ALCOHOL, DRUGS AND CRIME

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

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Chapter One

Introduction

This is Vera's third and last interim report on New York State's alcohol, drugs, and crime initiative; according to plan, a final report will be published next year. Vera's role in the initiative has remained a dual one, balancing technical assistance with formal evaluation and research. This report catches our monitoring effort at its height; the most thorough accounting so far is made of the people and agencies that have created and will continue to run the initiative's programs. Giving the initiative's central concepts a chance to become real, over the past three years, has confirmed the virtue of patience. And some good news about the quality of the services generated by this initiative, reported in these pages, illustrates the potential for innovation in public agencies.

Three years ago, the State launched a pilot project to demonstrate how the resources of executive agencies in criminal justice and mental hygiene could be meshed and brought to bear on reducing recidivism among alcohol- and drug-abusing ex-offenders. 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 that would reach offenders from the time they enter the State prison system through the difficult post-release period. The legislative initiative aimed to provide purpose, coherence and leadership to the State's search for a better programmatic response to this key criminal justice and crime control issue -- the relationship between alcohol, drug abuse, and crime. Vera was asked to help foster, record, and evaluate the initiative.

Just after the adoption of the initiative within the 1987 State budget, we attended a meeting of a remarkably diverse cast of legislative and executive branch officials who assembled to plan implementation of activities specified in the budget bill. Two key agents of State criminal justice operations were there: the Department of Correctional Services and the Division of Parole. The State mental hygiene authorities that fund and govern treatment services for drug abusers and alcoholics were there as well (the Division of Substance Abuse Services and the Division of Alcoholism and Alcohol Abuse). A key arbiter of Executive authority, the Division of Budget, was also represented. Staff from the increasingly proactive committee structure of the legislature were there too: Codes, Corrections, and Ways and Means were all represented.

Listening to the group talk about obstacles, we were struck by the breadth of the undertaking and how hard it might be to find consensus among the players.

Budget worried that funds appropriated for the demonstration would disappear into agency operations already in place, and would thus fail to spark visible and incremental activity. The drug and alcohol agencies were unenthusiastic about finding themselves legislated into roles as subcontractors to a criminal justice agency (Parole); they also made it clear that their funding of voluntary agencies in the community did not give them unambiguous leverage over these providers' private triage decisions. Corrections wanted more flexibility about how to spend its share of the appropriation than the budget bill appeared to permit. And differences brewed about which agency -- Parole or Corrections -- would employ the initiative's coordinator.

How to do both jobs at hand -- tackle an intransigent problem in public policy and practice and at the same time subject the process to valid research -- was not obvious. A way also had to be found to run the experiment in a context where there was little history of collaboration among the State agencies, and where there were many competing demands for their attention. The initial planning meeting was our first opportunity to facilitate and to record the work of the partners in the initiative; it would not have been hard to be cynical about the demonstration's prospects, as some in the room were. The group shared a purpose but had no common agenda.

As a result, we worried about the real prospects of testing the hypothesis embodied in the legislation. Along with the initiative's framers, we hypothesized that criminal recidivism among alcohol and drug-abusing ex-offenders can be reduced if patterns of substance abuse were brought to a halt (or periods of abstinence were managed) through participation in effective, comprehensive treatment. We also shared the view that treatment meeting that definition would require a continuum of services, including in-prison programs, pre-release planning, referral to community-based treatment, and follow-up of those referrals.

To carry out a fair test, however, a treatment continuum had to be created. Over the initiative's first 18 months, we (and everyone else) had reason for despair. For a while, it seemed that the Lincoln Correctional Facility, chosen for the pilot's pre-release center, would never reach census. After it did, the press of demands on Parole's Access counselors, coming from the general parole population, was a nearly fatal distraction from the need to focus on Lincoln graduates. Moreover, throughout that period, unexpected departure of key program staff became the norm. Thus, the initiative's early history makes it especially satisfying to report, three years later, about a maturing demonstration that is reliably serving offenders before and after release.

The four State agencies have forged the long-sought but previously unrealized collaboration that was properly viewed as prerequisite to the development of post-release treatment that actually reaches parolees and is responsive to their special needs. It is premature to say whether or not there is enough focus and

strength in the treatment of men passing through the pilot to produce unqualified findings about impact. But important and visible demonstrations are taking place. At Lincoln, alcohol and drug abuse services are reaching targeted inmates in the last stage of their imprisonment. Through Access, gains from that treatment are not nearly as likely to be thrown to the wind when the men are released as they used to be. These are not small achievements.

Most of our suggestions for change and improvement can be made, paradoxically, only because of the newfound strengths of the Lincoln Community Preparation Unit (the CPU) and its companion Access program. Let us illustrate how the demonstration's successes give us, at the same time, cause for satisfaction and opportunities to offer advice.

Staff and activity at the Lincoln CPU are now stable enough for the unit to be acquiring an individual identity that is largely independent of planning documents, theorizing, and system-wide ASAT supervision from Albany. That is a welcome development for a lot of reasons -- effective upstate ASATs seem to draw their strength from a sense of their own largely self-determined character and "personality." Because the day-to-day process of individualizing its own aims is now underway, we think this is the time for the Lincoln CPU to sharpen its focus on the role of an experimental unit preparing drug and alcohol abusing inmates for re-entry into the community. While upstate ASAT practices and approaches served as inspiration for the unit's creation, Lincoln needs to strive for a unique identity as a demonstrator of new activities that build on prior treatment, reflect pre-release realities (like open parole dates), and are integrated (not just coordinated) with an array of "generic" separation services like arrangements for work. In practical terms, at Lincoln this might mean pursuing an approach to treatment that is less reliant on an educational, didactic model and that pays more attention to activities which spur men to think and talk about concrete issues that will matter to them on the outside.

We would, for example, expand the practice of importing agencies and people from the outside into the unit's day-to-day program life. From the start, the initiative's designers sought to root the referral of pilot men to community-based treatment in actual encounters with counseling staff of those programs. For awhile, DOCS explored use of a furlough (or other temporary release provision) to create opportunities for inmates to visit programs before release. When it was determined that furloughs were unworkable in Lincoln's classification scheme, efforts began in another direction. Over the past six months, we have been pleased to see those efforts pay off in visits to Lincoln's CPU by representatives of community-based drug and alcohol programs. We would like to see this kind of work expanded, providing routine opportunities for the men to establish pre-release contact with community treatment agencies. On a related point, we would recommend a shift in the CPU's tactics for reaching out to engage participants' families. We would like to see the unit use its status as an important experiment to push ahead relentlessly at involving families, no matter how discouraging the history of such efforts. The

front line staff at Lincoln are already thinking about and acting on some of these ideas. Now is the time to adopt the style and substance of innovation, when the unit's personality and character are being formed.

On the release end of the treatment continuum, Access has come into its own. Here again, its success creates a purchase for our offer of advice. Access' growing sophistication in linking men to community treatment leads us to push it further. Now that Access has established a capacity to build bridges between in-prison treatment and enrollment in post-release community care, we would like to see it try to influence the shape and content of the treatment parolees get when they reach caregivers in the community. By that, we are suggesting that Access is now doing a good enough job for it to sharpen its focus on the fit between parolee and treatment regimen. Drug treatment agencies are not much geared, understandably, to relapse prevention: their doors are pounded down by addicts who want to stop. Men in the pilot don't need detox at release, but many are desperate in their need for help in staying sober under the stress of community re-entry. We think no one is better positioned than Access to campaign for a treatment response that is tailored to suit parolees in such straits.

In short, the experiment's achievements incline us to raise its sights.

Reporting on the Research. One purpose of these annual records is to provide policymakers and researchers with early findings as they emerge from the research component of this multi-year project. While these results are preliminary, we think they provide a policy-relevant and often vivid picture of the population of drug- and alcohol-abusing inmates who comprise a significant proportion of the men currently returning to New York City from our State's prisons. We hope that our final research product will make a useful contribution to State agencies' efforts to adjust policy and practices to the prevalence of substance abuse problems in the criminal justice population. Here, we preview the data and analysis that we hope will accredit the final record about a year from now.

One important group described in the body of this report, as well as in earlier reports, is the large sample (N=678) of general population inmates "screened" just prior to their release; these men are generally representative of the parolees returning to New York City from the state prison system. As Chapter Four discusses in greater detail, the rather sophisticated self-report techniques we used in interviewing them reveal that two-thirds of these men are potentially handicapped in their efforts to re-enter society by the significant drug problems they had just prior to entering prison. At the same time, a third were experiencing alcohol-abuse problems at the time of incarceration, and many of these also had a drug-abuse problem; overall, one out of four of the sample were poly-abusers at the time they entered prison.

