 C.P.O.D. inmates to conduct the screening -- that is, to determine their eligibility as comparison subjects. Thirty (6%) of the 485 men we approached refused to participate in the screening interview; thus, with the exception of rare case of missing data, the results described here are based upon a sample totalling 455 men.

MEASURES OF DRUG AND ALCOHOL ABUSE

Drug Abuse Results. Described in detail in the Methods section above, the Substance Abuse Frequency (SAFQ) and the Adverse Consequences-Drugs (ACQ-D) measures are used to assess recent drug abuse history. At screening, the SAFQ yields a simple frequency of use scale, in which each respondent is assigned a score of 0, 1 or 2, based upon his reported use of 13 commonly abused substances during the year prior to incarceration. (More precise coding for each substance is recorded on those members of the screening sample who become research subjects; these results are detailed in Chapter Seven.) On this scale, 55% (249 of 455 screened inmates) were categorized as "high frequency" drug users, scoring 2 on the SAFQ measure. These men (a) used one or more drugs daily or almost daily (most commonly marijuana or cocaine, followed by heroin or crack) or (b) used at least two substances weekly. Only 5% were assigned a score of 1 (these were inmates who used any drug other than marijuana on a weekly basis), and 40% used drugs with less frequency, scoring 0 on the SAFQ. Very few of these men reported little or no drug use, with most low frequency users saying that they used combinations of cocaine, marijuana, or crack one to three times a month.

The ACQ-D scale, which ranges from 0 to 9, measures the frequency with which the respondent had experienced negative consequences as a result of drug use (other than committing crimes, or arrests, which are measured separately). On this measure, nearly half the men (48%, 219 of 455) said they had experienced at least

one such difficulty during the prior year. Forty percent of the respondents scored at least a 2 on the ACQ-D -- either they had multiple troubles due to drug use, or had one consequence (such as getting into fights or missing work) occurring two or more times monthly. The average score for the 455 respondents was 1.8 [standard deviation (sd)=2.3].

These two drug measures were then combined into a simple index of drug problem severity.[1] Scores on this measure ranged from 0 to 4; 62% (284 of 455) of the respondents scored 1 or more on this scale (indicating some level of a drug problem). Moreover, of those scoring one or more, more than half (36% of the total) scored in the "most severe" group (3-4 on the composite scale).

These results were then compared with other data obtained on the inmates' use of drugs in connection with the commission of crimes. As described in Chapter Four, the inmate's file is reviewed, and he is asked in the screening interview about his use of drugs immediately before or after committing crimes. The proportion who took drugs on the day of committing the instant offense, or admitted to some regular use of drugs while committing crimes was 55% (248 of 453 inmates); this is not dissimilar to the proportion of men with scores of 1 or more on the drug severity index (62%).

Not surprisingly, there is a great deal of overlap between the men who had drug problems (as measured by our composite index) and those who used drugs when they committed crimes. Of the 248 men who reported taking drugs while committing crimes, 89% were also counted as having a drug problem on the basis of our index. Of the 284 men who evinced a drug problem, 78% showed a drug-crime connection. About half of the total sample (221 of 453) showed this drug use-crime connection and evinced a drug problem.

Alcohol Abuse Results. To assess alcohol problems during the year prior to this incarceration, a standardized index of alcohol problem severity, the Alcohol Dependence Scale (ADS), was used along with quantity-frequency (Alc-QF) and adverse consequences measures (ACQ-A). Additionally, MAST scores (administered to most inmates at intake into the DOCS system), and any file references to alcohol use or alcohol-related crimes or treatment were recorded. The MAST results, and a discussion of our findings in light of previous DOCS and Parole statistics are presented in a later part of this chapter.

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[1] An analysis indicated that these two drug use measures are sufficiently correlated (r=.54) to compute a composite index. To make the frequency and consequences dimensions of equivalent weight, the ACQ-D was first recoded to reflect the same scale range; a man scoring 0 or 1 on the original ACQ got a 0, a 2 was recoded to a 1, and 3 or more were recoded to a 2. The recoded ACQ-D and the SAFQ were then summed to yield a total drug severity score ranging from 0 to 4.

In the screening interview, the alcohol quantity-frequency index was scored dichotomously (excessive/not excessive).[2] (Computerized calculation of average daily alcohol intake was done only on research subjects, the results of which are reported in Chapter Seven.) With this scoring, 26% (116 of 454 respondents) reported regularly drinking quantities of alcohol that were judged to be excessive, and thus potentially indicative of an alcohol problem. On the alcohol-related adverse consequences scale, 22% (99 of 455) reported having one or more troubles due to alcohol; most of this group (18% of the total) experienced more frequent difficulties. The average score on the ACQ-A scale was less than one (mean=.73, sd=1.6).

The ADS results require more interpretation. Fifty-six percent (255 of 452) scored 0 on this scale, indicating no recent history of alcohol dependence. Based on scoring categories suggested in the ADS Guide (Skinner and Horn, 1984), the great majority of the remaining subjects scored in the "low dependence" group; of the total, 37% were in this group (with scores ranging from 1 to 13) while 6% of the 452 respondents were identified as having had moderate to severe levels of alcohol dependence.

This finding of a small proportion in the more advanced alcohol dependence categories is of particular interest. It suggests that the great majority of men in the present sample -- most of whom are reporting on symptoms experienced prior to incarceration, while in their late teens to mid-twenties -- have never developed the kinds of physiological symptoms characteristic of advanced stages of alcoholism. Rather, those who do abuse alcohol are likely to be psychologically dependent, which may have implications for the treatment of their abuse (Skinner & Horn, 1984).

Inspection of the correlations of the three alcohol measures suggested that a composite alcohol severity index, like that used with the drug data would be useful.[3]

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[2] Respondents were assigned a score of 1 (indicative of excessive, or "high" consumption) if for 25 or more days out of 30 they drank daily 24 or more ounces of wine, 64+ oz. of beer or 6+ oz. of liquor; for 15-24 days of 30 they drank daily 32+ oz. of wine, 96+ oz. of beer or 8+ oz. of liquor; or for 7-14 days of 30 they drank daily 48+ oz., of wine, 144+ oz. of beer or 10+ oz. of liquor. If a man did not meet any of these criteria he was assigned a 0 ("low" or not excessive consumption) at screening. The quantities represent a range of ethanol contents (from 2 to 3 ounces), and thus the scoring provides only an approximate, global indicator of excessive consumption.

[3] For the alcohol quantity-frequency and adverse consequences, r=.57; for the Alc-QF and the ADS, r=.58; for the ACQ-A and the ADS, r=.74). The alcohol composite score was determined by summing (1) the dichotomous quantity/frequency score; (2) a recoded ACQ-A score (recoded to range from 0-2, exactly as was done with the drug composite); and (3) a recoded ADS, where scores of 0-4 were recoded to 0, 5-9 recoded to 1, 10-13 recoded to 2 and 14 or more recoded to 3. In the recoded ADS, the assignment of different scale scores within the low dependence group (original scores from 1-13) appeared appropriate given the high variability of the original scores (sd=5.3) and the low frequency of scores of 14 or more.

When a single index of alcohol problem severity was created from these various measures, about one-third of the men (32%, 148 of 454) scored 1 or more, showing evidence of some level of an alcohol problem. Fourteen percent scored in the "most severe" group (3-6 on the composite index).

When the relationship between alcohol use and crime commission was examined, 29% (131 of 453) said they at least regularly drank alcohol on days they committed crimes (or when committing the instant offense); this was similar to the proportion identified as having a drinking problem on the basis of our alcohol composite index (33%). As was the case with the drug-related results, there was considerable co-occurrence of alcohol problems and drinking at the time of committing crimes. Of the 131 inmates who showed an alcohol-crime connection, 73% were identified as having a drinking problem (as measured by the composite index). Of the group with drinking problems, 65% said they drank while committing crimes. A total of 98 men (22% of the entire sample of 455) showed evidence of both a drinking problem and an alcohol-crime connection.

Poly-Abuse Results. Using the composite severity measures described above, further analyses were conducted to determine the extent to which these individuals experienced poly-abuse problems; these analyses offer further evidence of the variation between drug and alcohol figures, and the high prevalence of poly-abuse. About one-quarter (24%, 108 of 453) of the sample were found to be abusers of both drugs and alcohol (i.e., they had scores of 1 or more on both the severity measures). The proportion of the total sample with a drug problem only was 39% (175), while 9% (39) of the men had alcohol problems exclusively. Twenty-nine percent of the sample did not have either a drug or an alcohol problem.

Summary of Drug and Alcohol Abuse Results. Results of the drug and alcohol measures used at screening are presented in Table 5-A. In sum, 55% of the men were judged as heavy users of drugs (and another 5% used moderate amounts) and 48% had experienced troubles due to drug abuse. When these measures were combined into a single composite index, 62% were identified as having a drug problem; over half of this group, and 36% of the total sample were in the most severe category. As expected, the alcohol measures showed more variablility. The quantity-frequency data indicated that 26% of the men consumed excessive amounts of alcohol; 22% reported adverse consequences of alcohol use. The ADS test revealed a small group (6%) of men with moderate to severe alcohol dependency, and a relatively large group (37%) with low dependency. The alcohol composite showed 32% with an alcohol problem, and 15% falling in the most severe grouping.

TABLE 5 - A

Scores on Drug and Alcohol Measures at Screening

Scores		% of Total	(N)	Mean	(sd)
Drug Measures					
Use Frequency:	Low	40	(183)		
	Moderate	5	(23)		
	High	55	(249)		
(Totals)		(100)	(455)	1.14	(.96)
Adverse Consequences:	0	51	(236)		
	1-4	33	(152)		
	5-9	15	(67)		
(Totals)		(100)	(455)	1.75	(2.32)
Severity Composite:	0	38	(171)		
	1-2	26	(120)		
	3-4	36	(164)		
(Totals)		(100)	(455)	1.85	(1.64)
Alcohol Measures					
Quantity-Frequency:	Low	74	(338)		
	High	25	(116)		
(Totals)		(100)	(454)	.26	(.44)
Adverse Consequences:	0	78	(356)		
	1-4	16	(71)		
	5-9	6	(28)		
(Totals)		(100)	(455)	.73	(1.63)
ADS:	0	56	(255)		
	1-13	37	(169)		
	14-31	6	(28)		
(Totals)		(100)	(452)	2.86	(5.31)
MAST:	0-4	58	(166)		
	5-8	18	(53)		
	9-51	24	(68)		
(Totals)		(100)	(287)	5.82	(8.23)
Severity Composite:	0	67	(306)		
	1-2	18	(81)		
	3-6	14	(67)		
(Totals)		(100)	(454)	.91	(1.68)

NOTE: The scoring ranges presented in the table are those recommended by the scale's developers; the scales and scores are described in the text. Rounding errors may cause some totals to add to more or less than 100%

It should be obvious, from the range of results obtained through the use of different indices, that precision in measuring drug or alcohol abuse prevalence can at best be a goal; estimates tied to a single measure reflect a very limited definition of alcohol or drug dependency. Using the multiple drug measures, then, we estimate that about 60% of these offenders had a drug problem in the year prior to incarceration, while the results from the different alcohol measures indicate the prevalence of alcohol problems in this sample to be approximately 25%.

It is important to view these figures as tentative estimates. Indeed, our data could easily be used to expand both the upper and lower limits of these estimates. If, for example, the presence of any single sign of abuse (e.g., attended an AA meeting or treatment program, drinking or drug use at the commission of the instant offense, a single drug-related arrest) were used to qualify a man as having a drug or alcohol problem, the drug prevalence estimates would approach 80 or 90%, and the alcohol, 40%. On the other hand, we suspect that considerably fewer than 20% of these men have experienced "full blown" alcoholism, with its attendant signs of physiological dependence. We also suspect that fewer than 50% of these men's recent histories can be characterized as a life dominated by drug addiction.

DOCS and Parole Statistics on Drug and Alcohol Abuse. Both DOCS and Parole compile and issue their own estimates of the prevalence of drug and alcohol abuse among inmates and parolees under their respective supervision. DOCS has routinely obtained self-reported drug and alcohol abuse information from inmates coming into their system, and in 1981, in conjunction with the Fellowship Center of the New York City Mission Society, began supplementing this through the administration of the Michigan Alcoholism Screening Test (MAST). The Division of Parole compiles figures from regional offices based on field officers' judgments of parolees' drug and alcohol problems. On the basis of an initial interview with the parolee, a survey of the case file and family visits, the parole officer indicates if the parolee is currently using drugs and/or abusing alcohol, is suspected of such, has a history of abuse, or none of the above.

On the basis of recent self-reports from inmates entering the system, DOCS concludes that 76% of their inmate population have abused drugs prior to commitment.[4] Officials from the Division of Parole indicate a slightly higher estimate of the

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[4] This overall figure comes from analyses recently completed by DOCS, the results of which will be presented in a report they anticipate issuing in early 1988. This report will, for the first time, include information on inmates' use of specific substances, reflecting important improvements in DOCS's procedures for recording self-reported abuse data. Other preliminary findings from the DOCS report (provided to Vera in advance of publication), are discussed in a later section of this report, in the section on research sample results.

prevalence of drug abuse. Like DOCS, Parole is just now compiling their most recent data, which they anticipate showing that 80-90% of the parolee population has a past or present drug problem. The 5% to 15% difference between the DOCS and Parole estimates can be attributed to Parole's more inclusive criteria (past or present, definite or suspected abuse) and their use of file data in addition to self-reports.

Although the figures reported by DOCS and Parole are higher, it is perhaps most accurate to describe their results as consistent with Vera's findings. These agencies don't use time limits in recording instances of drug abuse, and they report these data in a simple, dichotomous way (present/absent). Therefore, in addition to the 60% of the population that we estimate have a serious, recent drug problem, it is likely that anywhere from 10-30% more used drugs at a less severe level, or further back in their history.

Addressing the prevalence of alcohol abuse, DOCS has released two reports summarizing MAST results for large samples of inmates entering their system. Based on two distinct cohorts of male committments in 1981 and 1985, the reports included notably consistent findings; the '81 study found 34% of the men with alcohol problems (scoring nine or more on the MAST), and the '85 study revealed a 35% figure.[5] Parole has reported even higher prevalence figures. Using the same inclusive criteria as stated above (definite or suspected, past or present abuse), their 1985 statistics indicated that 46% of State parolees had alcohol problems. Significant regional differences were observed, however, as upstate regions reported percentages of over 60%, while the overall New York City estimate was 38%.