While this picture reinforces the widely-held perception that men in our state's prison population suffer from extensive substance abuse problems, it does not tell the whole contemporary story. When we compare inmates in this group who were screened and released in 1988, with those screened and released in 1987, we see evidence of a deepening problem. As an illustration, while 54% of the earlier group admitted to using drugs on the same day as committing crimes, the proportion reporting this drug-crime connection increased to 71% among those more recently released. Similarly, the proportion of men reporting that they had been under the influence of alcohol while engaging in criminal acts rose from 28% to 42% during this brief time period.

An important sub-group within this larger group of inmates who were returning to New York City is the 70% who met our screening criteria, identifying them as individuals who had had drug or alcohol problems at the time they went to prison. In our study, these general population inmates comprise a "control" or comparison group which is being followed and will be compared to the participants of the Lincoln CPU and Access programs on various post-release problems and behaviors. Meanwhile, before the final evaluative results are in, the characteristics and experiences of this comparison group may be viewed as representative of those parolees bound for New York City who are especially vulnerable because of the seriousness of their past drug and alcohol histories.

Close examination of this group's experiences illustrates the nature and extent of their problems. Almost three out of five had been heavy drug users before entering prison (57%); either they had used cocaine, crack, heroin (or other major drugs) daily or had used at least two of these drugs weekly. Indeed, almost a quarter of them had used two or more of these major drugs on a daily basis. Cocaine was the most common substance of abuse: over half used it daily (35%) or at least weekly (20%). However, heroin was also widely abused by these men; 26% had used heroin daily and 8% weekly.

In-depth analyses of changes in drug use patterns among these inmates revealed some notable trends. Evidence of the impact of the "crack epidemic" was clear; while three percent of the men who went into prison before 1985 reported having used crack, 35% of those incarcerated in 1987 had been using crack. Unexpectedly, however, use of cocaine (other than crack) decreased somewhat in this period, from use by three-quarters of those incarcerated prior to 1987, to two-thirds of those who entered prison more recently. Heroin too, while heavily used among all these inmates, had been used somewhat less frequently among those more recently incarcerated (35% compared to 45% of the earlier group). In addition, intravenous use of drugs was down significantly among those more recently imprisoned: more than one out of two of those who entered prison prior to 1984 had been using drugs intravenously (53%), while less than one out of four of those incarcerated in 1987 reported intravenous use (24%).

For these substance-abusing inmates returning to society, their history of previous drug abuse is compounded by problems with alcohol. About one-third had been consuming an average of four ounces of pure alcohol every day before going to prison -- an amount roughly equal to six drinks of hard-liquor, a quart of wine or eight twelve-ounce bottles of beer consumed daily.

In Chapter Five we examine how both the State Department of Correctional Services and Division of Parole have attempted to deal with the significant drug and alcohol problems revealed in these data. We found, for example, that four out of five men in our comparison group had attended at least one of a broad range of drug and alcohol programs available in DOCS facilities; three out of five in this group had completed at least one of these in-prison programs.

While our research reveals, therefore, that the overwhelming majority of drug- and alcohol-troubled inmates returning to New York City from the state prison system have made use of the prison system's treatment offerings, this is not the complete picture. Two-thirds of this treatment was in the form of relatively unstructured, inmate- or volunteer-run programs that are ubiquitous in state prison systems. In contrast, the more structured, more professional ASAT treatment programs were attended by about a quarter of the inmates with significant drug and alcohol problems; of those attending an ASAT, four out of five successfully completed the treatment sequence.

Parole commissioners also appear responsive to the need to assist inmates in confronting substance-abuse problems, by using their authority to structure the conditions of supervision the men must meet upon their release. Three out of four inmates in our comparison group were given explicit substance-abuse-related conditions at the time of their parole: 40% for drugs, 12% for alcohol and 24% for poly-abuse. The majority of these men (60%) were required to attend a treatment program upon release. In addition, about one-third were required to meet drug- or alcohol-testing conditions, which were often coupled with the requirement to attend a treatment program.

In addition to providing these descriptive results, we structured analyses to address further questions: Are these two strategies for helping ex-offenders to avoid relapse -- treatment while in custody, and conditions to structure behavior in the post-release supervision period -- targeting those offenders who appear to need them the most? That is, did we find attendance in prison treatment programs and substance-abuse conditions of parole matched to inmates with the most severe abuse histories and who were, therefore, at greatest risk of relapse?

The findings discussed in Chapter Five suggest matching does take place. Again, however, this is not the whole story, because the data also suggest that both prison treatment resources and parole conditions could be better allocated. There is little evidence, for example, of screening of inmates for available in-prison

programs. Furthermore, it appears that the absence of appropriate screening is most evident for those treatment slots that provide the most professional treatment available (those in ASATs) but which are also the most popular and the fewest in number. Similarly, parole conditions mandating attendance at a drug treatment program (a very scarce resource in New York City) are given to 32% of the inmates who did not exhibit a severe and recent drug history, while they were *not* given to 44% of those who did have such a history.

The final chapter of this interim report focuses on some very preliminary findings that are emerging, as we follow the inmates in our study after their release. This examination includes both our comparison group of inmates with drug and alcohol problems (who are now parolees) and the men who participated in the Lincoln pilot and are now on parole. We interviewed both groups of men two months after their release and we also interviewed their parole officers. We suggest, however, that the early follow-up results discussed in this report be viewed with caution. In particular, the number of pilot group men from whom we have obtained interview data is still small (about half of those we intend to study) and our analyses of their experiences are still incomplete.

Nevertheless, Chapter Six presents some useful information about this group of parolees and their experiences immediately post-release. For example, while 17% were either arrested for a new crime or were charged with parole violations during this early period, an additional nine percent indicated in the interviews that they had committed crimes for which they had not been arrested. About four out of ten reported using drugs, and more than one out of ten reported heavy use -- daily use of cocaine, crack or heroin, or weekly use of two or more of these drugs.

The comparisons we present between the behavior of parolees who had participated in the Lincoln pilot program and those who had not are especially tentative. This is because they do not yet take account of differences that existed between members of the two groups *before* they entered our research. However, at this point in the analyses, we can report no statistically significant differences between the two groups with respect to post-release arrests, parole violations, or self-reported drug and alcohol use, although the direction of the results does tend to favor the pilot group. For example, while 13% of the men in the Lincoln pilot group were arrested or violated within two months of release, 19% of the comparison group were. Similarly, seven percent of the pilot men reported heavy drug use as compared to 12% of the comparison men. We cannot know, however, what will happen to these differences when we have interviewed both samples completely and when we have taken account of the pre-existing differences between them.

The same caveats apply to other preliminary findings which indicate emerging differences between the two groups. Overall, two and a half times as many men in the pilot group as in the comparison group report attending a drug or alcohol program at the time of the two-month interview. So far, this appears to be due to a

significant difference in the two groups' referral rates. Once referred, the same proportion in each group report being in treatment at the time of the interview. But because many more pilot men than comparison group men were referred to treatment, more of the pilot men appear to be attending programs. While the accuracy of these self-reports needs further examination, the early results suggest that the referral process and a related factor, the setting of parole treatment conditions, are important influences on continued post-release treatment.

Taken together, we think that on both fronts – research and demonstration – there is reason to expect investments in the State's drugs, alcohol, and crime initiative to pay off.

Chapter Two

The Lincoln Community Preparation Unit

Both this and the following chapter on the Access program begin with a discussion of operational matters and move on to issues of program content. The operational topics covered here -- Lincoln ASAT staffing and census -- will be familiar to readers of our previous reports. The following section is a thorough description of CPU program components; more so than in previous reports, we have tried to provide a complete picture of what happens "inside" such activities as large and small group counseling sessions. Considerable attention is also paid to those aspects of the program that, in our view, distinguish the Lincoln effort as an experiment in preparing drug and alcohol abusing inmates for transition into the community. These activities include family counseling, involvement of community-based treatment providers, and the program's integration of pre-release (or "separation") services, such as vocational assistance. In each of the sections we begin with a descriptive overview of the program's recent history and current status, and follow with commentary and recommendations. The chapter closes with the results of inmate "process" interviews, which shed light on the pilot participants' opinions about the CPU effort.