The discrepancies between these estimates and those arising from our own data collection are not as great as they first appear. Using DOCS files of Lincoln inmates, we also compiled MAST scores available on screening sample subjects (287, or 63% of the sample had a MAST score in their file). As shown in Table 5-A, these MAST results were in fact very similar to the results obtained with our measures, as 24% of the men qualified as having an alcohol problem on the MAST (scored nine or more).[6] When we spoke with DOCS staff about the discrepancies between the 24%

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[5] Although not interpreted in the text of the report, the 1985 study includes a table indicating that an additional 16% of the sample had scores of 5-8 on the MAST; some users of the MAST interpret this 5 to 8 score range as being "suggestive" of alcohol problems. Again, while the authors of the DOCS study did not make this contention and thus are not responsible for others' interpretations, the addition of this 16% to the 34% of men scoring 9 or more is apparently the source of an oft-repeated popular notion that "50% of State inmates are alcoholic."

[6] The high correlation between the MAST and ADS scores (r=.60) similarly points to the consistencies in these findings. This correlation is quite high, given the temporal and situational differences in these measures' administration. Though lower than the MAST-ADS correlation, the MAST was similarly significantly, highly related to the ACQ-A (r=.45) and the Alc-QF (r=.48).

MAST figure for our sample and the previously reported 34% figure, they indicated that their more recent data are moving closer to the lower figure. Reflecting what they think are the increasing number of cases incarcerated for drug-related crimes, DOCS research and evaluation staff reported to us that 27.9% of the new committments from January through September, 1987 score nine or more on the MAST; of those under custody in December, 1987, 29.5% meet or exceed the MAST criterion for alcohol problems.

Any difference that remains between Vera's 25% estimate of the prevalence of alcohol abuse and DOCS's most recent figures can likely be attributed to the different samples under study. Specifically, our numbers are based on men being released to Brooklyn, the Bronx and Manhattan, while DOCS's MAST results come from a state-wide inmate sample. If, as is commonly believed, alcohol problems are more prevalent in upstate communities than in New York City, we would expect higher figures for a state-wide sample than one limited to three boroughs of the City. It will be recalled that this upstate-N.Y.C. discrepancy was evident in Parole's data on alcohol abuse, which included a 38% prevalence estimate for the New York City region. As was the case with their drug abuse figures, the difference between this estimate and those from DOCS and Vera is likely due to Parole's broader criteria of abuse.

ATTENDANCE IN PRISON TREATMENT

Other data recorded in the screening interview concerned the man's attendance in alcohol and/or drug treatment programs during the present incarceration. As was the case with the results described above, this information is coded in much more detail for research subjects, and can be presented here in only a simple summary form, as taken from the screening logs. These data are also obtained from an initial survey of inmate files and from more extensive probing in the interview with the inmate.

In general, these data appear to offer a positive picture of DOCS's efforts to provide treatment programs for the inmate population. Of the 443 C.P.O.D. inmates interviewed who could report on these data, almost two-thirds (65%, 286 men) had participated in some kind of drug or alcohol treatment during their incarceration. Of those who attended, half of them spent four months or less in these programs (mean=6.3, sd=5.7). The most commonly attended treatment programs were drug-abuse oriented (27% of all inmates in the sample attended this type of program), followed by ASATs (16%), and AA (11%) and NA groups (9%). Just under 3% indicated they had attended a program (other than ASAT) which was both alcohol- and drug-abuse oriented.

Further analysis of these data revealed mixed results with regard to appropriate matching of inmates with the type of treatment needed. Although nearly three-quarters (73%) of the men who met Vera's criteria of having a recent drug or alcohol problem (as determined in the screening) had attended treatment, 45% of those whom we judged as not having a serious problem also attended a program.[7] These numbers clearly point in the direction of an appropriate needs-service match. Nevertheless, it is significant that 27% of those with a pressing need for treatment got none during their prison stay, while about one-fifth (21%) of the men who participated in programs did not have at least an obvious need for treatment.

CONCLUSIONS: SOME PRELIMINARY POLICY IMPLICATIONS

The high prevalence of alcohol and particularly drug abuse identified in the screening data suggest that treatment programs -- presuming they are effective -- are necessary for this population. The fact that as many as two-thirds of the men in our sample attended some kind of substance abuse program in prison is encouraging. However, almost half the men whom we judged as not having an immediate drug or alcohol problem were in prison treatment anyway; this is consistent with the widespread notion that most inmates (at least initially) attend programs to increase chances of "making parole," or as a diversion. These results, then, dismiss the notion that getting inmates to participate in programs is problematic; further, they suggest that one immediate way of increasing potential effectiveness is to get the right inmates into the right programs.

Apart from the issue of matching the inmate to the appropriate treatment, increasing effectiveness comes down to the simple, but pervasive matter of raising the quality of programming in the State system. While the sheer number of programs in the DOCS system is impressive, with the exception of the larger ASATs and a few drug programs, State prison programs are relatively informal groups, run by volunteers or a lone Corrections Counselor. (Moreover, our preliminary data suggest that these less

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[7] We also looked at the relationships between program types and the substance abuse problem types identified in the screening measures. For example, a range of problem types were represented in ASATs (46% drug abusers, 33% poly-abusers, 7% alcohol abusers, with 13% of attendees classified as not having a problem). Of the men participating in drug programs or NA, 72% were identified as having drug or poly-abuse problems (6% of the drug program/NA participants had an alcohol-only problem). On the other hand, of those men who attended treatment but were not considered as having a problem, a majority (70%) attended these drug programs or AA groups; this is perhaps predictable, since these programs tend to be smaller, ubiquitous and less selective than other prison programs.

formal programs attract inmates who have less need for treatment.) Raising the quality of prison-based programs so that participants become self-involved beyond the initial motivation to make parole or pass time -- to the point of recognizing their dependency and being committed to deal with it post-release -- must be a clear priority if these programs are to have any impact.

The findings presented in this chapter suggest one means of immediate improvement: we would encourage DOCS to redouble its efforts to develop routine methods of assessing drug and alcohol problems at entry (classification) to the system. DOCS's use of the MAST is an important first step in this regard; in fact, the results we gathered from various other instruments offered strong support for the MAST's validity.[8] While we would also recommend the use of an alcohol quantity-frequency measure, as a single, expedient means of identifying and quantifying alcohol problems in this population, the MAST appears quite adequate. Similarly, DOCS is to be commended for its efforts to improve their drug use assessment at classification. If, in addition to routine questioning on different substances, these assessments yield detailed data on frequency and recency of use, they could be extremely useful.

In addition to the obvious advantages these assessment methods bring to program planning and policymaking, perhaps their more critical value lies in clinical applications. At a minimum, MAST results and valid drug use histories could greatly benefit corrections counselors and Parole commissioners and officers in making decisions about an individual's treatment. After entering a program, assessment results could offer some further direction for counseling plans. Similarly, parole officers could use them to decide upon referrals for treatment. If agencies are to move beyond the simple goal of program expansion to one of program effectiveness, identifying individual treatment needs in a more precise fashion is critical.

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[8] This was true despite our initial skepticism about the MAST (that it was only useful as a screening device and, as that, "over identified" problem drinkers, i.e., yielded too many false positives). As described previously, the MAST shared high correlations with our other measures and identified a comparable number of men with alcohol problems when the criterion score of 9 or above was utilized (we do not recommend interpreting scores below 9 as signifying alcohol problems in this population).

Chapter Six

The Research Sample: Preliminary Descriptive Results

Results reported in this chapter pertain to men who had completed research intake at Lincoln C. F. by late September. The data are taken from 114 comparison subjects who had completed the screening interviews, had their DOCS file surveyed and coded, and had completed the intake interview, just prior to release from Lincoln. As explained previously, this sample is chosen from the Lincoln C.P.O.D. population, which, on the basis of discussions with DOCS officials, is likely to be representative of State inmates returning to New York City (we have not yet, however, tested this statistically). Selected because their drinking and drug histories were extensive enough to meet pre-determined criteria, this study group may only be representative of inmates returning to New York City with alcohol and drug problems. Intake data from pilot subjects are not reviewed because so few pilot participants had completed the Lincoln ASAT and been released by this date.

This chapter begins with a summary of background information on the comparison sample, followed by a summary of data regarding these subjects' plans for re-entering the community upon release. Prison and parole-related information is then presented. As indicated in Chapter Four, our central purpose in collecting this pre-incarceration and prison and parole information is for inclusion in future relational analyses with outcome results. As summarized at the end of the chapter, the data presented here are offered for descriptive purposes only, with minimal interpretation.

THE COMPARISON GROUP: BACKGROUND INFORMATION

Demographics. Of the 114 men in the comparison sample, most were Black (50%, or 57 of 114) or Hispanic (39%), with 36 of the 44 Hispanics reporting themselves to be Puerto Rican. The remainder were white (11%). According to DOCS file data, all but one of the men were at least conversant in English, with the lone exception speaking Spanish only. Ten men were born outside the U.S. (and became naturalized citizens) and eight were born in Puerto Rico; on average, these men had moved to the continental U.S. at age 10 [mean=9.9, standard deviation (sd)=7.5].

The median age of the 114 inmates was 28.5 (mean=29.6, sd=7.3), with the youngest subject being 18 and the oldest 63. Fourteen of the men (12%) had graduated from high school, and 9 of them reported some college attendance. Forty-eight men (42%) had received a G.E.D.; half of them earned the G.E.D. in the present incarceration. The rest of the men -- slightly fewer than half (46%) -- had neither a

high school diploma nor a G.E.D. On average, this sample had completed 9.8 (sd=1.6) years of schooling. According to DOCS files at Lincoln, for the 95 comparison study subjects for which such data were available, the mean grade level reading score was 7.5 (sd=2.9).

Slightly fewer than half of the men (46%) had never married; 34% were married (two-thirds of these were in common-law marriages); and 19% were divorced or separated. Of those who either were currently married or had been married, the median length of their marriage was six years (mean=7.6, sd=8.4). Two-thirds of the men reported having children. Most of these had one (32% of the total sample) or two children (16%), with 16% reporting from three to six children.

Residential and Familial Information. A considerable amount of additional data was collected on the inmates' residential and familial status in the year prior to this incarceration. The most common borough of residence was Brooklyn (40%), with about equal proportions living in Manhattan (25%) or the Bronx (24%). The remaining men were living on Staten Island, or outside of New York City. Almost all of the men (92%) had been living in private apartment buildings or houses prior to their incarceration; the remaining 8% were living in S.R.O.s, in residential drug or alcohol programs, or were undomiciled. About three-quarters (79%) had lived in these residences for at least a year (with a median of three years spent at the reported residence), while 15% moved once in the previous year, and 6% moved twice or more.

Most of these men reported living with their spouse or girlfriend (40%). Other living arrangements reported included with mother (18%), alone (12%), with two parents (i.e., mother/stepmother and father/stepfather, 11%), with other family (11%), and with friends or some combination of above (9%). In addition to reporting this primary living arrangement, 17% of the sample said they spent from one-fourth to one-half their time in a second residence -- typically these were men who lived with a girlfriend in addition to having a primary residence with their immediate family.

The 77 men who reported having children were also asked to specify the number of months they had lived with at least one of their children in the year prior to the present incarceration. About half of the men had not lived with their children at all during this period, while about a third resided with them during the entire 12 months. With regard to providing financial support to children and other family members (including girlfriends), 60% gave no financial support, while 20% said they gave partial support to a family member.

When asked to specify with whom they spent most of their "free time" (again, in the prior year), one-third identified their spouse or girlfriend. Another 23% reported spending most of their time with multiple friends/girlfriends; 7% were principally with their children, 7% with other family member(s), and 16% spent most of

their time with some combination of the above. About 15% of the sample said they spent most of their time alone, or with no one in particular. They were also asked to describe the activity they typically engaged in during their free time. One-quarter of the respondents said these activities centered around substance abuse, either alone or with others. Most of these men (17% of the total) specified that they mostly "did drugs" in their free time, while 7% said they drank alcohol and took drugs, and 3% drank most of the time. In terms of more positive activities, a little over half of the men (55%) described social activities outside the home (played sports, went to discos, movies, etc.), while 20% said they typically "hung out" at home, either alone (17%) or with others (4%).

Reflecting on their home and social life in the prior year, we asked the respondents to evaluate aspects of it using a 5-point scale (with 1 being "very good" and 5 being "very bad"). In general, these men had quite favorable impressions of these matters, as more than half (57%) thought their relations with their parent(s) or other significant family was "very good," and 45% rated their spouse/girlfriend relationships likewise. Relationships with spouses or girlfriends were generally more problematic, however, as 40% judged them to be neutral (the middle of the 5-point scale) to "very bad," while 28% evaluated their relations with parents/other family this way. Relations with children were rated particularly positive, with 80% reporting "very good" relationships. When asked to judge their overall home and social life, the most common responses were good to neutral (56%); about one-quarter of the men said very good, while one-fifth responded in the bad to very bad range of the scale.

Less positive (and more objective) family-related findings came from investigations of DOCS files, and specific interview questions about family difficulties. Data on prison visits revealed that almost one third of the sample (30%) received two or fewer visits a year from anyone (family, girlfriends, friends), and the same percentage were visited a total of three to 11 times (less than monthly). These visit data were consistent with the self-reported judgments described above; parents and other family were more likely to pay prison visits than were spouses or girlfriends. Specifically, 49% of the men received from 3 to 11 visits from parents and other family and another 37% were visited by them twice or less. This compares with 25% of the men being visited 3 to 11 times by a spouse or girlfriend and 62% visited by them fewer than three times.

File review and interview responses revealed that alcoholism in other family members was the most commonly cited problem, occurring in 40% of the cases. In contrast to the screening sample results described earlier, drug problems in other family members occurred less often, being reported in 25% of the sample. About one-quarter of the men were from families in which another family member had been in jail or prison, or was in some way reported to be involved in criminal activity. Another 10% of the men (or their files) reported some other specific family difficulty, such as the inmate being "rejected by a parent" at an early age, or the presence of an emotionally disturbed parent or sibling.

More extensive, earlier background data revealed that 46% of these men had spent most of their youth in a two-parent household (some combination of father/stepfather and mother/stepmother), while 38% were principally raised by their mother or a stepmother. The remaining subjects were raised by other family members or non-family members. Almost one-fifth (18%) of these men had spent some time in foster care; the median length of time spent in such care for these 21 subjects was six years.

For the 56 men reporting a male parent in the household, all but two of them said that while they were growing up, their father/stepfather worked "most or all of the time." For those with mother/stepmothers in the household, 39% of these women were reported to work most or all of the time, while 28% worked "off and on," and 33% did not work. A little less than half of the men (45%) said their families received public assistance while they were growing up; 19% received public assistance sometimes, while 27% received it most or all of the time.

Employment and Income Information. With regard to their own employment history, all but 13% of these men had at some time held a full-time job for four months or more. The median length of the longest held full-time job was two years (mean=32.5 months, sd=26.9). Most typically, these jobs were service-related (29%), skilled (25%) or semi-skilled labor (19%) positions. Despite these work histories, more than half of the men (55%) said they were not working at the time they were incarcerated for the instant offense. Including non-taxed "off the books" (or "under the table") jobs, 39% of them said they were working full-time at the time of incarceration, while 6% said they held part-time or "spot" jobs.

In addition to the 51 men who held a job at the time of incarceration, another 30 (26% of the total) had held a job at some point earlier in the year prior to incarceration. The median total annual income from employment for this year for these 81 men was $9,100 (mean=$10,562, sd=$9,065). They were also asked about other sources of income during this year, such as unemployment compensation, SSI, and cash support from family and friends. About one-third of the sample received some such income, the median total of which (for the year) was $2,090. Totalling employment and other income sources (but not including illegal sources), 87% of the men reported some income during this year; the median annual income for this group was $7,152 (mean=$9,685, sd=$8,682). Given these figures it is not surprising that about half of the sample (46%) said they were at least in part dependent upon a family member or friend to help support them -- usually to pay for rent, food and other necessities. Fifteen percent reported being entirely dependent on others, and similar proportions said that others paid for some (14%) or most (15%) of their expenses.

At the end of the employment and income section of the interview, assuring them again of confidentiality and anonymity, Vera interviewers asked these men to estimate the total amount of money they had made in the prior year from illegal activities. About two-thirds were willing to provide such an estimate. Fifteen of these 71 men reported an annual income from illegal sources of over $100,000. With $99,999 used as the coded figure for $100,000 or more, the median income from illegal sources for the prior year was $26,000, with the average being $39,780 (sd=$37,923).[1]

Medical and Psychiatric Information. Medical history data were obtained from files and interviews with inmates. Not surprisingly, the most common medical problems noted in their histories were gunshot or stab wounds (45%) and serious accidents (33%). Aside from these, the common problems cited in their files or by the men as "bothering [the inmate] on a regular basis" were eye and ear disorders (23%), gastrointestinal disorders (22%), lung disorders (20%), heart disorders (15%) and hypertension (14%). Apart from any drug or alcohol abuse diagnoses, almost 90% of the men either had a history of or were currently experiencing one or more medical disorders, with 27% having two disorders, and 38% with three or more disorders. Perhaps a better indicator of current medical problems, non-psychiatric medication was being taken on a regular basis by 18% of the men.

Seventeen of the men (15%) had spent one or more days in a prison hospital during the current incarceration; the median number of days spent there was 14. Prior to this incarceration, about three-quarters of the men said they had been hospitalized for a medical problem overnight on at least one occasion, and 42% had been hospitalized overnight on three or more occasions.

The inmate files revealed some reference to psychological problems in 21% of the cases. A little less than half this number (10%) were found to have taken medication for a psychological problem during the current incarceration. A similar percentage (9%) reported some psychiatric hospitalization prior to the incarceration.

INMATES' POST-RELEASE PLANS

One of the reasons we arranged for the subjects to take part in the intake interview just before leaving Lincoln was to permit an adequate assessment of their post-release plans. Almost all of them said they were planning to return to the same

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[1] Although Vera interviewers generally felt that this information was accurately given, or in a few cases underreported, there is no way to verify this data. In future analyses, consistency checks will be run to test whether self-reported illegal income corresponds to other items, such as paying for household expenses.

boroughs of New York City from which they had come (Brooklyn, Manhattan and the Bronx), most commonly to live with their mother (25%) or some family member other than a parent (28%). Compared to living arrangements reported for the period prior to the incarceration, fewer (18%) planned to live with a wife or girlfriend. About 7% of the sample didn't know with whom they were going to live, or were planning on going to a shelter, if necessary. When asked to estimate how long they could stay in the anticipated residence, over three-quarters (77%) said "as long as I want," while 16% said six months or less (5% said six months to a year).

Using questions similar to those posed about the period prior to incarceration, the men were asked what they were planning on doing with their free time upon release. In terms of whom they were planning on spending it with, about equal proportions said with a spouse/girlfriend (18%), their children (21%), other family members (22%), or alone (21%). The remaining one-fifth of the men mentioned other friends, or a combination of family and friends. With regard to what they would be doing in their free time, almost half of them (48%) cited active, social activities away from home. Another 22% said they would spend most of their time at home with their family, and 11% said they planned to stay around the house alone. Notably, only two of the 114 men said they planned to "hang out with friends," without citing an activity such as going to movies, playing sports, etc.

In summarizing their residential, familial and social plans, the respondents were asked to use a 5-point scale similar to one described earlier, and evaluate how easy or hard (1=very easy, 5=very hard) they expected their life to be in certain areas. On this measure, two-thirds said finding and maintaining a stable place to live would be very easy, while one-quarter rated it from the midpoint (or neutral response on the scale) to very hard (3 to 5). Similar results were found in their judgment of how difficult it would be to "settle in with [whom they planned to live with]." To this question, 59% said it would be very easy, while 24% gave it a neutral to very hard rating.

The inmates were also queried about their plans for employment and other income. Slightly fewer than one-third of the men (31%) identified a specific full-time position which they said had been promised them upon release (typically in a letter from the prospective employer). Roughly equal numbers of men thought they "had a good chance" for a full-time job with a specific employer (25%), specified plans for attending a particular jobs program (23%), or simply could not specify any employment plans (20%). Using the same 1-5 scale, 43% of the sample said they thought finding and keeping a job would be very easy. One-fifth of them indicated that it would be easy, 26% had a neutral reaction, and only 11% said it would be hard or very hard.

Subjects were also asked to estimate the proportion of income they anticipated from several sources upon their release. Almost two-thirds of the men (63%) said

they were depending upon a job as the sole source of income. Another 19% expected a job to provide 50% of their income after release, with the rest coming primarily from family and friends ("until I get myself on my feet"). About half of the men (46%) anticipated some financial support from family and friends, and 37% of them thought this support would constitute from 50% to 100% of their income after release from prison. Very few of them expected support from sources such as public assistance or SSI. Depending on savings was hardly an option for any of these men; only 45% of the sample reported having any money saved upon release, and for these men, the median amount saved was $200.

PRISON AND PAROLE INFORMATION

Criminal history data collected at intake are limited to two items pertaining to the man's record as a juvenile, and scores on two measures utilized by the Division of Parole.[2] With regard to juvenile history, 59% of the men said they had never been arrested as a juvenile (i.e., when under the age of 16); 16% had been arrested once, and about one-quarter (26%) of them had been arrested two or more times. A similar proportion (23%) of the men had spent some time at a juvenile correctional facility.

The average length of the present incarceration for the study sample was 2.8 years (sd=1.9; the median term was 2.3 years). These men spent, on the average, 2.3 years (sd=1.7; median=1.8 years) of this incarceration time in the State DOCS system. Upon release, their average time to be spent under parole supervision was 3.7 years (sd=2.6; median=3 years). These figures are similar to those for the general population: DOCS reports that the average total prison time in 1987 was 2.7 years and that the average time in the State DOCS system was also 2.3 years.[3]

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[2] Extensive criminal history data for all study subjects are being collected from Division of Criminal Justice official records ("rap sheets"). Routinely obtained two to three months after the man is released to Parole, rap sheet information is being coded for computer processing on a separate database and is not available for the present report. Apart from these historical data, any arrests and/or parole revocations which occur after the present incarceration (these being viewed as post-release "outcomes" rather than background information) are recorded on follow-up forms and logs; these results are reported in subsequent sections of this report.

[3] Information was also collected on three other items which may be of interest in future analyses of predicting outcome but, at this point in time, does not have any descriptive value. On Prior Criminal History and Current Offense indices, intended for use by Parole Boards as a guideline for assessing lengths of prison terms and risks to Parole supervision, pilot participants averaged 3.0 [on a range of 0 (low) to 11 (high)] and 3.8 [on a range of 1 (low) to 9 (high)] respectively. In the DOCS system, "adjustment" to prison life can be assessed in two ways. First, data were obtained on the number and severity of disciplinary actions for 109 of the 114 comparison group subjects: just under two-thirds of the men (62%) were charged with one or more of the least severe action (known as "Tier 1"), fewer subjects (44%) received any Tier 2 actions, and just under one-fifth (19%) received the most severe disciplinary charge. On a routine basis, corrections counselors also assess inmates as to whether their adjustment is "outstanding," "satisfactory" or "poor." For the average comparison group subject, outstanding adjustments were recorded in less than one in ten assessments; more than half the men never received an outstanding rating.

Detailed information was collected on drug- and alcohol-related conditions of parole specified for individuals in the sample; descriptive information on these conditions is presented in the next chapter of this report. Apart from drug and alcohol conditions, the most common parole conditions set for these men was to "support dependents" (i.e., their children), which was specified for 16% of them. Other conditions included attending educational programs such as for the G.E.D. (9%), going to psychological counseling (9%), and attending vocational programs (6%).

Program Involvement. Information on participation in prison programs and jobs was recorded from files, and in interviews, inmates were questioned about the usefulness of these programs. Vocational and educational program data are presented here, with drug and alcohol program information reported in the next chapter. Apart from programs dealing with substance abuse, the most commonly attended type of program was vocational. Over half of the men (56%) completed a program, with 45% of this group attending one program, 33% attending two, and the remaining 22% attending between three and five vocational programs. On average participants spent a total of 17.9 months in vocational programs (sd=20.3), with 50% of them spending a year or longer in such programs.

For all prison programs attended, Vera researchers asked the subjects to rate on a scale from "extremely helpful" (1) to "of no use at all" (5), how useful these programs would be once the man got out of prison, and second, if they felt their participation helped them get paroled early. Vocational programs were rated quite favorably, with almost three-quarters (72%) of the participants saying they thought the programs would be extremely helpful after they re-entered the community. Fifteen percent of them had neutral to negative ("of no use at all") judgments of these programs. With regard to early release on parole, almost half (48%) thought vocational attendance was extremely helpful, although the next most common response was that they were of no use at all (27%). The remainder of the responses clustered around the neutral rating on the scale.

Fewer of the men completed educational programs, most often A.B.E. (which are pre-G.E.D. classes) or classes for the G.E.D.; 11 men completed A.B.E. programs and 28 received their G.E.D. during this incarceration. Three men attended pre-college and 50 attended college programs; however, only a third of those attending college programs actually received any credits (which ranged between 9 and 30). Participants rated educational programs even higher than the vocational programs, as 82% of them thought they would be extremely helpful to them after they got out. In terms of early parole release, respondents gave virtually the same answers as indicated above for vocational programs; 46% thought their attendance was extremely helpful, while another 27% said their participation was of no use in getting paroled earlier.

Most of the men (100 of 114) held jobs while in prison, usually one (43%) or two (32%). On average they were employed for nearly two years (mean=23.3 months; sd=24.5), with half the men working for 16 months or longer. When asked whether they thought the prison jobs would be helpful after they got out of prison, most answers were positive; nearly half the men thought they would be extremely helpful (47%), while one-quarter of the men thought they would be of no use. With regard to getting paroled early, the most common response was that they were of no use at all (39%). However, 30% responded with the other extreme (extremely helpful), and the remaining 30% were fairly evenly distributed through the mid-range of the scale.

As is the case with "prison adjustment," corrections counselors also rate inmates with regard to overall program involvement. When these DOCS records were analyzed, it was found that the subjects did worse than they did with the adjustment ratings. Specifically, the average inmate was judged outstanding in terms of program involvement only once in every twenty assessments (5% of the time); 75% of the men had no outstanding program assessment on their record.

SUMMARY OF DESCRIPTIVE RESULTS

The data reported above indicate that the comparison sample was composed of predominantly minority group members who were under 30 years old. Although just over half had earned a high school diploma or GED, the average man in the sample was able to read at an eighth grade level. Just over half the inmates had ever married, and two-thirds of the men had children.

Prior to this incarceration, nearly all of the men had lived in private residences in Brooklyn, Manhattan or the Bronx; about three-quarters of them had lived there for a year or more. They most often lived with their spouse or girlfriend, followed by their mother or both parents. Twelve percent lived alone. Among the men who had children, about one-third had lived with them for the entire year, and about half for none of the year.

Over half the sample reported spending most of their free time with a spouse, girlfriend or multiple friends; 15% of them spent most of their time alone. About half the men spent their free time engaged in social activities outside the home; about one-quarter of the men spent most of their time involved with drug or alcohol abuse; and the remainder just "hung out." They tended to judge their relationships with parents or children to be very good, and relationships with spouses or girlfriends somewhat less positively. Despite these positive judgments, during their incarceration almost a third of the men received from none to two visits per year from anyone, and another third were visited less than monthly.

Close to 90% of the sample had at some time been employed full-time; half of them had held a job for two years or longer. The jobs tended to be service-related, skilled or semi-skilled labor. Fewer than half the men were working at the time they were incarcerated for the instant offense; an additional one-quarter had been employed at some time during that year. The average income (from employment and other legal sources) during the year prior to incarceration was under $10,000. From illegal sources their average income was nearly $40,000 (only two-thirds of the sample provided such estimates).

When asked about their post-release plans, nearly all the men indicated they planned to return to their home borough, most often to live with their mother or other family member. They planned to spend their free time with friends and family members; about one-fifth planned to spend their free time alone. As they did prior to incarceration, about half the men intended to be involved in social activities outside the home, and about one-quarter would spend their time at home with their families. Very few planned just to "hang out."

Regarding employment prospects, nearly one-third of the subjects had been promised a full-time job upon release, and one-quarter thought they had a good chance of securing a specific job. The remainder planned to attend an employment program or had no specific plans (20%). They expected to support themselves at least in large part with the incomes they earned, although about half of the men expected to receive some support from family or friends.