Staffing. The stabilization of staffing has provided the necessary foundation for advances at the Lincoln Community Preparation ASAT over the past year. Since the appointment of the program's first full-time supervisor (a GS-22 Senior Counselor) in the spring of 1988, and the hiring of two new GS-19 Correction Counselors (ASAT) in late June, the program has experienced its first stable period, in marked contrast to the recurring vacancies and turnovers of the previous year. With the hiring of a new GS-14 ASAT Program Assistant in December, the program's front-line staff, consisting of the two GS-19 counselors and two GS-14 program assistants, reached full strength for the first time. The program's management and supervision remain in the hands of the senior counselor, with support and oversight from Lincoln's superintendent and from regional and central office DOCS program services staff. The decreased day-to-day involvement of these latter staff -- particularly of the DOCS regional ASAT coordinator, who lent crucial support during past periods of staffing shortages -- signals to us greater program stability and maturity.

One unresolved staff shortcoming is the absence of a Spanish-speaking counselor. Program managers report unsuccessfully trying to recruit Spanish-speaking personnel when vacancies have arisen (e.g., for the recently filled program assistant position). Given the large number of Hispanic inmates going through the program, this continues to be a notable deficiency in the CPU staff.

As described in our last quarterly report, ASAT counselors were permanently placed in two offices on the CPU floor in early September. Each office is shared by an ASAT counselor and a program assistant. As expected, this move has brought both tangible and intangible benefits. With the increased privacy, the counselors can now conduct confidential individual counseling sessions; they can also more readily monitor and enforce punctuality and attendance in meetings. Less concrete advantages include better opportunities to build relationships with inmates and greater program cohesion and unity. The ASAT supervisor continues to share an office with the program's institutional parole officer on a separate floor.

Census and Inmate Preparation. The resolution of the census problem, like stable staffing, has positively affected the program. Since October, the CPU has consistently had more than its on-floor capacity of 38 men, averaging about 44 participants. When all beds on the CPU are full, new participants are temporarily housed with Lincoln CPOD inmates; as men are released to the community, those with the longest time on CPOD floors are moved to the ASAT unit. Stays in CPOD units are typically five to seven days. This pool of waiting participants assures that the program will not drop below capacity. Without it, DOCS officials report that mechanical delays in transferring men throughout the system would inevitably result in slots going unfilled for short periods.

The steady flow of candidates to Lincoln appears to reflect the success of "early identification" procedures and other procedural improvements developed over the spring and summer. As Figure 2-A shows, however, candidates continue to come from a relatively limited set of ASAT feeder sites despite DOCS' decision to encourage referrals from as many as 14 ASAT programs across the state. In fact, over two-thirds of the men transferred to Lincoln have come from just three facilities: Mt. McGregor (which has accounted for 34% of all Lincoln candidates), Otisville (20%) and Collins (15%). Moreover, two facilities (Woodbourne with 11% and Sing Sing/ Tappan with 9%) account for most of the remaining men; none of the other seven facilities that have sent men to Lincoln account for more than 3% of all those referred.[1] DOCS staff say that ASATs sending the fewest men are in facilities whose typical inmate profile does not fit Lincoln criteria. Still, to reinforce diligent identification of Lincoln candidates, DOCS' central office staff visit these facilities, reviewing early identification procedures and selection processes. Commendably, central office staff have gone a step further at one facility, working with counselors on a case-by-case review of inmates who have been judged ineligible by facility staff.

From the program's inception in March of 1987 through late January of this year, our records show 246 candidates were transferred to the Lincoln pilot unit;

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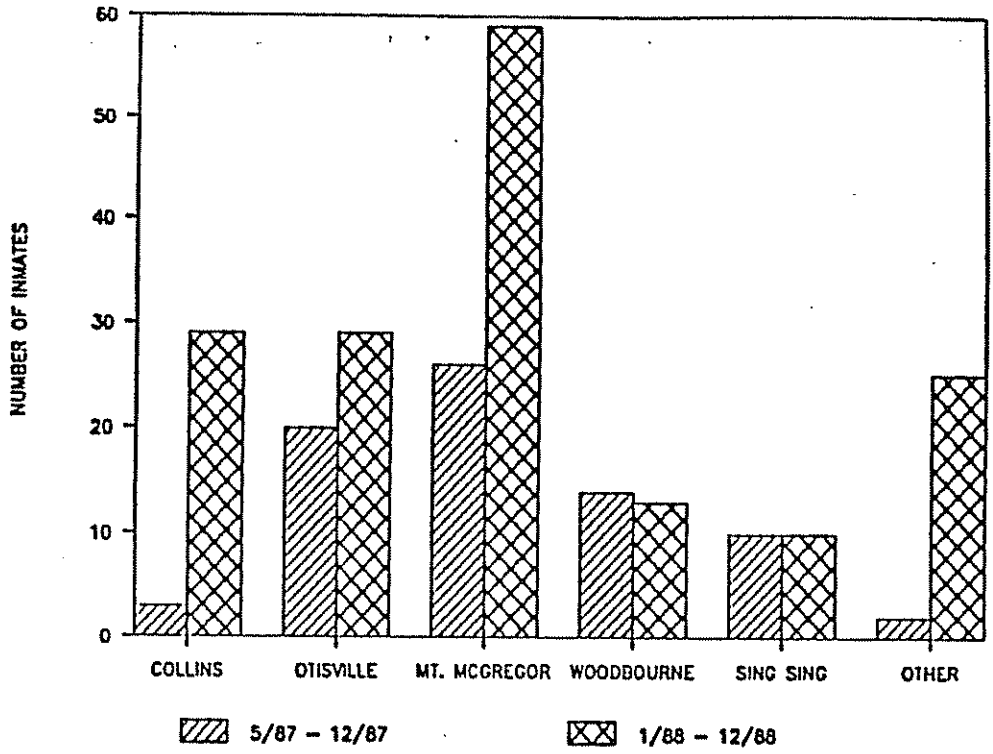
[1] These include Arthur Kill, Coxsackie and Fishkill (each with about 3%) and Hudson, Greene, and Taconic which have each sent 3 or fewer men, accounting for 1% of the total. Transfer patterns over the past year offer evidence of modest increases in referrals from Arthur Kill, Fishkill and Sing Sing/ Tappan.

FIGURE 2-A: INMATES FROM FEEDER SITES



two-thirds of these men (169) arrived after the beginning of the 1988 calender year. A total of 158 men finished the program and were released in this period, while 50 were removed from the program and returned upstate or, in a handful of cases, transferred to the CPOD unit. Most of those sent back upstate had been either denied parole after coming to Lincoln or removed for disciplinary reasons; early on, there were also a few men returned because they had been incorrectly screened for Lincoln candidacy. In recent months, we note more men have been removed from the program for disciplinary reasons; in addition to those breaking system-wide rules (fights, etc.), a few men refused to participate in pilot activities. This increase in "failures" does not reflect more resistance on the part of participants, but rather the CPU's stricter enforcement of participation rules -- a welcome benefit of census "overflow." In the past, there was hesitation about removing such cases because of chronic census problems.

With the census now stable, we are encouraged by recent signs of a collaborative DOCS and Parole effort to bring a renewed focus on relationships between Lincoln and its feeder sites, and particularly to assure improved preparation of inmates transferred to the Lincoln program. This latter need is most evident at CPU inmate orientation meetings, where many of the new arrivals do not have an adequate notion of what to expect as prospective Lincoln ASAT and Access clients. With fierce resistance and pervasive denial a hallmark of alcohol and drug dependency, the feeling that one has been misinformed or uninformed can provide "a hook" for resistance. While usually handled adeptly by both ASAT and Access staff

at orientation sessions, this kind of reaction signals an inauspicious beginning to the Lincoln experience.

Several strategies for improving inmate preparation have been discussed. One possibility is creating and using better documentation of procedures for informing inmates and obtaining their consent to participate prior to coming to Lincoln. While such procedures currently exist (and "informed consent" is routinely obtained -- despite occasional lapses), there is evidence of considerable variance in their application. Presently, the informed consent text specifies only that "the program and [its] basic requirements have been explained" to the prospective candidate; one option is to provide an outline of these requirements in the text. Other ways to improve the way candidates are informed include developing a one-page description of the Lincoln pilot that can be distributed to candidates at feeder sites. A standardized oral protocol covering both the CPU and Access programs might also promote a better understanding among facility staff and inmates. In our view, these descriptions should underscore Lincoln's unique community preparation orientation as well as Access' integral involvement with inmates before release. To disseminate and discuss these enhanced procedures for Lincoln candidate preparation, DOCS and Parole managers will have to make more visits to feeder sites. We think a repeat of last year's day-long workshop with feeder staff would also help.