It appears, based on limited information, that these men had varied criminal histories. Just over 40% had been arrested one or more times as juveniles, and nearly a quarter of them had spent time in a juvenile corrections facility. [Their Prior Criminal History scores covered the entire range (0-10), with an average of 3.0, and their Current Offense scores ranged from 1 to 9, averaging 3.8.] On average these men had been incarcerated for close to three years (for the instant offense), two of those years in State DOCS facilities. Upon release they were to spend an average of 3.8 years on parole.

Other than special parole conditions regarding drug and alcohol problems (reported in the next chapter), relatively few men were given special conditions by the Parole Board (all parolees are routinely given some conditions, such as "seek, obtain and maintain employment"). Sixteen percent were instructed to support their dependents, while 10% were to attend vocational programs, and the same number were to attend educational programs.

Almost all the sample subjects (88%) held prison jobs at some point in their incarceration; they averaged two years in those positions. More than half (56%) also completed vocational programs (averaging a year and a half in these programs), and a third completed G.E.D. or A.B.E. classes. Forty-four percent of the men attended

some college classes while in prison, but only one-third of these (15% of the total) actually received any college credits. Those attending the vocational and educational programs evaluated them highly. When asked if they thought attending these programs would be of use to them after their release, 82% of those attending educational classes and 72% of the vocational participants thought they would be extremely helpful. About half of the men thought attending educational and vocational programs had helped them obtain an earlier release on parole, while a third said, in both cases, that program participation was of no use. Not surprisingly, prison jobs were viewed less highly, although still positively. About half thought holding these jobs would be extremely helpful to them upon release, and a quarter thought they'd be of no use; the men were split with regard to how helpful these positions were in terms of "making parole."

Chapter Seven

The Research Sample: Drug and Alcohol-Related Information

In addition to the information presented in the previous chapter, various drug and alcohol-related data were collected at intake on research subjects. Much of this information was gathered in the screening interview, and then coded in more detail on the intake form (in addition to the screening log), for those men selected at screening to participate in the study. Related data recorded on the intake form included special parole conditions concerning drug and alcohol abuse, detailed information on attendance in prison-based treatment programs, and on alcohol, drug abuse and criminal history. Results of simple descriptive analyses of these drug and alcohol-related data are presented in this chapter, for the same group of 114 comparison group subjects discussed in Chapter Six. As was the case with the results presented in the previous chapter, complete drug and alcohol-related data were available (for purposes of the present report) on only eight pilot subjects, and were therefore inappropriate for even simple descriptive analysis and presentation. Instead, we include here results obtained in preliminary "screening" interviews with the pilot subjects, currently available on 46 participants.[1]

DRUG AND ALCOHOL-RELATED PAROLE CONDITIONS

Because of the range of terminology used by different Parole Board members in setting special conditions pertaining to substance abuse (and their potentially unique interpretation by enforcing officers), Vera's forms allowed up to nine distinct conditions of this type to be coded. These results indicated that almost half (47%) of the 114 comparison subjects were given some kind of explicit drug-related condition. Most commonly, the condition set for these men was "drug testing" or "drug alert," calling for urinalysis checks or special attention to potential drug use, which was specified in just over a quarter of the cases (27%). About the same number of men (26%) were given a condition requiring them to attend some kind of drug treatment (6% of the men had both drug testing/alert and treatment conditions). Of those with treatment conditions, most (67%) had outpatient treatment specified; residential treatment was indicated for very few individuals. In 17% of the cases given drug-related conditions, the supervising (field) parole officer was explicitly given the option

[1] As described in Chapter Four, pilot participants are not in fact screened for inclusion in the study, as all Lincoln ASAT participants are automatically accepted as pilot subjects. In a preliminary interview, pilot subjects are administered the same measures and items used in comparison screening interviews; these measures are just not used for screening purposes with pilot subjects.

of enforcing the condition (these are indicated by the phrase "at the discretion of the parole officer" being included in the condition).

Specific alcohol-related conditions were set for only 10% (11) of the men. Five men had both "alcohol abstinence," and alcohol treatment conditions; three had treatment alone, and the same number had abstinence alone. Of the eight men with treatment conditions, five were specified to attend AA, and three were set for "AA and substance abuse treatment."

In addition to the men receiving explicit drug and alcohol treatment conditions, another one-quarter were given a condition for "substance abuse counseling." Although this group may include some number of men perceived as needing treatment for poly-abuse, this phrase is likely also used by some Parole Commissioners to mean a mandate for drug treatment, or more rarely, alcoholism treatment. Thus, we cannot be sure of its interpretation. In any event, it is clear that the Parole Board responds to the high prevalence of drug and alcohol abuse in this sample: almost 60% of them were given some kind of condition to attend treatment.

ATTENDANCE IN PRISON DRUG AND ALCOHOL PROGRAMS

Subjects were asked whether they attended any drug or alcohol programs during the current incarceration, and if so, they were asked another series of follow-up questions. (It will be remembered that some of these same data were reported in the previous chapter on screening sample results. Results reported in the present chapter are much more detailed, and apply only to the research subjects who "passed" the screening, and thus have more extensive drinking and drug histories.) The interviewer coded each program as ASAT or non-ASAT, and for the latter programs, the program type (drug-oriented, AA, etc.). Sixty-nine (61%) of the comparison group subjects attended non-ASAT programs in 30 different correctional facilities (spread fairly evenly among them). Seventeen of these men also an attended ASAT program, which were altogether attended by 36 of the inmates (32%) at 16 different correctional facilities (again, evenly distributed among the facilities). Three-quarters of the comparison group, then, attended a treatment program in the present incarceration.[2]

Subjects who attended any of these programs were asked what motivated them to enter the program in the first place. If they cited several reasons, each was recorded. The most common rationale for going was that "I heard it was good for parole" (64%); however, a similar proportion (55%) also said "I wanted to deal with my drug/alcohol problem." A third of the subjects said they had been encouraged by

[2] These high attendance figures in part reflect the selectiveness of the sample and the fact that no qualifications were set regarding length or intensity of participation. In future analyses of program impact, some restrictive criteria are utilized to determine participation (e.g., minimal length of two months in participation); using these criteria, 41% of the present comparison sample are considered as not attending treatment.

prison staff to go to a drug or alcohol program, and 20% said they entered because it sounded interesting or easy, or no other program option interested them.

Those who had not attended any drug or alcohol program were asked why they hadn't. The most common reason, cited by eight of the 21 subjects who responded to this question, was that they didn't need help for a drug or alcohol problem. The next most common reasons, cited by four subjects each, were that they were too busy in other programs or no one had suggested it. For three subjects, the program was full or had a waiting list; for one there was no program (or he didn't know of any) at the facility; and one subject didn't like the particular program that was available.

For the 69 men attending non-ASAT programs, the most common type of programs attended were drug-abuse oriented (37%), followed by AA (26%), combined drug/alcohol (19%) and NA (18%). The median length of time spent in these programs was about five months [mean=28.9 weeks, standard deviation (sd)=24.2]. The huge majority of them reported that they had either completed the program (49%), or had to leave it early because they were transferred to another facility (43%).

Each subject who had attended these programs was asked to rate (on a 5-point scale) how helpful the program was in increasing his chances of early release and how useful it would be in helping him to "stay straight and sober" once he was released. Regarding early parole, the most common response was extremely helpful (39%); however, about one-quarter of the men (24%) indicated it was of no use at all. Most of the remaining 36% selected either the second highest rating (17%) or the midpoint (15%). More critically, responses were more positive regarding the programs' potential impact on staying straight after release. Forty-one percent thought the program would be extremely helpful, and only 13% said it would be of little or no use; 21% chose the second highest rating ("helpful") and 25% the midpoint, or neutral response.

With regard to ASAT programs, for the 36 inmates who attended them, the median length of time spent in the program was 5.7 months (mean=32.3 weeks, sd=26.3), a slightly longer length of attendance than that found for non-ASAT programs. As many as two-thirds of these subjects reported leaving the ASAT program because they were transferred to another facility, while just over one-quarter (28%) said they had completed the program. One man dropped out and another was terminated by program staff.

More extensive data were collected on degree of program participation in ASAT programs. These data indicated that most of the men (31 of 36) had attended group counseling sessions, with an average of 59.2 (sd=32.35) such sessions attended (median=56). Many fewer (14) attended individual counseling sessions, and they went less often (median number of sessions=11.5). Twenty-eight (78%) of the men had been to educational meetings, such as lectures, films or tapes. The median number of these meetings attended by the participants was 28. Twelve men had attended

AA meetings (median=28 attended) and nine had attended NA meetings (median=24 attended).

Participants of the ASAT programs were asked to judge the programs on four dimensions, each on a 5-point scale, from very good to very bad. They were asked how good the ASAT program was at "getting you really involved" and if it "stimulated communication among inmates about their problems"; they were also asked to rate the staff's understanding of inmate's problems and the staff's ability to educate about alcohol and drugs. Responses on these questions were very consistent and positive; roughly 70% of the men said the ASATs were very good, and another 15% rated them good along all four of these dimensions. When responses on these items were summed to form an index with possible scores between 4 and 20 (four being the most positive response), the average score was 6.0 (sd=4.2), and the median was 4.5.

In addition, these subjects were asked to judge the ASAT program in terms of how helpful it would be with regard to staying straight or sober after release. While quite positive, the men's judgments of the long-term impacts of participation were notably more mixed than their views on group participation and staff competence. Half of the comparison group members indicated that they thought it would be extremely helpful. Another 21% of them rated the ASAT as helpful, 9% were neutral in this regard, and 21% of them said the program would be of no help. These ratings are roughly comparable to those described above for the non-ASAT programs. Slightly more (71% vs. 62%) of the ASAT participants had positive impressions of the program's impact; however, negative ratings were also slightly more frequent in the ASAT group (21% vs. 13% of non-ASAT participants).

DRUG AND ALCOHOL ABUSE INFORMATION

Drug Abuse. Information on drug abuse was collected from inmate records and subjects' self-reports during the initial interview. Nearly three quarters (74%) of the subjects' files contained references to either drug abuse or drug treatment, and 16% of the files showed references to both abuse and treatment. No reference to abuse or treatment appeared in DOCS files for the remaining 10% of the comparison group subjects. Although more complete data on arrest records will be available from State "Rap sheets" (which we have not yet analyzed), a check of available file data indicated that 41% of these men had been convicted of a drug-related crime.

For those subjects whose files indicated some history of drug abuse, the "referenced" drugs were coded. Marijuana use was most commonly cited, occurring in 63% of the cases. Cocaine (50%) and heroin (47%) abuse were also referenced in a large proportion of the files; methadone was cited in 4% of the cases. No other single drug (e.g., PCP, barbiturates, etc.) was noted in more than 3% of the cases; together, drugs other than those mentioned above were referred to in 20% of the files. These file data were further analyzed to yield a common measure of drug abuse severity -- the number of different drugs abused by an individual. One-tenth of the files contained no

references to drug abuse, while about one-third (35%) mentioned marijuana use only. Use of two different drugs were found in approximately the same number of cases (32%), and 23% of the files indicated abuse of three or four substances (at some time, i.e., not necessarily simultaneous use).[3]

In addition to recording DOCS file data, more precise drug abuse information was obtained through administering a Substance Abuse Frequency Questionnaire (SAFQ) during Vera interviews. As detailed previously, subjects were asked how frequently they had used each of fourteen categories of drugs during a typical 30-day period just prior to the current incarceration. Men were asked to chose one of four categorical responses: less than once a month, one to three times a month, one to two times a week, daily or almost daily. The most frequently used drugs were marijuana, used daily by 47% of the comparison group subjects; cocaine, used daily by 30% of these subjects; and heroin, used daily by 28% of the subjects. The least popular drugs, used more than once a month by less than 10% of the comparison group, were amphetamines (6%), sedatives (6%), barbiturates (4%), and inhalants (1%). Tranquilizers were used by 18% of the comparison group, generally between one and three times a month. Similarly, PCP was used by 17% of the comparison group, usually one to three times a month. Street methadone (11%) and opiates other than heroin (12%) also fit this pattern. The one drug that deviated from the pattern was crack, used by 12% of the sample, most of them (7%) once or twice a week. These frequency of drug use results, for both Vera's measures and as found in the DOCS files, are summarized in Table 7-A.

The frequency data on these fourteen drug categories were then summarized into an ordinal quantity/frequency variable with six categories. Ranging from zero (no drug use) to six (at least daily use of a drug other than marijuana and weekly use of a second drug), this method of quantification is roughly based on a method used by Hubbard et al. (1984); it incorporates into a single measure frequency of drug use and the number of drugs used.

Severity of drug abuse among comparison group members, as revealed by results on this measure, was widely varied. Over a third of the sample (35%) had scores reflecting the highest level of severity ('6'); these individuals used at least one drug other than marijuana on a daily basis and (at least) a second drug on (at least) a weekly basis; at the other end of the scale, 5% used no drugs. Perhaps the most telling statistic is the number of men with scores of three or more on this scale; to obtain a three, an individual must be (at least) using marijuana on a daily basis or

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[3] It must be remembered that these files include information on all previous incarcerations, as well as the current one. Thus, these data are not time-specific and should be regarded as reflective of history and not necessarily current or most recent level of abuse.

TABLE 7-A

DRUG USE AMONG COMPARISON GROUP
(in percents)

	None	Marijuana	Cocaine	Heroin	Tranqui-lizers	PCP	Metha-done	Other Opiates	Crack	Other[1]
SAFQ Daily Use:	24	47	30	28	4	2	2	2	7	2
Weekly to monthly Use:	5	25	41	13	14	15	9	10	5	32
(Total - Any Use):		(72)	(71)	(41)	(18)	(17)	(11)	(12)	(12)	(34)
DOCS file:	10	63	50	47	-	-	4	-	-	20[2]

[1]This category includes amphetamines, barbiturates, sedatives, inhalants, etc.

[2]Because we coded only for marijuana, cocaine, heroin, and methadone when examining the DOCS files, the "other" category includes crack, PCP, tranquilizers, etc.

using two or more other drugs on a weekly basis. Using this score ('3') as the minimal criteria for a "serious" drug problem, 76% of the respondents qualified as such.[4]

After indicating the quantity and frequency of drug use, subjects were asked to identify their primary drug problem. A quarter of the sample did not think they had a serious enough problem to identify a single, primary substance of abuse. Another 9% indicated that their primary drug problem was marijuana; therefore, despite the fact that nearly half the sample used marijuana daily, over a third of the sample either considered themselves to be primarily marijuana abusers or felt they did not have a problem. Over one-fifth of the comparison group (21%) identified cocaine as their primary problem, and 9% identified crack as their primary problem.[5] Over a third of the comparison group members (37%) identified heroin as their primary drug problem.

As described in earlier chapters, a series of questions were asked regarding the adverse consequences of drug abuse (ACQ-D). Included in the total ACQ-D score reported here was a question regarding use of drugs while involved in criminal activity, with possible responses ranging from (0) "rarely or never" to (2) "frequently." Scores on the adverse consequences of drug use scale could range from zero (no problems) to 12. The average score for comparison group members was 4.0 (sd=2.9).

Subjects were also asked about their experience with drug abuse treatment apart from participation in programs during the current incarceration. The percentage of men reporting some treatment experience was consistent with the high prevalence of drug abuse in this sample. Forty-three percent of the subjects had attended some kind of drug abuse treatment; about half of these men had been in detoxification, methadone maintenance, or drug-free residential rehabilitation (the rest participating in a range of less intensive programs, including NA, outpatient drug-free, or prison programs previous to the current incarceration). The most commonly attended program was methadone maintenance, with 13 comparison group members (11%)

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[4] The frequency and criteria associated with each of the six scores are as follows: score of '1' (13% of the comparison subjects) -- used marijuana weekly or any other drug monthly; '2' (5%) -- used a drug other than marijuana weekly; '3' (14%) -- used two or more drugs (other than marijuana) weekly or used marijuana daily; '4' (13%) -- used marijuana daily and another drug weekly; '5' (14%) -- used one drug other than marijuana daily; and '6' (35%) -- used at least one drug other than marijuana on a daily basis and (at least) a second drug on (at least) a weekly basis. Men who did not qualify as at least a '1' on the scale were assigned a '0' (5%).

[5] It should be noted that a high percentage of inmates interviewed were incarcerated before crack use became prevalent (the mean length of these men's current "bid" was 2.8 years), or at least was recognized to be prevalent. Our figures on crack use to not, therefore, reflect current levels of its usages or the purported relation between crack and criminal activity.

attending at least one such program. Detoxification and residential rehabilitation programs were each attended by nine subjects, outpatient rehabilitation by eight men, prison programs (in previous incarcerations) by seven men, NA by one, and two men attended some other type of drug treatment program.

Alcohol Abuse. Data on alcohol abuse were collected in the same manner as drug-related information. These data included standardized paper and pencil assessment instruments (i.e., MAST and ADS) as well as subjects' estimates of how much they drank and how often. Additional information was collected regarding each subject's treatment history (prior to this incarceration) and his own assessment of the severity and consequences of his drinking problem.

Scores on the MAST (administered when the inmate first enters the state prison system) were available from DOCS files for 69 (61%) of the comparison group members, who averaged 10.3 (sd=10.3; the median score was 8) on the instrument. A little less than half (46%) of the subjects had a score of nine or more, which is the standard cut-off used to qualify a MAST respondent as alcoholic. On the ADS, the mean for comparison group subjects was 5.4 (sd=7.2), and the median was 2.5. Using the suggested ADS scoring categories, 37% of the men showed no signs of alcohol dependence, 49% were in the low dependence group (scores of 1-13), and 14% were classified as having moderate to severe dependence.

As described in the discussion of the screening interview, each subject was asked to think back to the month before his incarceration (or the most recent 30-day period during which he was drinking) and estimate how much he drank during that period. Responses were recorded separately for wine, beer, and liquor, coding for each how many days he drank that beverage, how many ounces he consumed per day, and whether the beverage was fortified. On the research sample, these data were used to compute the man's pure ethanol consumption on a typical day, thus compensating for different alcohol concentration (or the "proof") of different beverages. On average, these subjects' alcohol consumption was 4.1 ounces per day (sd=6.4), though half of them consumed less than two ounces on a typical day. One could consume four ounces of alcohol by drinking about a quart of wine, nine 12-ounce bottles of beer, or nine ounces (roughly five drinks) of liquor.

As was the case with the drug-related measures, during the screening interview subjects were asked a series of questions designed to determine the adverse consequences of their alcohol abuse (ACQ-A). Again, in the present scoring, the total adverse consequences score includes a question about how often the subjects drank while involved in crime; scores can range from 0 to 12. The average ACQ-A score for these men was 2.1 (sd=2.8), predictably lower than comparable scores on the ACQ-D, presented above (4.0).

Complete alcohol treatment histories (prior to this incarceration) were collected from all subjects. After preliminary analysis of detailed data revealed very low

numbers of men with any alcohol program experience, the information was collapsed into one variable with three categories: detoxification, inpatient or halfway house treatment; previous prison, outpatient, or AA attendance; and no treatment. Only three subjects had been in detoxification, inpatient treatment or a halfway house, and another three had participated in previous prison or outpatient treatment, or an AA group.

Additionally, in the initial interview, subjects were asked to evaluate the severity of their pre-incarceration drinking problem on a scale from (1) "no drinking problem at all" to (5) "severe problem or alcoholic." More than half of the men (54%) indicated that they did not have a drinking problem, and less than 15% responded with a '4' (8%) or '5' (6%). The remaining one-third responded with either a '2' (12%) or a '3.' The forty-two subjects who responded with a '3' or higher were asked at what age their drinking problem had begun. On average, they said it started around the age of 17 (mean=16.6, sd=4.6), and the median age was 15.5.

Finally, two questions were asked to determine the frequency and quantity of alcohol used in conjunction with drugs. Each subject was asked how often he consumed alcohol while using drugs, and how much he drank on a typical day (when taking drugs). Nearly one-third of them (30%) said they never drank while using drugs. Another third said they occasionally drank while taking drugs, and the remaining subjects drank most (19%) or all (18%) of the time while taking drugs. Excluding those men who said they didn't drink while taking drugs, the men averaged 4.8 ounces of alcohol (sd=4.5) while taking drugs; half of this drinking group averaged less than 3.2 ounces.

ALCOHOL, DRUGS AND CRIME

Using DOCS files and subjects' responses during the initial interview, data were collected on drug and alcohol use at the time of the instant offense and while involved in criminal activity in general. For the overwhelming majority of the sample (87%), there was no evidence of alcohol use at the time of the instant offense. The validity of these data are questionable, however, given the inconsistency with which this information was reported. Specifically, eight of the subjects told Vera researchers that they had been drinking or were in alcohol withdrawal at the time of the instant offense but had no corroborating evidence in their DOCS file, and five had references to alcohol use in their DOCS file, but denied an alcohol-instant offense connection to Vera interviewers. Only two had references to alcohol use in the file and said they had been using alcohol. When asked more generally how frequent they drank alcohol on the same day as committing crimes, about one-fifth said "sometimes," and the same proportion said they drank "frequently" on those occasions.

In any case, drug use at the time of committing crimes was apparently far more common and more consistently reported to Vera interviewers. Over half (52%) of the men said they frequently were "high on drugs" or in withdrawal on the day of committing crimes, and another one-quarter said this happened sometimes. With regard to the instant offense, one-fourth of the men reported they had been high or were in withdrawal from drugs (but had no file reference as such), and another 16% told Vera they had been using drugs and had references in their files to drug use. Only one subject who had not reported drug use to Vera research staff had a reference to drug use in his DOCS file.

In a further attempt to specify the relationship between drug and alcohol use and crime, subjects were asked whether they committed crimes to support a drug habit; they were also asked to describe what for them was the typical connection between drug or alcohol use and crime. Just over half (54%) of the men said they had committed crimes to get money to buy drugs. Of the total sample, 21% said they "sometimes" committed crimes to support a drug habit, while one-third said that "most" (11%) or "all of the time" (21%) their crimes were motivated by a need to buy drugs.

These results were supported by the responses to the question regarding the typical connection between drug or alcohol use and crime. The most common response was that they committed crimes to get money to buy drugs or alcohol (24%), and another 8% specifically said they were typically in withdrawal while committing crimes. Other than to support a habit, the most common connection between drugs or alcohol and crime was that these substances made them feel more courageous or less inhibited (14%); another 6% indicated that alcohol or drug use made them feel aggressive or violent, which led to a crime. A few of the men committed crimes as part of a social ritual with friends that included taking drugs or alcohol (5%) or took drugs or alcohol to relax after committing a crime (5%). Just over a third of the comparison group (34%) said there was no relationship between their use of alcohol or drugs and committing crimes.

PRELIMINARY RESULTS ON THE PILOT GROUP

Because complete intake data were available (for this report) on so few pilot participants, only drug and alcohol-related information obtained in the preliminary "screening" interview with these inmates are reported here. It will be remembered that these data are recorded on a "screening log" which permits much less detailed recording of information than that collected (at a later point) on the intake form; less precise coding, for example, is used on the drug and alcohol measures, and much less data are recorded on prison treatment programs. The advantage to the screening log is that it provides immediate information on more subjects; as of early January, these data had been collected on 46 Lincoln ASAT participants.

With regard to prison program participation, 44 of these 46 pilot group subjects had previously attended an ASAT program; one man had previously attended AA, and one had participated in a non-ASAT drug program. The median length of time spent in these programs was 3.7 months (mean=5.8, sd=5.2), which is actually shorter than the mean length of attendance for comparison subjects who had previously attended ASAT programs (5.7 months). The ASAT programs represented in this group included the six "feeder" facilities noted in Chapter Two, but most of the present sample attended ASATs at Mt. McGregor (21), Otisville (8), or Woodbourne (6).

Drug and Alcohol Abuse Measures. As described in Chapter Five, participants in the screening interview are administered a Substance Abuse Frequency Questionnaire (SAFQ), where they are asked to specify how frequently they used each of fourteen drugs in a 30-day period prior to the incarceration. Using these responses, the SAFQ is preliminarily scored in the screening interview. With possible scores ranging from 0 to 2, 78% of the pilot group (36 of 46 men) scored in the high frequency category ('2'), meaning that they used a drug other than marijuana on a daily basis, or two or more substances at least one to two times weekly. Nine percent scored '1,' using a drug (other than marijuana) on a weekly basis, and 13% used drugs on a less frequent basis, scoring '0' on this measure.

In the screening interview, inmates are also asked about adverse consequences resulting from drug use (ACQ-D). The pilot group averaged 2.1 (sd=2.06) on the ACQ-D, with more than half (54%) reporting two or more problems (or frequent occurrences of one problem) due to drug use, and 11% scoring 5 or more on the measure. Almost three-quarters of this group also reported at least regular use of drugs while committing crimes, or taking drugs on the day of committing the instant offense. These results are quite similar to those presented above for the comparison group.[6]

To assess alcohol abuse problems, the Alcohol Quantity Frequency (Alc-QF) and ACQ-A measures are preliminarily scored in the screening interview (as described in Chapter Five), the ADS is administered and scored, and MAST scores from DOCS files are recorded. On the dichotomously scored (high-low alcohol consumption) Alc QF test, 33% of the pilot group were classified as drinking excessively high levels of alcohol. Scores on the Adverse Consequences due to Alcohol scale could range from 0 to 9 at screening; the pilot group averaged 1.2 on this measure, with 65% evidencing no troubles due to alcohol, and 35% reporting two or more problems (or frequent

[6]The ACQ-D mean presented above for the comparison group also includes scoring on the item about use of drugs and crime; if the pilot group's mean on this item (1.7) is added to their ACQ-D mean (2.1), their "total" ACQ-D mean (3.8) is very similar to that reported for the comparisons (4.0).

occurrences of one type). On questions related to alcohol use and criminal activity, 39% reported at least regular use of alcohol when committing crimes, or on the day of committing the instant offense. These results are similar to comparable findings on the comparison group.

ADS scores for the pilot group, on the other hand, were notably higher than the scores of the comparison subjects. (No significance tests were done on these preliminary findings.) While this difference was expressed somewhat by the mean scores of these groups (pilot participants averaged 6.6 vs. 5.4 for the comparison subjects), it was especially striking when scoring categories were applied. Among pilot participants 18% showed no signs of alcohol dependence, as compared to 37% of the comparison subjects. While the proportions in the low dependence grouping was similar (43% of the pilot and 49% of the comparison subjects), the numbers in the moderate to severe dependence category were very discrepant; 39% of the pilot participants qualified in this highest severity category, while only 14% of the comparison group was categorized as such. MAST scores were available for 33 of the pilot participants. Of these, 57% scored above the cut-off (scores greater than 9) suggesting an alcohol problem, with an average of 13.7. Again, these scores were higher than those of the comparison group, where 46% scored above 9 or more, with an average on the MAST of 10.3.

As described in the chapter on screening sample results, the drug and alcohol measures were each combined to yield preliminary composite indices of drug and alcohol problem severity; these indices could then be used to calculate problem types. Ninety-two percent of the pilot sample scored a '1' or more on the drug measure (indicating the presence of a problem) and 53% scored a '1' or more on the alcohol measure. When combined, it was revealed that 46% of the pilot group could be considered as having a poly-abuse problem. The same proportion (46%) qualified as drug problem-only cases, and 6.5% were determined to have an alcohol problem only. Only one person did not score on either scale. While comparable data are not presently available on the comparison group, preliminarily it appears that alcohol problems are more frequent among pilot participants (perhaps occurring in 10-20% more of the cases). We will look more closely at this apparent difference in future analyses of the "complete" intake data on these groups.

Chapter Eight

Preliminary Follow-Up Results

As detailed in Chapter Four, Vera staff attempts to interview each subject and his supervising field parole officer two months after the man's release from Lincoln. Thirty-four such interviews, all done with comparison group subjects and their POs, were completed and available for analysis for the present report.[1] As was the case with most of the results presented in the two previous chapters, time and sample size limitations allowed only for simple frequency counts to be performed. Later reports will include much more complete analyses, particularly relating the follow-up results to the intake data described earlier.

The chapter begins with a summary of the parolees' status with regard to residence and marital and family relationships, followed by their experiences with employment, medical and mental health treatment, and vocational and educational programs since their release from prison. The chapter also includes information on any alcohol or drug use and treatment. It concludes with an analysis of data, generally covering the same topics, obtained in interviews with the parole officers.

RE-ENTRY INTO THE COMMUNITY

Residence Information. Thirty-one of the 34 parolees were living in the community at the time of the interview; one was in detention due to an arrest and two had been detained on parole violations.[2] As anticipated in their pre-release plans, the men tended to reside in the same boroughs in which they had lived prior to their incarceration, the Bronx (13), Manhattan (10) and Brooklyn (9); two of them lived in Queens. All but two of them lived in private residences, generally with their mothers (10) or other family (12). Seven of the men lived with their wives or common-law partners, and three lived with both parents or their wives and parents. The two men

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1 Because we have not yet merged this follow-up database with the intake data, it is not possible to compute the exact time at which these interviews were conducted in relation to the subjects' release dates. Most of the interviews took place after the respondent had spent nine to ten weeks in the community, although a few were done at a later point. The parole officer interviews tend to be more timely, occurring near the two-month point.