CPU administrators also plan to intensify monitoring of individual facilities and, at the same time, provide them with feedback on the efficiency of their inmate preparation. Until recently, routine reviews of feeder sites have focused on candidate identification and transfer. We urge them to continue these assessments, but also to look for patterns across time and to anticipate problems. We look forward to similar efforts in the candidate preparation area. CPU staff have begun to review case folders as they arrive at Lincoln, checking for signed consent forms and "discharge evaluations" prepared at upstate facilities; if they routinely contact feeder site staff when mistakes or oversights are found, a better informed -- and likely less resistant -- pool of Lincoln participants should result.

Program Description. Lincoln CPU programming can be described as including a "core" curriculum that follows a relatively structured schedule of large and small groups focusing on education and counseling, self-help (AA, NA and CA) groups, and individual counseling. In recent months, the CPU has successfully added other program elements that were essential parts of the original plans for the Lincoln pilot. These include family counseling workshops, visits by community-based providers, and pre-release or separation services. These newer community preparation components are described in a separate section below.

The CPU's large groups follow a "12-week ASAT cycle" that is unchanged since it was originally proposed in the fall of 1986. Organized around themes suggested by the 12 steps of AA and NA, the topics specified in the schedule range from "promptness and positive thinking" to "pattern and habit." In the large

groups Vera has recently observed, discussion follows the presentation of a video which may or may not directly relate to the theme at hand. When no immediately obvious connection exists, counselors try to explore with the group possible relationships between the video and the week's theme. The content of the videos varies greatly, from parable-like vignettes on the evils of substance abuse, to more straightforward educational approaches.

Not surprisingly, inmate attitudes at these group sessions also vary considerably. Some men are genuinely interested, some apathetic, and a few appear contemptuous. Many of those expressing boredom report having seen the same videos in their upstate ASAT experience. But even among these men reactions are not uniform. In a meeting we recently attended, one inmate, responding to loud moans and groans accompanying the beginning of an "old" video, spontaneously reminded the group that "good therapy is repetitious, brother." Several participants immediately seconded this notion.

Still, in our view, those responsible for the Lincoln curriculum need to recognize more fully the prior exposure of these men to ASAT treatment. Although the participants' ASAT backgrounds differ, nearly all have gone through rudimentary alcohol and drug education. This presents two kinds of challenges to Lincoln. On one level, the staff need to be especially knowledgeable as this relatively sophisticated audience can recognize inaccuracies and can be turned off by simplistic or strident messages. Our observations of the Lincoln staff indicate they are up to this challenge; they bring to their work a more than adequate knowledge of alcoholism and drug abuse. On a second, more subtle level, the inmates' previous exposure to the basics of drug and alcohol education challenges the CPU to go beyond the basics. Repetition can be helpful, but the pilot's unique potential lies in its capacity to build on -- not repeat -- the work of upstate ASATs. In large groups, this underscores the importance of the discussion *after* the video; while repetition can be therapeutic, we think this applies more to psychological lessons of recovery than educational ones.

Small counseling groups in the CPU vary depending upon the counselor; the two ASAT counselors conduct small groups with 13 persons while each program assistant has eight inmates in his or her group. Generally speaking, themes such as those mentioned above form the matrix within which discussion takes place. A wide range of topics are raised within this context, however, and our observations, confirmed by counselor reports, are that community preparation issues are commonly raised in these sessions. Men talk about such matters as pre-release anxiety, adjustment to the community and family, situations leading to relapse, and other issues that are generally too sensitive for discussion in the larger groups. These meetings are conducted more like traditional therapy groups, with a group of diagnostically similar clients discussing concerns which they have in common. The counselor's role is generally less directive -- emphasis is placed on guidance, facilitation, and the introduction of themes.

Compared to their larger counterparts, small groups exhibit less unruliness and greater relative intimacy. Despite these advantages, counselors report that inmates are often unable to discuss more personal matters in small groups for fear of reprisal or ridicule outside of the therapeutic setting. This is one reason behind the recent move to mandatory bi-weekly individual counseling sessions. The content of these sessions varies greatly, reflecting a mixture of inmate concerns too intimate for group settings and the particular therapeutic techniques and philosophies of the individual counselor. Greater intimacy and trust were clearly in evidence on the one occasion we observed an individual session.

The scheduling of mandatory individual sessions is just one illustration of several programming improvements and modifications that surfaced in the latter half of 1988. These came in the form of more structured, consistent implementation of earlier curriculum plans and an increased focus on preparing inmates for release. With the greater CPU stability, program plans and procedures that had previously existed largely "on paper" were developed and enforced. Individual counseling is a good example. We mistakenly reported last year that individual sessions were routinely held weekly (this was the CPU "policy"), when they were in fact occurring only on an "as-needed" basis; some inmates were seen in individual sessions frequently, others seldom or not at all. Now, however, counselors must see each inmate on their caseload individually a minimum of once every two weeks.

Similarly, while AA, NA and CA meetings have always been officially mandatory, only recently have sign-in lists been used and reviewed to enforce this policy. The transitions Lincoln has experienced in the past half-year are also evident in the large group meetings. While attendance here is ostensibly required, in the past inmates have come and gone from these groups quite a bit. In recent months, however, authoritarian approaches have been more apparent, with more frequent threats of disciplinary action for non-attendance or unruly behavior. The senior counselor also reports that she is encouraging the counseling staff to check dorm units and "write up" participants who regularly miss program sessions or don't follow rules and regulations.

CPU managers deserve credit for working on the disorganization and lack of structure that plagued the program's early period (indeed numerous inmates cited "a lack of discipline" in early 1988 interviews). Still, these are difficult changes to make. Punishment is widely held to be the least effective way to elicit behavior change in the long run. To be successful, negative reinforcement must be administered in an objective and rigidly consistent manner, and always in an environment where there is plenty of opportunity to obtain rewards for positive behavior.

Developing and encouraging these opportunities seem especially crucial at Lincoln. Unlike those in upstate ASATs, many men at Lincoln have been granted release dates and thus require additional incentive to participate. Moreover, they are

understandably anxious and often confused about their imminent transition to the community; frequently, these anxieties are masked by hostility or apathy. At the same time, Lincoln participants, having successfully completed ASATs upstate, express considerable motivation and commitment to further treatment. In the face of this complex, sometimes contradictory picture, Lincoln staff need an array of armaments. Structure and discipline are necessary, but vigorous, stimulating, intrinsically rewarding programming is most important. The CPU staff recognize this and do their best to make it work. Moreover, the continued development of community preparation activities (provider involvement, family counseling) signals critical progress in this regard.

We raised the cadre issue in earlier reports to suggest that more could be done, however. Our last quarterly report recorded the arrival of three inmates in July to serve as the CPU's cadre. Discrepancies between these inmates' expectations and the cadre role as defined by CPU managers led to DOCS' decision to terminate the cadre function in the unit. DOCS central office officials have further articulated the view that "peer counseling and inmate role models" are not appropriate to Lincoln's community preparation orientation. Rather, they suggest these roles are better served by "professional staff and community volunteers" who can direct participants to community-based resources and support continued treatment after release.

This seems to us a sensible position. Our initial interest in a Lincoln cadre stemmed primarily from concerns over staffing shortages and from what we perceived as insufficient clinical and counseling experience of the staff then in place. These misgivings have abated. On the other hand, the use of a cadre might be one means of resolving a remaining concern -- the need to do everything possible to spark participants' motivation and enhance their chances for rewards. Of course there are other ways to forge these improvements; we are not wedded to the notion that these opportunities need be formalized in a cadre or in some other explicit designation of inmate leadership. But we continue to believe that greater emphasis could be placed on inmate input and responsibility as a means of fostering self-sufficiency and self-respect. CPU managers have reported some initial advances in this area, noting that group sessions are occasionally led or co-led by inmates. They also report having solicited inmate input when new procedures for room and unit checks were developed. Finally, they have moved toward more inmate involvement in groups, through role-playing and other techniques requiring active participation.

Family Orientation and Counseling. Perhaps the most tangible progress in programming has been the continuation of some family participation, the steady involvement of community-based treatment providers and other outside agencies, and some increased participation by CPU men in Lincoln's "separation services." Since the first "family orientation workshop" in September, Lincoln has hosted similar sessions in December and February. The December workshop was especially well attended, with ten ASAT inmates and fifteen of their family members

participating. Unfortunately, the recent February session saw only four inmates and seven family members attend; this is slightly less than the September total, which included six inmates and eleven family members.

Although sparsely attended, the February workshop was successful in terms of involving the family members who did attend. Lasting approximately two and a half hours (with breaks and refreshments for the participants), the meeting began with descriptions of ASAT and Access roles at Lincoln, then turned to the overall intent and goals of the pilot programs. The Lincoln senior counselor and Parole Access coordinator participated, as did Lincoln's institutional PO, several ASAT and Access counselors, and two guest speakers. The guest speakers -- from experience as recovering alcoholics and as parents of substance-abusing offenders -- delivered eloquent and forceful messages regarding familial participation in the recovery process. They also offered education, information and support for family members seeking continued help post-release, and invited families to participate in additional, individual family counseling sessions at Lincoln up through the date of the inmate's release. The meeting closed with refreshments and an opportunity for informal contact with the Lincoln staff. Enthusiasm ran high and, afterwards, inmates and family members thanked Lincoln ASAT and Access staff for a job well done.

In our view, these thanks were deserved; this was an excellent collaborative effort, with staff putting their collective "best foot" forward to engage families in the recovery process. Thus, the poor attendance was particularly disappointing. We continue to urge the CPU administrators to experiment with incentives for increased participation; the well-delivered message should not remain unheard by most participants' families. One place to begin is the scheduling -- 6:30 on a Friday evening (the time of the February meeting) is probably inconvenient for many potential participants. Holding orientations during the day (perhaps on a weekend) might also improve attendance, as we have frequently heard the observation that Lincoln's location (and subway access) is less than inviting after dark. While the perennial spectre of space problems and staff overtime have been raised as limits to experimenting with scheduling, CPU managers have indicated a willingness to consider the changes.

Apart from making logistical adjustments, we would simply press for renewed determination to engage inmates and their families. As noted in earlier reports, the CPU administrators take the view that resistance from inmates and families is to be expected and that efforts to overcome it will ultimately prove futile, if not counterproductive. They argue that families are too threatened by the tackling of such thorny issues as enabling; that most inmates are resistant to family involvement, and that the short period of time inmates spend at Lincoln inhibits opportunities for the kind of direct intervention that would have clinical impact. Instead, they view Lincoln's role as one of providing education on the impact of substance abuse upon families and guiding them toward suitable community resources (Al-Anon, Nar-Anon, etc.).

While this serves as a good starting place, it seems overly passive and limiting. It is too early to consider whether the Lincoln family counseling effort has had clinical impact, or whether additional family involvement would make a difference. We urge the program to continue extending opportunities for individual sessions, such as has recently been done by making them available to families every weekday and a few weekday evenings (whenever a counselor is on duty). CPU managers have also agreed that more can be done to assure better attendance at orientation sessions; families and inmates should not be hounded, but should be asked what it would take to get them to participate, with their suggestions used as avenues for change. We return to the notion that this is a small experiment; if it takes higher quality refreshments, weekend scheduling, or several extra phone calls or letters, the family counseling hypothesis deserves to be fully tested.

Visits by Community-based Treatment Providers. Involvement at Lincoln by members of the Task Force of alcohol treatment providers, anticipated in our last quarterly report, came to fruition in early November with a visit by representatives of Greenwich House's alcohol program. With excellent presentations and group facilitation from the program's director and a staff counselor, the two-hour session was marked by a spirited discussion of "on the street" treatment and reintegration issues. Heralded as a success by both inmates and Lincoln staff, several pilot participants remarked to us how much they identified with these outside visitors, particularly with the counselor who was a recovering alcoholic and ex-offender. Since the Greenwich House visit, representatives of three other alcohol programs have conducted similarly successful sessions with Lincoln participants. Two of these, Long Island College Hospital (which came to Lincoln November 18) and Cumberland Family Care Center (December 2), are members of the alcohol treatment providers Task Force. Outreach efforts by the DAAA supervisor led to a visit in mid-January by the Substance Abuse Division of Lincoln Hospital, which is not a Task Force member. Arrangements have also been made for another non-member, South Beach Alcoholism Treatment Center, to visit Lincoln in late March.

Parole Access supervisors have been instrumental in bringing about Lincoln visits from Task Force representatives. Appreciation should also go to the providers who have held Lincoln sessions, and to a fifth member of the Task Force, Our Lady of Mercy alcohol program, which is scheduled to visit Lincoln in April. With continued guidance and encouragement from the director of the City Mental Health Department's Alcoholism Bureau and the regional DAAA office, as well as Access and CPU administrators, we expect these visits to become an institutionalized program component at Lincoln.

Although a corollary task force of drug treatment providers remains notably absent, four such providers, Promesa (which visited Lincoln December 13), Elmcor (January 27), VIP (February 21) and Project Create (March 10) have sent representatives to Lincoln in the last quarter. These visits have been orchestrated largely

through personal contacts and efforts of DSAS officials working with Access; also well-received by inmates, they have been marked by extensive question-and-answer dialogue.

Visits by Other Community-based Agencies, and Participation in Separation Services. Another way Lincoln's ASAT administrators have bolstered community involvement has been by arranging visits from Harlem Hospital's medical outreach program. Covering a broad range of pertinent public health matters such as family planning and AIDS, the hospital's outreach representative made five one-to-two hour presentations to ASAT participants over December and January.

Further signs of greater community preparation programming are increased inmate participation in activities sponsored by the Separation Services Unit at Lincoln. Vera's last quarterly report expressed regret over the decision to change participation in these services from mandatory to voluntary. Our impression is that the costs of reduced participation when attendance is left to inmate initiative more than outweigh whatever benefits arise from the absence of compulsory participation.[2] We are encouraged then, by movement back in the other direction—some sessions are now mandatory and counselors have the responsibility to urge inmates on their caseload to attend a minimum of two separation-service activities each week.

One set of mandatory sessions is a workshop series run by Planned Parenthood centering on family and community reintegration issues. In addition, an upcoming series of presentations on behavioral alternatives to violent acting-out will be encouraged for pilot participants with a relevant background. Apart from these mandatory or emphasized sessions, counselors must now take their own regular small counseling group to one separation-service session each week, and participants are asked to review the separation-service schedule for topics of interest. If these efforts do not result in an individual on the counselor's caseload attending two to three sessions weekly, the counselor confronts the inmate with his lack of participation, and together they determine a plan for increasing participation. To the extent these ground rules and procedures are implemented and enforceable, they seem to offer an appropriate balance of carrot and stick.

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[2] CPU staff convincingly point to Vera's own seemingly contradictory position on this point – our earlier argument for more inmate input and governance, while urging mandatory attendance in some sessions. This echos the unique challenge of Lincoln. The anxiety and loss of motivation that often accompany "making parole" hits the CPU in the middle of its 12-week programming cycle; it doesn't help that a few inmates might be initially dubious because the program is relatively new (and suffered from difficulties early in its history that were passed along the "inmate grapevine"). In our view, the still nascent CPU needs to use all its treatment weapons -- ranging from mandatory attendance to more positive means of supporting and nurturing more participation.

Process Interview Results: the Inmate's View. Vera's "process interview" with CPU participants is a relatively unstructured questionnaire designed to solicit an inmate's subjective views on the Lincoln CPU initiative and Access referral procedures. The interview is administered in a confidential setting and is typically held two to four days before the man's release from Lincoln. This section includes a discussion of interview results that pertain to the Lincoln ASAT program; the Access chapter elaborates on inmate responses concerning Access and Access referral efforts.

As of early January, we had completed and analyzed 155 process interviews; results of interviews collected prior to May, 1988 have been summarized in earlier reports. Data reported here are from the 61 interviews we conducted between May and early January of this year. On average, these men had spent 13.6 weeks in the Lincoln CPU. As has been the case previously, there was significant variation in time spent in Lincoln treatment, with three men there only eight weeks, and 17 men spending between 16 and 19 weeks in the CPU; 80% attended between 10 and 16 weeks.

Dissemination of information about Lincoln by upstate ASAT and correction counselors still remains the primary means by which inmates learn of the CPU program. About three-fourths of the men reported that they were informed about Lincoln by an ASAT counselor or a general correction counselor. The majority of the remaining participants heard about Lincoln ASAT from other inmates; only four learned about Lincoln from an institutional parole officer.

The bulk of ASAT inmates claimed that motivation to participate in the Lincoln CPU was twofold: to be closer to home and family, and to receive additional treatment for their drug/alcohol addiction. When we asked participants the reasons for their willingness to attend Lincoln, three-fourths said being nearer to home and family was very important or somewhat important to them. About the same proportion of men said that their desire to continue ASAT treatment was very or somewhat important. Several respondents also said they came to Lincoln because they hoped that participation in the program would enhance chances for obtaining early release on parole, and others said they'd simply heard upstate that Lincoln's CPU was a good program; just over half of the participants said these were important reasons for wanting to attend Lincoln.

When asked if the Lincoln CPU program lived up to their original expectations, more than half of the men answered no. Comments made by those who said Lincoln had not met their expectations were varied and often specific: some were disappointed because "no furloughs or temporary release passes were being issued," others found "the level of discipline and respect on the floor too low," and still others said they "expected the program to be more like [their prior ASAT]."