2 As noted previously, if subjects were detained or incarcerated at the two-month point, we attempted to interview them in the jail facility and went ahead with the PO interview. In these cases, the respondent was told to answer questions as they would apply to the time the man spent in the community since his release. For example, even if the subject was at Rikers at the time of the interview, residential data relating to the place(s) he had lived between Lincoln release and Rikers was coded in the residence section of the interview.

not living in private residences were staying in a Salvation Army mission. In addition, most of the men (28) indicated that they stayed regularly at another residence apart from their primary residence -- typically this was with a girlfriend or other friends. Twenty-nine of the men had been living in the same place since their release; the remaining five had to move once since being released from prison. As a group, these men felt it had been very easy to find a place to live: on the basis of their responses to a five-point scale, 27 of them found it very easy, four easy, and three said it was hard to very hard.

Given their responses on the intake interview, it was not surprising to find that more than half of the men (20), reported that they were still unmarried; nine reported being married (most of them common-law), and five were divorced. Eighteen of the men had children; nine had one child and nine had two. Eight men said they were providing partial support to a dependent at the two-month point, typically a child or spouse. Only five men said they were providing the entire support for one or two dependents.

Most of the subjects reported spending their free time either alone (9) or with their spouses or girlfriends (8); the rest spent their time with family and/or friends. To relax or for recreation, they usually went out to movies, discos, sporting events, etc. (13), or stayed home alone (12) or with others (5). Three men reported taking drugs to relax or for recreation and one man "hung out" with friends. On the basis of their accounts in interviews, this relatively high proportion of subjects who reported spending time alone reflects a proactive attempt to avoid "old friends," typically described as "the guys I used to run with -- that I got into trouble with."

When asked to judge their home-life, two-thirds thought it was generally "very good" (17) or "good" (6); only four rated it bad or very bad. As was the case with their judgments of relationships prior to incarceration, parolees rated their relationships with their parents more positively (79% very good or good) than their relationships with spouses or girlfriends (55% very good or good). Thirteen of the 14 who responded to the question regarding their relationships with their children said they thought these relationships were very good or good. Expressing some of the difficulties of social reintegration after prison, these men were less positive about their friendships and social life in general (44% very good or good and 24% bad or very bad). The parolees were also asked to judge on a 5-point scale from "extremely helpful" (1) to "of no use at all" (5), whether their parole officers had been helpful in terms of these family and social relationships. Generally they found their parole officers to be helpful (15 gave the highest rating and four rated him or her a '2'), but seven of the men found their parole officers to be of no use and four each were unable to judge or had a neutral reaction.

Employment and Income Information. Twenty-eight of the men reported having held one or more full-time jobs (for some length of time) since their release, and only four reported no employment since that time. More than half the men had held the same full-time job for six weeks or longer (up to 12).[3] Nine respondents reported that this employment was entirely "off the books," and fourteen subjects said that some of their employment was of this type. As would be expected from their employment experience prior to incarceration, most of their post-release jobs were in semi-skilled or service (11 each) occupations, with seven of them having skilled jobs. The 28 men who reported income from full-time jobs had earned between $350 and $3120 on those jobs, with half of them earning less than $1200 over the two (to three) month period. The most common means of getting a job was by hearing about it through family or friends (12 men) or having held a previous job at their place of employment (6). The remaining 12 men reported a variety of methods, such as through a jobs programs (3), hearing about the job while in prison (3), and receiving a referral from their parole officer (2).

The men reported surprisingly little time out of work since their release, two weeks or less for 21 of them (ten men spent four or more weeks unemployed). During the time they were unemployed, fewer than half the men reported looking for work either off and on (10 men) or most or all of the time (6). Given their post-release employment experiences and the little time they spent looking for work, it's not surprising that more than half the men felt it had been very easy (13) or easy (5) to find a job, and only five men thought it was hard or very hard.

With regard to income from sources other than job-related earnings, one man received SSI payments during the time he was unemployed, and one received welfare. Just under half the sample reported having received support from other sources (such as spouses or girlfriends), with all but three of those receiving between $100 and $1000 from such sources since their release. Thus, most of the men had paid for all (11) or most (8) of their expenses since their release; however, seven men had been entirely supported by others.

Medical and Mental Health Information. Very few of the parolees had received medical treatment from any source since their release: five men had received outpatient treatment, three of them in a clinic and two from their family doctor. Two men had been treated in an emergency room and one had been admitted to a hospital for one day. Consistent with this, only four men were regularly taking medication prescribed for a physical problem. Generally the men had not felt any need for medical care; however, one man said he did not attempt to get treatment because it was too

[3] It should be noted that any question of duration (e.g., time lived in one place, weeks worked, etc.) is limited by the fact that this is a "two-month" follow-up interview. Thus, for those men who were interviewed two months after their release, the longest they could possibly have lived anywhere or held a job is about eight weeks.

expensive (he didn't have insurance) and another felt it was too difficult ("too much of a hassle") to get. Only seven of the men had any medical insurance (including Medicaid), and most of the rest felt they didn't need it (11) or had been too busy with other things to get insurance (8). Only one man had sought counseling for a psychological problem; the help he received was from his parole officer and was a specified condition of his parole. None of the men had been prescribed medication for a psychological problem.

Participation in Vocational and Educational Programs. Each respondent was asked a series of questions regarding any vocational or educational programs he might have gone to since his release. As was the case with other parts of the interview concerning service use, the men were queried with regard to their referrals to these programs and their length of attendance. Nearly half the men reported they had been referred to one (13) or two (3) vocational programs; however, of these 19 referrals, 11 were never followed-up by the parolee or he went once but chose not to return; in two cases the man left the program early for some other, "neutral" reason.[4] Three men were pending placements in these programs, one was still attending regularly, and two men had "completed" the program and were successfully placed in a job by the program. Of these 19 referrals, only two resulted in a man spending more than a week participating in the program. The vast majority of the vocational referrals (11) were to comprehensive vocational programs specifically for ex-offenders. Four referrals were to job training programs; the others were assessment and placement programs. Almost all of those (17) who had been referred to a program had gone on referral by their parole officer.

Six of the parolees reported being referred to educational programs; four of these were to a GED program, one to a full-time technical school, and one "other" referral. As was the case with vocational programs, some of these men left the program early, attending for short periods of time; two men spent one week in a program and one man reported attending for eight weeks. One man was pending placement in a program, one was still attending a program regularly, and a third was attending, but not regularly. Two men reported that they had been referred to the program by their parole officer, two others were referred by family or friends, and two were self-referrals. Those individuals who had not attended educational programs were asked why they had chosen not to go. Most of them (14) didn't feel they needed such a program or intended to enroll but hadn't yet started a program (10). The others either didn't know what was available, couldn't afford it, or had some other (unspecified) reason for not attending any educational program.

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[4] In our coding scheme, this code for program status is used to represent a "non-negative," but early termination. Thus, this code signifies that the man has not left the program prematurely because he chose to, or that he was not kicked out by the staff for doing something judged inappropriate. An example of when this code would be used is when the man and the program staff mutually agree that he doesn't need the program, or that it is no longer appropriate for him.

ALCOHOL, DRUG ABUSE, AND CRIME

Before asking questions about the parolee's alcohol or drug use, interviewers reminded the respondent of the confidentiality of his answers. However, despite assurances that neither the parole officer nor other authorities would have access to their responses, it is likely that some of the parolees underreported their post-release alcohol and drug use.[5] Moreover, in interpreting these preliminary findings it must be remembered that they concern a small, non-random sample; until future analyses are done, it is not possible to determine if those responding to the two-month interview differ from subjects who do not participate in the follow-up.

The alcoholic beverage of choice for this group appears to be beer, drunk by 22 of the 34 men; eight men reported drinking some wine during a typical 30-day period since their release, and seven drank liquor. Among beer drinkers, half of them reported drinking twelve ounces or less on days when they were drinking. Researchers also administered the ADS as part of the two-month follow-up. Of the 33 men who took the ADS, 23 received a score of 0, indicating no alcohol dependence. The remaining ten men scored between one and eight, indicating low dependency. About a third of the men (11) reported that since their release they had abstained from drinking, and over half the sample (18) drank socially. Five men reported heavy, but controlled, drinking; none reported any binges or loss of control. The same series of six questions concerning adverse consequences of drinking that were asked in the initial screening interview were repeated in the follow-up. Although total ACQ-A scores are not yet available, very few positive responses were received to any of the questions. For example, one person reported arguing or fighting (1-2 times per month) while drinking and two men had lost time at work or failed to find a job as a result of drinking. Three men reported psychological problems (e.g., depression or violence) more than twice a month, and one man reported such problems one to two times per month.

Again, in interpreting the drug use data, it must be remembered that it is likely that at least some of these men underreported their use. As was done at intake, the men were asked how often during the time since their release they had used each of 14 drugs (the SAFQ questionnaire). The drug most commonly reported, with the greatest frequency of use, was marijuana, used by 13 of the parolees. Four of them reported daily use, five weekly, and another four used marijuana between one and three times a month. Five of the men reported using cocaine, two of them weekly and three daily; another three used crack daily. Heroin use was reported by two men, one

[5] Because of this concern, interviewers were asked to estimate the honesty of the respondents' answers to alcohol and drug questions. In 90% of the cases, interviewers thought the responses appeared honest; they thought one subject probably underestimated his drinking and four underestimated their drug use. Interviewers also observed that one person was probably on drugs at the time of the interview, one definitely on drugs, and another definitely on alcohol.

daily and one between one and three times a month. One man reported occasional use of tranquilizers. No one reported taking any of the other nine drugs. Five of the men reported having a "primary" drug problem at the time of the interview; two said crack use was a primary problem, one each reported marijuana, cocaine and heroin as their primary drug problem.

Not surprisingly, as a group these parolees perceived few adverse consequences of drug use. Two men reported losing time at work and three missed work more than twice a month due to drug use. Two had bouts of depression or violence, and one had fights or arguments while on drugs or in withdrawal. One man reported being told by a physician to refrain from taking drugs, and one had medical problems resulting from drug use.

Respondents were also reminded of the confidentiality of the interview before being asked about any post-release illegal activities. Seven of the men reported having been involved in criminal activities; six of these reported only one such instance, and one man reported having committed nine (or more) crimes. Five of these men reported earning between $10 and $4500 either selling or running drugs, and two men had income from some other illegal source (one earned $250 and the other $5250). Two of the men had been drinking beer and three reported using drugs on the day they had been involved in crime.

ALCOHOL AND DRUG ABUSE TREATMENT

Similar to the data gathered about post-release use of vocational and educational services, information about referrals to and attendance in alcoholism and drug treatment programs were obtained in the interviews. Only two of the 34 parolees had been referred to any alcohol-related treatment since their release, and both went to AA for a week or less and then stopped. [6] One of them went to AA because it was a condition of his parole, and the other said he was encouraged by family or friends. One man reported that his parole officer had plans to refer him to treatment but had not yet done so. Nearly all of those men who had not attended any alcoholism treatment felt they didn't need treatment, either because they weren't drinking enough (27) or because they felt they could take care of any drinking problem by themselves (6).

Considerably more parolees had been referred to some kind of drug treatment. Four men reported being referred to NA, and one each had referrals to methadone

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[6] Most likely, these men participated in a single AA meeting. On Vera's follow-up questionnaire, length of attendance is coded by weeks, so attending a single meeting is coded the same as if the man attended meetings for a week and stopped. Almost all cases coded as attending one week in a service program reflect, in fact, a single intake session or meeting, and no subsequent visit to the program.

maintenance, residential treatment, drug-free outpatient and some other type of drug program. But, as was the pattern observed with participation in other programs, only two of these eight men reported attending for more than a week. Five had not followed the referral or left the program after a single meeting; two were still attending; and one was pending placement. All eight had been referred to these programs by their parole officer, one with the aid of an Access counselor. Six of the men said their motivation in going to these programs was because it was a condition of their parole, or because their parole officer explicitly referred them. Three men who had not had treatment for drug abuse indicated that their families thought they needed it, as did friends of two men. Most of the parolees felt they did not need treatment, either because they were not taking drugs (17) or because they could take care of any drug problem themselves (8).

Each respondent was also asked where he would go for help if he developed an alcohol or drug problem. Over a third of them said they would talk to their parole officer (12), and a quarter would go to friends or family members. Those men who had used alcohol or drugs since their release were asked to estimate how it had affected their behavior. Half of the 26 men who answered this question felt their alcohol or drug use had no effect and would not get them into trouble, and another ten said it made them feel relaxed or happy, not violent. Only two men said they were more aggressive (but saw no need to control their use) and one man had plans to curtail his alcohol or drug use because it made him violent. About a third of the men (10) thought the alcohol or drug treatment received during the last incarceration had helped them to remain straight or sober, and an equal number found such treatment to be of no use at all. Even more negative (and in contrast to their pre-release assessments of these programs) were their evaluations of the effectiveness of such programs in motivating them to attend post-release treatment; 19 of 26 people answering this question said the programs were of no use at all.

PAROLE OFFICER INTERVIEW RESULTS

Most of the parole officer interviews covered the same topics as were in the parolee interview. Discrepancies between parolees' and parole officers' responses are noted below.[7] These discrepancies -- which were notably infrequent -- could be due to the time difference between the two interviews (which tended to be a week or two) or various other, more obvious reasons. One discrepancy that was clearly attributable to the time difference was the number of parolees reported to be living in the commu-

[7] At the time of this writing, we had not had time to do individual (one-to-one) comparisons of parolee and parole officer reports. Thus, the comparisons discussed here are only for aggregated parolee reports vs. aggregated PO reports. Although the former method of comparing is obviously more accurate and meaningful, because the differences between parolee and PO responses were relatively minor, the presently available aggregate comparisons seemed worthy of presentation.

nity at the time of the interview; one man had been detained and violated between the time of his interview, and the interview with his PO. In all, 30 subjects were living in the community at the time of the interview, according to the supervising POs. Two subjects had been detained for drug-related violations, one for some non-drug or alcohol-related violation, and one man had been arrested for a drug-related crime.