Using a 1 to 5 scale with one representing "extremely helpful" and five being "of no use at all," we asked these men to judge how helpful their Lincoln ASAT experience would be in keeping them free from drug or alcohol problems after their release. Just over a third (36%) of those interviewed predicted that their Lincoln participation would be extremely helpful. One of these inmates commented that at Lincoln "they deal more with day-to-day life, family problems, the streets, where upstate [the ASAT] focused more on addiction itself." Another 25% of graduates in this period estimated that the program would be somewhat helpful after their release. Nine inmates responded neutrally to this question, four saying the program had a marginal effect upon them, and eleven participants judging the program to be of no use at all. A typical negative comment was, "I already got all the programming I needed while upstate," or "the program here didn't teach me anything new."

Process interviews conducted after December, 1987 incorporated several new questions regarding the number and type of activities in which ASAT men participated during their Lincoln stay. Consistent with Lincoln's prescribed curriculum, reported attendance in activities points to the predominance of group and self-help sessions. Pilot men reported attending, on a weekly basis, about five group counseling sessions, three educational sessions, and three NA, CA or AA meetings. A notable difference was observed on participation in the self-help groups, as almost half of these men said they had attended no AA meetings, while only four had never gone to a NA or CA meeting during their time at Lincoln. There was also substantial variation in reported individual counseling sessions; most important, over one-fourth of the men reported having no individual sessions, while 20% of the men (apparently with their own unique definition of individual counseling) reported 40 or more such sessions.

To obtain some general impressions about these men's views of the ASAT staff's efforts, we instructed respondents to use a 1 to 5 scale similar to the one described above (in this case one was "very good" and five was "very bad") to answer eight opinion questions about the staff. The greatest proportions of 1 (50%) and 2 (24%) ratings were in regard to "the staff's ability to educate about alcohol and drugs." The staff's ability to "stimulate communication in group settings" received the same positive responses, with half of the group rating the staff a 1 and an additional 21% judging them a 2. Although generally favorable, opinions were slightly less so concerning such topics as getting participants involved in the program, understanding inmate problems, discussing re-adjustment issues, and instilling motivation to continue treatment post-release.

The most clear-cut findings here were in the area of staff efforts to help participants contact their families and to include them in the recovery process. On this question, 43% of the inmates said they could not judge these efforts because they didn't know enough about them. Most disappointing, of those who felt they

could judge the staff's efort, half responded with a 5, the lowest possible score. This stands in stark contrast to the distinctly positive responses on all other staff-related items.

Questions regarding aspects of the program that were viewed by participants as especially good or bad revealed some intriguing results, but notably, no single response was mentioned by over 40% of the respondents. Two responses to the query about the "best things about the Lincoln CPU" stood out. (Up to two "best" and "worst" responses made by each participant were coded for purposes of this report.) Thirty-eight percent of the men cited an increased level of awareness, or some improved psychological insight from attending Lincoln. In giving this answer, one man said his Lincoln participation made him "realize that I'm not cured -- I still have an addiction and I'll always have to be aware of that." The other commonly cited "best thing about Lincoln" was the self-help groups; 38% also reported NA/CA/AA sessions to be the most valuable part of their stay at Lincoln. One difference between these findings and those obtained in earlier interviews was that, for the first time, a fair number (12 of the 61) said the small group sessions were a valued program component. Typical of comments here was an individual's assertion that "small groups is when you really begin to understand -- you get to the root of your problem." A host of other responses were recorded in this area: eight men said the films and videos were best, while five claimed individual counseling was most valued. Seven men couldn't specify any one "best thing," but asserted that the "entire program was good." Five graduates (8%) could not cite a single positive feature of the program.

Consistent with these responses, no single negative comment was cited by a majority of the group. One of the most common complaints, cited by one-fourth of the 61 inmates, was that the program lacked structure and/or a sense of discipline. Typical comments here were "things should be more regular -- you know, happen on time, a stricter schedule needs to be followed," and "the program needs more discipline -- but don't overdo it -- especially for those with open dates. Once they know they're going home they don't do anything." A quarter of the men also claimed that the negative attitude of other participants was most detrimental to overall program effectiveness. A number of these men suggested that "those who are not motivated should be transferred out of the program." A lack of skills and/or effort among staff was cited by about one-fifth of the participants, while about 10% of the men felt that there was too little information about post-release treatment and other services. Another 10% had specific complaints about the quality of life at Lincoln (showers didn't work, rats were on the floor, they had to do garbage duty at 5:00 in the morning, etc.). Finally, 11% said that no improvements were needed. It should be noted that no pattern of responses was associated with attendance in particular ASAT programs upstate. Thus, no longer do men from Mt. McGregor, for example, uniformly respond differently than men from other feeder sites.

In sum, participants' reactions appear to reflect the CPU's progress and maturity. With the one exception of family counseling, it is notable that no single aspect of the program was the target of much criticism. Compared to earlier inmate assessments, the program was perceived as more stable and the staff more skilled; three-fourths of the men had praise for the staff's ability to educate, and to stimulate communication in groups. Apart from the many participants who identified a personal lesson gained from CPU participation, the most commonly acclaimed program component continued to be the NA/CA/AA groups led by local volunteers. Overall, these 61 participants were more positive in their view of the program's ultimate usefulness; while earlier groups were split evenly on this question, of the most recent interviewees, 61% offered favorable assessments.

Chapter Three

The Access Program

Similar in structure to the last chapter, this discussion of the Access program covers such operational issues as staffing and the mechanics of Lincoln referral and post-release case monitoring, as well as more specific substantive issues tracked in previous reports, such as identification of and referral for alcohol problems, treatment mandates for Lincoln participants, and parole officer involvement. A unique cooperative venture of Parole, DSAS and DAAA, Access is the best example of the original legislative initiative's emphasis on interagency collaboration. We have tried to focus our assessment of program status on factors that have brought these agencies and DOCS together. Principal among these are Lincoln team meetings; the cooperative (yet distinct) supervisory and clinical roles of Parole, DSAS and DAAA Access administrators; and post-release treatment issues, such as the availability of community-based program slots for Access referrals. Participants' opinions of Lincoln Access services are summarized at the end of the chapter.

Staffing. Coverage of the Lincoln pilot by Access staff has stabilized over the past half-year. Since early November, when new DSAS counselors were placed at Lincoln, the program has had close to the equivalent of two full-time counselors. One counselor works exclusively with Lincoln participants and another is assigned to the pilot for four-fifths of her time; the DAAA clinical supervisor has also handled some counseling duties during this period. A full-time institutional parole officer (IPO) continues to be assigned to Lincoln cases. The IPO interviews participants upon their initial transfer to the facility and, at other times, to prepare them for parole board hearings, and for their transition to field parole. He is also an important contributor to orientation sessions with new inmates and to team meetings with ASAT and Access staff. Distinct from the Access pilot effort at Lincoln is the service it provides to general population parolees out of Parole district offices; this "field Access" program is outlined below.

By all reports, the shared supervisory responsibility laid out in the Access "Memorandum of Understanding," signed by Parole, DAAA and DSAS in September, has succeeded. Detailed in Vera's quarterly report for this period, the document specifies a unique collaborative effort by Parole's Access coordinator and clinical supervisors from DAAA and DSAS. Specialized duties of the clinical supervisors include managing counselors in district offices as well as at Lincoln; providing ongoing in-service training to these counselors; developing arrangements with community-based treatment providers; and organizing and conducting parole

officer training. The Access coordinator oversees staff activities for field Access and is involved in all aspects of the Lincoln effort, ranging from monitoring counselors' case records and post-release transfers to field staff, to moderating and presenting at team meetings, inmate orientations and provider workshops.

Until recently, the DAAA supervisor also handled counseling duties at Lincoln, focusing on men needing referrals for alcohol problems and on identifying alcohol problems among men diagnosed as drug cases. With the resumption of parole officer training by Access in January, the DAAA supervisor has moved out of a direct counseling role; alcohol cases are now handled by both Access counselors at Lincoln. The DAAA supervisor continues to spend one to two days a week at Lincoln, providing input on clinical issues. The DSAS supervisor plays a similar role, but spends much less time at Lincoln. Unlike the DAAA position, which is funded by Parole, she is "on loan" to Access through a cooperative arrangement with DSAS, and only has about two days a week to devote to both Lincoln and field Access.[1] We would support efforts to make this key position a full-time, funded personnel line. Access has commendably maintained Spanish-speaking staff at the Lincoln facility to serve the needs of the many Hispanic participants in the pilot program; the part-time Lincoln counselor, the DAAA supervisor and the Access coordinator are all Spanish-speaking.

The addition of the full-time Lincoln counselor and Access' move in August to "permanent" quarters on the Lincoln CPU have yielded many anticipated benefits. For the first time, Access counselors are virtually a part of the unit on a daily basis. The full-time counselor is also the first Access staff to be hired exclusively for Lincoln duties; his approach to the job is discernibly different from that taken by previous personnel who moved to Lincoln from field office duties, or split their time between Lincoln and field Access. Obvious improvements center on Access counselors' relations with both ASAT staff and inmates. The increased proximity and frequency of interaction have led to a better understanding of Access' role, a more collaborative "team" approach, and a greater feel for continuity of care. Perhaps most important, the frequency and quality of time spent with inmates have risen dramatically since the summer months. Access counselors now report an average of four to five individual sessions per inmate with varying amounts of time spent in each interview. Presence on the floor also produces a great deal of informal contact with inmates which is often difficult to quantify or document, yet adds to the rapport and trust between counselors and inmates. Finally, the stabilized staffing and floor presence have fostered a sense of program identity for all participants and staff. Access at Lincoln is a reminder that the CPU is "special," a step beyond upstate ASAT, and a unique opportunity to facilitate the life-change back to the community.

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[1] Parole Access administrators have frequently commended DSAS' willingness to loan staff to the program; in addition to the clinical supervisor, considerable (and much needed) clerical services have been provided to Access by DSAS staff.

Field Office Access. The Manhattan, Bronx and Brooklyn district parole offices have also enjoyed stable Access staffing since the DSAS personnel placements in October. During the previous summer, Access managers had made efforts to staff some of these district office positions with part-time personnel "loaned" by DSAS, two DAAA counselors and the Access/PO counselor. The "permanent" moves in October resulted in a field Access staff consisting of a DSAS and DAAA counselor at each of the Manhattan and Bronx district offices, the Access/PO counselor working in the Brooklyn office with part-time help from the part-time Lincoln DSAS counselor, and the full-time DSAS counselor at Lincoln. These are the seven staff supervised by the Parole/DSAS/DAAA administrative troika. Parole reports that it seeks to expand Access services to its Queens office in SFY '90 and, accordingly, has submitted budget requests to hire two additional counselors.

Lincoln Assessment and Referral. Parole continues to collaborate with DOCS on selecting and preparing Lincoln candidates at CPU feeder facilities. As detailed in the CPU chapter, procedures for identification of Lincoln candidates have improved, but the preparation of these men could be more consistent and reliable. Collaborative efforts by DOCS and Parole to address preparation problems were recently initiated; to review briefly, tentative plans include developing and disseminating to candidates a brief document describing Lincoln, expanding the consent form signed by participants, and increasing visits to feeder facilities by CPU and Access administrators. In addition, DOCS will be providing lists of prospective Lincoln candidates to Parole during the "early identification" process. Parole officials will use these lists to check with staff at individual feeder sites in order to assure adequate screening and preparation of candidates by Parole staff.

As noted earlier, the quantity and quality of Access interaction with inmates and ASAT staff have increased over the last half-year. Since the DSAS counselors who assumed Lincoln Access responsibilities in November are still learning their Lincoln roles, we anticipate continued improvement in this regard. One measure of this progress is the Lincoln Access staff's growing ability to articulate the assessment and referral procedures they use with each pilot inmate.

Access counselors now report four or five formal meetings with each inmate, averaging about a half-hour each. The first two sessions are typically devoted to assessment. The counselors report that inmate resistance or denial at this point is usually overcome by confronting the inmate with his own history and the practical consequences of his substance abuse. Where denial runs high, the counselor may ask the inmate to detail his drug and alcohol use history. The next two sessions review the results of the assessment with the inmate. Together, inmate and counselor detail the man's weaknesses and strengths; these are then used in the subsequent session to set goals to fit his individual needs and abilities. Appropriate program choices are also discussed and, where possible, counselors provide a list of available programs. Given the scarcity of treatment resources, however, choices are limited and treatment needs receive the most emphasis. A brief, final meeting usually

occurs a day or two before release at which point program-contact information is handed to the participant. The above scenario will vary from inmate to inmate, sometimes involving more but, according to Access, rarely less contact. The counselors stress that throughout this entire process they are sensitive to complementing ASAT efforts and to guarding against generating inconsistencies with treatment the man is receiving. To the extent these procedures are followed in each case, they are a good example of how assessment and intervention can be optimally combined.

Progress is also evident in the weekly ASAT-Access team meetings, where more focused, directive participation is apparent. The Access coordinator and her CPU counterpart are well prepared, and Vera observers increasingly have found found the Access staff to be clinically astute, knowledgeable about the case and treatment options, and assertive regarding the benefits and appropriateness of their recommendations. The ASAT counselors have made similar gains in initial case presentations at the meetings; they have been encouraged to continue providing input as they become more familiar with a case over the course of a man's stay at Lincoln. We credit these improvements to the stability and quality of both programs' counseling staffs (which have experienced considerable turnover since the spring of 1987), to the skill and hard work of the Access coordinator and CPU senior counselor, to the clinical leadership of the DAAA and DSAS supervisors, and to the rapport that has developed among the counseling staff and their managers. The DAAA and DSAS supervisors play similarly valuable roles in steering meetings in clinical directions. The part-time status of the DSAS supervisor unfortunately, prevents her sustained presence in these meetings.[2]

As hoped, the DAAA supervisor has stimulated both Access and ASAT counselors' sensitivity to signs and symptoms of alcohol problems among the Lincoln participants. Increasingly, team discussions of treatment options have included consideration of the counselors' finding that the "social" drinking of many heroin and cocaine addicts often escalates into full-blown dependency when heroin and cocaine usage have ceased (see also Appendix A). In keeping with the mandates of the Access plan (Parole, DSAS and DAAA's joint "Memorandum of Understanding" on Access), the Lincoln counselors are developing assessment and referral proficiency in both drug and alcohol areas.

The counselors' increased ability to identify alcohol problems, however, has not resulted in a notable increase in Access alcohol referrals. Since August, when there were four alcohol referrals, there have been no more than two parolees referred to alcohol treatment programs in any single month. These numbers show no appreciable difference from those of the first half of 1988. To put this in perspective,

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[2] This is not meant to downplay her or DSAS' contribution; as noted previously, while her time is limited, the DSAS supervisor comes to Access free of charge, and Parole Access managers comment that "we are lucky to have her."

of the first 129 individuals completing the program for whom Vera had this information, 94 received drug referrals, 20 were referred to alcohol programs, six to poly-abuse treatment providers, and nine men were not referred to treatment. The 26 referrals to alcohol or poly-abuse programs represent 22% of all Lincoln Access referrals; by comparison, our data on recent drug and alcohol history indicate that 31% of the pilot group had a very severe alcohol or poly-abuse problem and another 14% had serious (slightly less severe) poly-abuse problems (see Chapter Four).

In our view, this apparent contradiction -- that the staff (and even participants) have shown increasing awareness of the existence of poly-abuse but that there has been no accompanying increase in alcohol and poly-abuse referrals -- is attributable to the limits of the treatment system to which these men can be referred. In this sense, Access' expertise has surpassed this system; while Access counselors' diagnostic capabilities are increasing, they are still forced to make referrals to a system that largely maintains the anachronistic drug-alcohol dichotomy. Because their referral options are (with rare exceptions) limited to drug programs or alcohol programs, they are forced to diagnose a "primary problem," and, typically, end up sending a man to a drug program that might or might not address a "secondary" alcohol problem.[3]

The relative salience of the drug problem in poly-abuse cases is a phenomenon we also see in how conditions are set by the parole board. Chapter Five includes a thorough examination of this issue, with the benefit of data collected on over 300 comparison group subjects. As we have previously reported, drug-related conditions continue to considerably outnumber alcohol conditions among Lincoln participants, and Access referral decisions are largely consistent with the board mandates. The more critical issue that we've monitored throughout the pilot effort concerns whether Lincoln participants are receiving any treatment conditions from the Parole Board. Concern was expressed in our last quarterly report because more than one out of four men going to Lincoln boards from July through September were not mandated to treatment. The numbers from more recent boards are more favorable. Thirty-five (85%) of the 41 men going to Lincoln boards in November and February were given treatment conditions.[4] Despite progress, after assessing

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[3] There are encouraging signals from some drug and alcohol programs used by Access that indicate an increasingly pro-active approach to "secondary" addictions. Unfortunately, however, examples of treatment models explicitly directed at both drug and alcohol dependencies are most often limited to expensive programs serving middle and upper-middle class (often EAP-referred) clientele.