Residence and Reintegration. The parole officers' descriptions of the parolees' residential status were very similar to those offered by the parolees. There was general agreement on type of residence (32 lived in private residences), number of times they had moved since their release (none for all but five of them), whom they lived with (generally mother or other family). Parole officers were also asked to judge the parolees' living situation on a 5-point scale from "very stable" (1) to "very unstable" (5). Most parolees were judged to be very stable (17) or stable (5); only two were considered to be in unstable or very unstable living situations.

Using another 5-point scale [from (1) "very good" to (5) "very bad"], parole officers evaluated how well the parolees were doing in terms of positive reintegration with their spouses or girlfriends, family, and friends. Though less positive than the judgments made by parolees, the POs were positive regarding parolees' relationships with family; 19 were judged very good or good, seven very bad or bad, and the rest neutral or unable to judge. Parole officers found it much more difficult to judge parolees' relationships with spouses/girl-friends and friends. Of the 13 parolee/spouse relationships POs were able to judge, about half (7) were considered very good or good (55% of parolees judged such relationships to be very good or good). Although POs felt able to judge parolees' relationships with friends for only half the cases, 11 of the 17 were rated very good and five were rated very bad or bad; the POs had a somewhat more positive view of the parolees' friendships and social lives than the parolees themselves.

Employment and Income. Although the questions asked on employment and income differed for parole officers and parolees, it is possible to make some comparisons of their responses. Parolees' descriptions of their employment appeared slightly more positive, with 28 of them reporting having held at least one full-time job since their release, half of them for six weeks or longer. Parole officers indicated that, at the time of the interview, 21 of the parolees were working, 15 of them 35 hours or more per week. The difference between the PO and parolee reports on employment may be in part explained by the high number of men reporting "off the books" employment; parolees may be reluctant to report this to their parole officers.

Regarding income, parolees and their parole officers were remarkably close; the median for parolees was $1200 and for parole officers was $1190 (excluding the four men who earned no money). Parole officers were also asked whether parolees' participation in prison job or vocational training programs had helped them get jobs. The overwhelming majority (25) responded, "no"; two each said such programs had helped somewhat or were able to specify jobs parolees had gotten through the prison

programs. Regarding how much effort the parolees had put into looking for work, parole officers generally thought they had tried very hard or hard (20); they thought six parolees had "not tried at all" and five received a '4' (the second lowest response).

Vocational and Educational Programs. The parole officers' judgments about parolees' attendance at vocational programs since their release was fairly congruent with parolees' self reports. The most popular referral was to ex-offender programs (16), with most of the parolees dropping out early (11); four were still attending such programs and one had completed it. Parole officers reported that they had referred three men and had plans to refer another to vocational training programs, but only one man was currently attending such a program. Similarly, of the eight referrals to other job or placement programs, only one man was currently attending. While the questions asked parolees were somewhat different, their answers with regard to type of referrals and dropping out were very similar to those of the POs. Parole officers reported referring two parolees to GED programs, both of whom had dropped out, and one referral, for a man who was still attending, to some other type of educational program.

Medical and Mental Health. Parole officers made very few referrals for medical treatment or psychological counseling. One man went for treatment to an emergency room on his PO's referral, and two men went for other outpatient treatment, one of them on referral by his PO. One parole officer reported a parolee being admitted to a hospital, but not on the PO's referral. Three parolees went to the Parole Office OMH (Office of Mental Health) on their POs' referral for psychological counseling, and one PO had plans to make such a referral. One parolee received a referral to some other type of therapy, but wouldn't go. These responses are similar to those given by parolees, but parolees reported receiving slightly more medical and slightly less psychological help.

Alcohol, Drugs and Crime. Parole officers' assessments of parolees alcohol consumption were remarkably similar to parolees' self-reports: 18 parolees reported drinking socially and POs judged that 17 parolees drank socially. Similarly, parole officers thought that seven parolees had been abstinent, as compared to 11 self-reported abstainers. For nine parolees, parole officers were unable to judge consumption.

While parole officers were sometimes unable to judge whether their parolees were using drugs, they identified the same drugs as did parolees, with similar frequencies. For example, parole officers judged that 20 of the men did not use marijuana, a fact asserted by 21 parolees. Thirteen parolees reported marijuana use; parole officers estimated the extent of such use for five men and were unable to judge whether or how much marijuana was used by the remaining eight. Similarly, five men reported using cocaine, and four were identified by POs as cocaine users. Three parolees said they used crack daily, the same number identified by POs. One man reported occasional use of tranquilizers, and one parole officer identified a parolee as taking tran-

quilizers between one and three times a month. Two minor discrepancies were evident in these results; two parolees reported using heroin, while only one heroin user was identified by a parole officer, and one parole officer thought a parolee was using PCP, while there was no self-reported PCP use.[8]

Considering the temptation for parolees to underreport alcohol and drug use, the apparent agreement between them and their parole officers is both surprising and encouraging with respect to validity of responses. Parole officers also judged alcohol or drug use to have negative effects on very few parolees. Four parolees each were judged to have had work-related problems, involvement with crime, or negative relations with their families as a result of alcohol or drug use. Parole officers also thought alcohol or drug use had negative effects on three parolees' relationships with their spouses or girlfriends, and had caused medical problems for two men.

With regard to parolees' involvement with crime since release from prison, parolees and their parole officers were in agreement. Parole officers were sure that one man was making money hustling and suspected three others; one man reported earning $1000 in this way. Parole officers suspected two men and were certain that a third was earning money selling or running drugs; five parolees reported doing so. Two parolees reported income from other illegal sources; POs suspected one man and were sure about another.

Alcohol and Drug Abuse Treatment. As was discussed above, parolees had very little alcoholism treatment since their release. Only one parole officer reported having plans to send a parolee to any treatment (AA), and that was an explicit parole condition. For parolees with alcohol problems, parole officers were asked to assess these parolees' motivation to deal with their drinking problems. Three of the parolees with alcohol problems were described as not motivated to get treatment because they denied having a problem, and two were described as thinking they could handle their drinking problems on their own. The one man who was in treatment was thought to be doing so for fear of receiving a parole violation from the PO.

Parole officers were also asked to judge on a 5-point scale the availability and effectiveness of alcohol treatment programs for the parolee population. Nineteen of them felt able to judge State prison programs; half of these (9) thought they were accessible and effective, eight were neutral, and two gave negative evaluations. With regard to its ability to deal effectively with alcohol problems, the Access program was judged by 21 POs, 14 of them positively and seven negatively. Only seven POs were

[8] One must remember that these are not direct comparisons; e.g., from the presently available results, it is not possible to say that the four men POs identified to be using cocaine are four of the five parolees who report using cocaine. Nor are the three self-reported crack users necessarily the same three men identified by the POs. Since the numbers are so similar through-out these comparisons of aggregated data, we suspect this to be the case, but this cannot be confirmed with these data.

able to judge other Parole programs that had dealt with alcohol problems; four gave them a positive rating, one a negative rating, and two were neutral. The question on AA received 23 responses, half of them positive, five negative, and six neutral. Parole officers had trouble judging community-based alcohol programs; thirteen were able to do so. Four of them were positive about the accessibility of such programs and five thought they were effective. Five thought community-based programs were inaccessible to parolees and two parole officers thought they were ineffective for this population.

As would be expected from the parolees' reports, parole officers made more referrals to drug treatment programs than to alcoholism treatment. Again, as was reported by the parolees, very few of these referrals resulted in treatment. For example, POs referred or planned to refer thirteen men to methadone maintenance programs. Three of them never showed up at the program and five who did were rejected by the program. Parole officers had plans to refer the last five but hadn't done so at the time of the two-month follow-up. Of the five parolees who were referred to drug-free outpatient treatment, two were attending, two had left early, and one was rejected by the program. One man was attending NA and another attending some other type of treatment. Both parolees and their POs reported that eight men had actually been referred to drug treatment by their POs. Additionally, POs were asked why they had chosen particular programs; the most common reason (given for three parolees) was that the PO knew he could get the man in because there was space available. Referrals were made in two cases because the PO heard the program was good, and the remaining three were made because it was an explicit parole condition, the parolee had used that program before, or he wanted that particular program. Referrals to the Access program were chosen either because the parolee had used the program before (2) or because the parolee had specified that he wanted to go to that program (2).

POs characterized all 13 drug abusers as thinking they could handle their drug problems on their own. In addition, they said that 10 of these didn't think they had a drug problem. Eight parolees were said to be committed to treatment for fear of receiving a parole violation. Four were said to have some motivation to attend treatment because they wanted to "stay clean," and three men went back and forth between trying to deal with their drug problem and using drugs.

Just as they had rated alcohol programs, parole officers were asked to judge the availability and effectiveness of a variety of drug programs using a 5-point scale. They were most positive about the Access program, with 12 of the 25 who responded saying it was very effective and accessible to this population. While they rated the effectiveness of community-based drug programs positively (14 of 26), these were not considered to be very accessible to parolees (12 of 25 gave negative ratings, '4' or '5'). Twenty-one judgments were made of State prison programs, nine positive, nine neutral, and three negative. Judgments of other parole programs and NA tended to be fairly evenly distributed across the scale.

FOLLOW-UP RESULTS: PRELIMINARY FINDINGS ON SELECTED OUTCOMES

The results presented in this section concern a selected subset of information collected in the follow-up interviews with parolees and parole officers. For purposes of the present report (and other interim analyses) we recorded a few post-release data elements of particular interest -- arrests, violations, drug and alcohol parole conditions and program participation -- on a log as interviews were completed; this section summarizes the two-month follow-up log data entered as of mid-January. While this recording procedure permits us to report these results for a larger sample than was available for the data presented above, these results must be regarded as preliminary and tentative. The most obvious reasons for this is that it is not possible to assess what may be critical relationships between these variables and others not recorded, nor have we statistically controlled for variables affecting these "outcome" findings.[9] We present these results for descriptive purposes only, and caution against any conclusive interpretation of them.

Results on the two-month follow-up log were available on 139 comparison cases and 34 pilot participants (these numbers vary slightly due to missing data on individual data items). In the comparison group, 112 (81%) of the men were residing in the community; 13 men had been rearrested, 9 absconded, and 5 were violated for breaking the conditions of their parole. All five of the violations and six of the rearrests were drug-related. Results for the pilot group, available on 31 subjects, were quite similar. Twenty-six of these men (84%) were residing in the community, 3 had absconded and 2 had been re-arrested. One of these re-arrests was for a drug-related crime.

Sixty-two percent of the comparison sample had special parole conditions pertaining to a drug or alcohol abuse. The great majority of these were drug-related, as 43 men (32% of the total) had drug treatment conditions, 14 (11%) had drug treatment and testing (or were a "drug alert"),[10] and 11 (8%) had a drug testing or alert condition. Only nine men (7% of the total) had alcohol-related conditions (treatment, testing or both) and six others had a more general condition for substance abuse treatment and/or testing.

Perhaps the most surprising preliminary finding revealed in these two-month follow-up data was the discretionary manner in which parole officers enforced drug

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[9] Additionally, the log data are not scrutinized and "cleaned" like those recorded on the individual follow-up data collection forms. We also do not specify the source of information recorded on the log (whether it comes from the parolee, parole officer or a treatment provider); rather, the log reflects what Vera researchers judge to be the most recent and most accurate data on the case.

[10] Special conditions which we code as "urinanalysis" include either the phrase "drug testing" or "drug alert," both of which are used by Parole Boards.

and alcohol-related special conditions. Within the first two months after release from prison,[11] 41% of the POs supervising men with drug and alcohol-related conditions had not acted to enforce those conditions, such as making a referral for treatment or collecting a urine sample. (POs who made any single referral -- including to AA or NA -- regardless of the parolee's response to that referral, were counted as having enforced the condition.) Further investigation of these data indicated that conditions specifying drug testing (with or without treatment) were slightly more likely to be enforced than those specifying treatment alone (the numbers were too small to conduct statistical tests or further comparisons, e.g., enforcement of drug vs. alcohol conditions).

The most common rationale given for not enforcing these conditions was that other matters -- housing, employment, family reintegration -- took priority. The picture that emerged in our interviews was that regardless of treatment mandates, for many of these officers a treatment referral soon after release was not appropriate unless a man admitted to or was showing obvious signs of substance abuse. Numerous other reasons may explain this tendency to not refer, not the least of which is that making referrals, particularly to New York City's notoriously overcrowded drug treatment facilities, is perceived as at least a difficult proposition. (Though not recorded on the log and thus not available here, POs' opinions regarding treatment accessibility and effectiveness are being collected and will be analyzed for future reports.) Still, it should be apparent that waiting until a parolee is showing signs of abuse at the parole office makes him a likely candidate for the least accessible program slot of all, an inpatient (detoxification and/or residential care) bed. A kind of preventive approach to enforcing drug and alcohol treatment conditions, such as referral to NA, AA or an outpatient program, particularly when a man is first released from prison, may be a more effective (and perhaps ultimately the easiest) means of enforcement.

As expected, results regarding special drug and alcohol-related parole conditions for the pilot participants differed considerably from those for the comparison subjects. All but one of the group of 35 pilot subjects for which such data were available had been given a special condition for treatment, with some also having testing as a condition; while this is undoubtedly a reflection of the salient abuse histories of these men, it also signifies Access' success in making treatment conditions an important component of the pilot program. The drug-alcohol breakdown on these conditions was similar to that observed for the comparison group, with only 5 men having alcohol treatment conditions (2 of these also had testing specified), 5 with a substance abuse condition (1 of these also had testing) and 24 (68% of the group of 35)

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[11] Data is entered on the log up to 3.5 months post-release, depending upon when the PO and parolee happens to be interviewed. On average, interviews with POs occur fairly close to the two-month point (usually 2-2.5 months post-release), while parolee interviews are much more variable, and typically later.

with drug treatment conditions. Of these 24 with drug conditions, more than half (13) also had drug testing or drug alert specified as a Board mandate.[12]

Post-Release Treatment Outcomes. Of the 134 comparison subjects, 26 (19%) were actively attending a drug (21 cases) or alcohol (5) treatment program at the time we recorded their two-month data. Another 13 parolees (10%) had been referred to treatment but either dropped out after a meeting or two (4 drug, 2 alcohol), were attending irregularly (3 drug, 2 alcohol), or were awaiting a referral date to be set by their parole officer (1 drug, 1 alcohol). As one would expect, for those comparison subjects with specific treatment conditions, the proportion attending was higher; of this group, 34% were actively attending at the two-month point, and another 14% had been referred, but left early or were awaiting placement. A similar incremental jump in the attendance rate was evident for those cases where the treatment conditions were enforced. Of these 44 cases, 24 (55%) were attending treatment, and 10 had left early, attended irregularly or awaited placement.

The treatment outcome findings for the pilot participants are disappointing. Of the 29 pilot cases with available data (as of mid-January), 10 men were actively attending treatment -- an attendance rate no better than comparison subjects with treatment conditions. Although, again, the numbers are so small that caution is required in their interpretation, it may be significant that four of those attending are in alcohol or poly-abuse programs, while, of the more than 20 referred to drug treatment program, only 6 are still attending. One notable though expected difference between the pilot and comparison results is the greater proportion of "left early" cases and irregular attenders in the pilot group. Access services clearly led to more men (20, or roughly two-thirds of this first pilot group) initially presenting at the program for treatment. However, the pilot program apparently had little impact with regard to maintaining attendance in community-based treatment, as half of this group had not remained in these programs as of two (to 3.5 months) post-release.

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[12] The extent to which these conditions were enforced by the field POs supervising pilot participants is not reported here, since we considered all the POs to be playing some role in the Access referral given to these men. It will be particularly interesting to see if there are differences in enforcement for the pilot cases in the periods two to six months post-release, when the PO probably plays a more critical role.

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Appendix A

Consent Forms

VERA INSTITUTE OF JUSTICE
RESEARCH DEPARTMENT
377 Broadway
New York, N.Y. 10013
(212) 334-1300

Consent to Participate in Research Project

A researcher from the Vera Institute of Justice,

_____, has informed me as follows:

1. Vera is studying the community adjustment of drug/alcohol abusing men who have served time in a New York State Correctional Facility. It will be studying both men who have participated in different treatment programs and those who have not.

2. The purpose of the study is to evaluate various treatment programs, to see how effective they are in helping men adjust to returning to their homes and communities. The study seeks to determine which program (or combination of programs) is the most effective in helping men stay straight and sober on the street and from returning to the criminal justice system. I and other clients of these programs will probably not derive any personal benefit from the research, but the study may provide a basis for improving services in the future in and out of correctional facilities.

3. If I participate, I will be interviewed by a researcher near the end of my stay at Lincoln and I will be interviewed twice more within the year following my release to Parole. The Vera Institute of Justice will also collect information from any treatment or community service program in which I participate. Vera may also obtain, and record in confidence, information about me held by the Division of Parole.

4. I will be paid at least $10 for each of the two interviews I participate in <u>after release</u>. The researcher will be interested in knowing about my living arrangements, my employment record, and any involvement I may have with educational, vocational, drug or alcohol, and any other social service programs. These two interviews will be arranged through my Parole Officer but s/he will not be present nor will s/he be involved in the interviews in any way. Vera will refuse any request from the Division of Parole for access to any information it collects on me.

5. Any information which is collected, either from my files at Lincoln (to which The Vera Institute of Justice has been given access by DOCS and the Division of Parole), from files held by Parole, or from interviews with me is to be held in strict confidence. Any request for access to this information from anyone, including any law enforcement agency will be refused by the Vera Institute. This information will be used for study purposes only, and I will never be identified by name in research reports.

6. If I have any questions about the research or my rights as a research subject, the researcher who is interviewing me will answer them.

7. I may discontinue participation in the research at any time, without penalty. I may also refuse to answer any questions asked of me. Discontinuation or refusal to answer will not affect my open date or my status with Parole or DOCS. By the same token, participation will in no way enhance my status in those areas.

8. After considering the foregoing, I hearby consent to participate in the Vera research described above.

_____ _____

Date Signed Signature

As a Research Assistant on the Project for Alcohol and Drug Abusing Offenders of The Vera Institute of Justice, I have informed _

____ of the nature and purposes of the research project. He has been given a copy of this Consent Form and has signed it in my presence.

_____ _____

Date Signed Signature

_____

Vera ID #

VERA INSTITUTE OF JUSTICE
RESEARCH DEPARTMENT
377 Broadway
New York, N.Y. 10013
(212) 334-1300

Consent to Release Treatment/Service Summary Data

I have agreed to participate in a study being conducted by The Vera Institute of Justice. I have been informed of the purpose and potential benefits of the research, and about the types of information that would be collected from and about me. I was told how the information would be used, and that it would be held by the Vera Institute in strict confidence. I agreed that Vera could obtain information about any treatment or service I receive within the first year following my release to Parole.

I hereby authorize the following program(s):

_____,
to release to the Vera Institute of Justice the following information: a brief description of the type of service I obtained in this program; the dates I attended the program; and the status of my participation in the program (including completion or non-completion, and reasons for leaving the program). Information about my participation status after

_____ is not covered by this consent agreement.

I understand that all information released to the Vera Institute will be used for study purposes only and will be kept confidential. Vera will refuse any request to turn this information over to anyone, including my Parole Officer, or anyone else associated with any law enforcement agency. I will never be identified by name in any research reports.

_____ _____
Date Signed Signature

As a Research Assistant on the Project for Alcohol and Drug Abusing Offenders of The Vera Institute of Justice, I have informed

_____ of the nature and purposes of the research project. He has been given a copy of this Consent Form and has signed it in my presence.

_____ _____
Date Signed Signature

_____
Vera ID #

Assurance of Confidentiality

I have been reminded by a researcher from the Vera Institute of Justice that all information collected in this interview will remain strictly confidential. Vera will refuse to release any information collected during the interview to the Division of Parole, State Corrections, or any other law enforcement agency. Any request for information collected from a treatment or community service program I am involved in will be similarly rejected.

I have also been reassured that my name will never be used in any report related to this study.

_____ _____

Name of Researcher Name of Interviewee

_____

Date

Appendix B

Drug and Alcohol Measures

DIN#_____ ID#_____

VERA RESEARCH
SUBSTANCE ABUSE FREQUENCY QUESTIONNAIRE

Think about the one-year period before you came to prison this time. That would be between _____ and _____. [Show him the date card.] I am going to read to you a list of drugs, and using this card [give the participant the white frequency scale card], I would like you to tell me which answer on this card best describes how often you took the drug I name during this one-year period. How often did you use... [code 0-3]

_____ 1a. Marijuana, hashish

_____ 1b. Inhalants, such as glue, paint thinner, etc.

_____ 1c. Cocaine

_____ 1d. Crack

_____ 1e. Illegal or street methadone

_____ 1f. Heroin

_____ 1g. Other opiates, such as opium, morphine, codeine, demerol, percodan, dilaudid

_____ 1h. Tranquilizers such as Valium, Librium, Thorazine, Stelazine, Lithium or Mellaril

_____ 1i. Sedatives or hypnotics, such as Quaalude, Ativan, Sopor, Parest etc.

_____ 1j. Barbiturates, such as Nembutol, Seconal, Tuinal, Phenobarbital, Doriden

_____ 1k. Amphetamines, speed or diet pills, such as Benzedrine, Dexedrine, Preludin, Desoxyn

_____ 1l. Hallucinogens, such as LSD, AMT, peyote, mescaline

_____ 1m. PCP or angel dust

_____ 1n. Any other drug (specify)_____

2. IF answered 2 or more to any drug: What would you say was your primary drug problem? (circle drug)

3. Did you ever mainline or inject drugs? (circle one; if yes, specify)

No Yes (specify)_____

4/17/87

DIN # _____ ID # _____

VERA RESEARCH
ALCOHOL Q/F QUESTIONNAIRE

Think now about the **month** before this incarceration. Were you drinking alcohol during this period? (IF No: PROBE regarding time of last drink and proceed with 30-day period before this drink).

1. I WANT TO TALK FIRST ABOUT WINE.

____ (1a) On about **how many days** of that 30-day period did you drink wine? On a typical day when you drank wine, about how much would you drink?

____ (1b) Glasses (8 oz. or large glass -- PROBE on size of glass)

____ (1c) Pints (16 oz. or about 2 large glasses)

____ (1d) Quart bottles (32 oz.)

____ (1e) Was this fortified wine, such as sherry or port (0 = No, 1 = Yes)

2. NOW HOW ABOUT BEER?

____ (2a) On about **how many days** of that 30-day period did you drink beer? On a typical day when you drank beer, about how much would you drink?

____ (2b) Bottles or cans (12 oz. or 1.3 glasses)

____ (2c) Quarts (32 oz.)

____ (2d) Was this malt liquor? (0 = No, 1 = Yes)

3. NOW LETS TALK ABOUT LIQUOR, SUCH AS WHISKEY, VODKA, RUM, ETC.

____ (3a) On about **how many days** of that 30-day period did you drink liquor? On a typical day when you drank liquor, about how much would you drink?

____ (3b) Shots, or straight or mixed drinks (1.5 -- 2.5 oz. of liquor)

____ (3c) Pints (16 oz. of liquor)

____ (3d) Fifths (26 oz.)

____ (3e) Was this usually "bonded" (100 proof) or especially high proof liquor? (0 = No, 1 = Yes; IF Yes, PROBE, indicate brand)

DIN#_____ ID#_____

VERA RESEARCH

ADVERSE CONSEQUENCES QUESTIONNAIRE

I'm now going to ask you another series of questions about alcohol and drug abuse. These questions also refer to the year prior to this incarceration. Think about this period and tell me, during this time...

Alcohol	Drugs	
_____	_____	1. Did you ever have arguments or fights with others -- such as girlfriends or spouse, friends, or people in a bar or on the street -- while drinking alcohol or high on drugs? IF Yes, how frequently? (0 = No, less than 1 time/month; 1 = 1-2 times/month; 2 = more than 2 times/month)
_____	_____	2. Did you ever miss work due to drinking alcohol or taking drugs? IF Yes, how frequently? (0 = No, less than 1 time/month; 1 = 1-2 times/month; 2 = more than 2 times/month)
_____	_____	2a. Did you ever lose time at work or couldn't find work as a result of drinking alcohol or taking drugs? (0 = No; 1 = Yes)
_____	_____	3. Did you have bouts of depression or get violent or "crazy" as a result of taking drugs or drinking alcohol? IF Yes , how frequently? (0 = No, less than 1 time/month; 1 = 1-2 times/month; 2 = more than 2 times/month)
_____	_____	4. Did a doctor ever tell you that you should refrain from drinking alcohol or taking drugs because it was causing a physical problem? (0 = No; 1 = Yes)
_____	_____	4a. Have you had any medical problems as a result of drinking or taking drugs? (0 = No; 1 = Yes)
Alcohol	Drugs	TOTAL SCORE
_____	_____	5. Think now about the crime for which you were arrested and which led to this incarceration. At any point on the day when the crime happened, were you drinking or high on drugs? (0 = No; 1 = Yes)
_____	_____	6. How about other times when you committed crimes -- how often, on the day of a crime, would you be drinking or be high on drugs? (0 = Rarely/Never; 1 = Sometimes; 2 = Frequently)
Alcohol	Drugs	

4/16/87

NAME: _____ DATE: _____

ALCOHOL USE QUESTIONNAIRE (ADS)

The questions in this booklet are about your use of alcohol during the *12 months preceding this incarceration.*

INSTRUCTIONS

1. Carefully read each question and the possible answers provided. Answer each question by circling the ONE choice that is most true for you.
2. The word "drinking" in a question refers to "drinking of alcoholic beverages."
3. Take as much time as you need. Work carefully, and try to finish as soon as possible. Please answer ALL questions.

If you have difficulty with a question or have any problems, please ask the questionnaire administrator.

These questions refer to the 12 months preceding incarceration.

1. How much did you drink the last time you drank?
   a. Enough to get high or less
   b. Enough to get drunk
   c. Enough to pass out

2. Do you often have hangovers on Sunday or Monday mornings?
   a. No
   b. Yes

3. Have you had the "shakes" when sobering up (hands tremble, shake inside)?
   a. No
   b. Sometimes
   c. Almost every time I drink

4. Do you get physically sick (e.g. vomit, stomach cramps) as a result of drinking?
   a. No
   b. Sometimes
   c. Almost every time I drink

5. Have you had the "DTs" (delirium tremens) — that is, seen, felt or heard things not really there; felt very anxious, restless, and over-excited?
   a. No
   b. Once
   c. Several times

6. When you drink, do you stumble about, stagger, and weave?

   a. No
   b. Sometimes
   c. Often

7. As a result of drinking, have you felt overly hot and sweaty (feverish)?

   a. No
   b. Once
   c. Several times

8. As a result of drinking, have you seen things that were not really there?

   a. No
   b. Once
   c. Several times

9. Do you panic because you fear you may not have a drink when you need it?

   a. No
   b. Yes

10. Have you had blackouts ("loss of memory" without passing out) as a result of drinking?

    a. No, never
    b. Sometimes
    c. Often
    d. Almost every time I drink

11. Do you carry a bottle with you or keep one close at hand?

    a. No
    b. Some of the time
    c. Most of the time

12. After a period of abstinence (not drinking), do you end up drinking heavily again?

    a. No
    b. Sometimes
    c. Almost every time

13. In the past 12 months, have you passed out as a result of drinking?

    a. No
    b. Once
    c. More than once

14. Have you had a convulsion (fit) following a period of drinking?

    a. No
    b. Once
    c. Several times

15. Do you drink thoughout the day?

    a. No
    b. Yes

MORE ——————————→

16. After drinking heavily, has your thinking been fuzzy or unclear?

    a. No
    b. Yes, but only for a few hours
    c. Yes, for one or two days
    d. Yes, for many days

17. As a result of drinking, have you felt your heart beating rapidly?

    a. No
    b. Once
    c. Several times

18. Do you almost constantly think about drinking and alcohol?

    a. No
    b. Yes

19. As a result of drinking, have you heard "things" that were not really there?

    a. No
    b. Once
    c. Several times

20. Have you had weird and frightening sensations when drinking?

    a. No
    b. Once or twice
    c. Often

MORE ——————————→

21. As a result of drinking, have you "felt things" crawling on you that were not really there (e.g. bugs, spiders)?

    a. No
    b. Once
    c. Several times

22. With respect to blackouts (loss of memory):

    a. Have never had a blackout
    b. Have had blackouts that last less than an hour
    c. Have had blackouts that last for several hours
    d. Have had blackouts that last for a day or more

23. Have you tried to cut down on your drinking and failed?

    a. No
    b. Once
    c. Several times

24. Do you gulp drinks (drink quickly)?

    a. No
    b. Yes

25. After taking one or two drinks, can you usually stop?

    a. Yes
    b. No