[4] In almost one-third of the 35 cases with conditions, however, the boards added the proviso that the condition was "to be enforced at the discretion of the parole officer." We have argued previously that the use of this phrase provides the opportunity for FPOs to avoid enforcing and monitoring post-release treatment. On the other hand, we would urge efforts to persuade board members to make more use of the phrase "comply with Access" as a treatment mandate. While used with some frequency by Lincoln boards held during the early part of 1988, the phrase was used rarely by recent boards. In our view, this language encourages leaving referral decisions in the hands of expert counselors.

board actions on Lincoln men over the past year and a half, we are not confident that this matter has been entirely resolved. The variability with which boards have set treatment conditions over the course of the Lincoln pilot is inconsistent with our own, less variable data on substance abuse history of these same cases. Although, arguably, some small proportion of pilot participants do not require post-release treatment, we continue to believe that the great majority of these men can benefit from a board-mandated treatment condition. Parole conditions not only make Access' job easier but they also send an unambiguous message to the FPO.

Parole Access managers have discussed several procedural changes that could yield consistently higher proportions of Lincoln men getting treatment conditions (the last quarter's 85% figure is in the ballpark). These include a formal Access presentation to all parole commissioners and arranging for Access counselors to present individual cases to the Lincoln board. Another plan would use a better description of Lincoln participation and a list of suggested conditions including treatment in all Lincoln board reports prepared by institutional POs. This could be done in an addendum to the report compiled at Lincoln (although Access indicates that persistent clerical shortages inhibit their ability to do the latter). These appear to be useful strategies; we urge their implementation.

Parole Officer Involvement. Participation by field POs in pre-release conferences with the parolee and Access counselor continued to occur approximately 60% of the time, despite vigorous efforts to increase it. Although Access has succeeded in gaining the cooperation and respect of most field officers, some FPOs continue to resist giving priority to treatment referrals. In these cases, little happens to monitor or enforce post-release treatment participation. One response to these problems was introduced as this report was being written. Beginning in early February, two parole officers, representing Parole regions I (Bronx and Manhattan) and II (Brooklyn, Queens and Staten Island), have assumed all responsibility for CPU participants prior to and for one month following release. They will do all pre-release visitation and field work in addition to post-release enforcement of treatment participation for the one-month period. The case is then re-assigned to a FPO with a normal caseload. This post-release work will be coordinated with the Lincoln Access counselor who will continue to monitor treatment attendance and provide relevant feedback to the FPO.

This arrangement offers several advantages, not the least of which is the transfer of some of the more difficult and time-consuming tasks previously left to Access counselors. The counselors, for example, will no longer need to do extensive outreach to the myriad FPOs formerly assigned to Lincoln cases, freeing up time for other efforts. Dealing with only two individuals also makes it more likely that the counselors' suggestions regarding post-release treatment will be heeded, or at least that a dialogue and an informed decision will ensue. This plan should reduce problems that inevitably arose from the variability in FPOs' clinical sophistication and from their divergent views on the importance of post-release treatment. Both

Access and the parole officers will now be dealing with a known quantity. Finally, there are also simple mechanical advantages to this plan. For example, on those occasions when the counselor learns that a parolee was a program "no show" or "drop out," it should eliminate (during the first 30 days after release) the time lag previously experienced in contacting the FPO to assure another referral is made.

In general, this change should mean more continuity and consistency than has existed in the past; from the initial pre-release meeting with the FPO and counselor, all participants should perceive themselves as part of a coordinated effort to support (and if necessary, enforce) their continued involvement in community-based treatment. Parole plans to continue the Lincoln specialized caseload indefinitely while conducting an assessment of its initial impact in the late spring, after three months of experience with the plan. To the extent our budget permits, Vera will also monitor and report on its outcome. Should the plan yield its anticipated benefits, two immediate directions for expansion include assigning a parole officer from each borough to the effort, and increasing the length of time each Lincoln parolee stays on the specialized caseload. These would both result in more continuous supervision of pilot parolees through the early post-release period. We look forward to seeing the results of the plan; Access managers are to be commended for devising and shepherding it through to implementation.

Efforts to familiarize and involve field officers with district office Access continue in the form of direct outreach and field officer training. Access counselors are charged with informing FPOs of the treatment outcomes of parolees who are referred by Access; with pilot participants, the counselor monitors attendance by contacting the treatment program within a few days of the initial referral, and monthly thereafter for men who stay in treatment. It is Access policy to routinely inform FPOs of these results and, at the same time, encourage them to re-refer parolees who fail to follow through with a referral (i.e., program no shows or drop outs).[5] It is at this point that persistent, persuasive outreach to FPOs is most necessary. Access administrators report that they stress the need for counselors to "knock on doors" of field officers who don't follow-up on referral failures. Further outreach continues to be done for cases with parole board conditions for alcohol treatment. In an attempt to increase alcohol referrals, Access DAAA counselors get monthly lists of parolees being released with alcohol treatment conditions. The FPOs supervising these cases are sent a memo around the time of the parolee's release date, encouraging the FPO to send the individual to Access for an alcohol program referral.

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[5] Monthly monitoring of program participation and direct, personal outreach efforts are limited to pilot parolees. Field office Access monitors the outcome of the initial referral of general population parolees, and then sends a form to the FPO indicating the result. From that point it is up to the FPO to monitor attendance or if necessary, re-refer the case to Access or another program.

It appears to us that the Access administrators are appropriately aware of the importance of these various monitoring and outreach efforts, and do what they can to stimulate staff performance in this regard. However, they also stress that the continual shortage of clerical staff makes this more difficult. With some finger-crossing, they point out that, so far, the counselors have been willing to assume much of the clerical work involved in the monitoring and any "on-paper" outreach. These often thankless tasks are the cornerstone of good follow-up; Access' ability to influence parole officer supervision of treatment attendance will depend on how successfully its counselors perform these detailed follow-up chores.

In addition to training a group of new parole officer recruits in December, Access resumed the training of field parole staff on a relatively heavy schedule in January. Unlike past sessions that usually extended for several days, current efforts are intended as follow-ups of training already completed. They specifically focus on pertinent issues raised in earlier sessions or in post-training evaluations filled out by previous trainees. Organized to fit into a parole bureau's regular half-day monthly meeting, twelve training sessions have been scheduled for the period from mid-January to mid-March to cover all the bureaus in the Bronx, Brooklyn and Manhattan district offices. The training agenda was developed and is presented by the DAAA and DSAS clinical supervisors, in cooperation with Parole's Access administrators. Ranging from basic education on the addictions (e.g., substance abuse terminology and the different patterns or types of abuse) to more practical wisdom (dealing with the resistant client and the treatment versus work dilemma), a rather detailed seven-page working curriculum has been developed by the trainer/supervisors. At the end of each session, FPOs are asked to assess the training using an evaluation form designed by Access; all three participating agencies review these forms.

For the most part, we have heard positive reviews of the presentations to date. Unfortunately, the one session we attended (in early January) was, according to all involved, one of the least successful. Still, even at this training we came away impressed with the professionalism and clinical competence of the presenters in the face of considerable passive and not-so-passive resistance on the part of some of those in attendance. Since this early experience, reports indicate that the audiences have been more responsive and that the trainers have become increasingly adept at diffusing resistance when it occasionally arises.

Post-Release Treatment Issues. We have already discussed several factors -- the appropriateness of Access assessment and referral, the success of counselor monitoring and outreach, and the nature of FPO involvement -- that impact on the success or failure of the Access side of the treatment continuum. Apart from the man's own motivation to continue treatment, remaining factors influencing post-release outcome include Access' relationship with community-based providers and the accessibility and effectiveness of these programs. (These factors' impact on the larger criminal justice population are discussed in Appendix A.) Systemic

deficiencies in these last two areas -- New York City's notoriously overcrowded drug treatment system, and the absence of an effective treatment for most crack and cocaine abusers -- make the Access role that much more difficult, and that much more important. The character of the Lincoln experiment does soften the disadvantages intrinsic to this situation, however. First, the great majority of Lincoln men need to be placed in outpatient programs which, while stressed and crowded, are (unlike residential beds) usually available. Second, even with frequent program overcrowding, Access has considerable lead time (the weeks the man stays at Lincoln) to arrange for a program to accept a pilot participant. With these advantages and hard work, Access has managed to provide a referral to virtually all Lincoln participants.[6]

Still, Access' continuing efforts to develop and reinforce connections with providers through individual and program-wide efforts remain essential. Access counselors are encouraged to network with providers and peers to develop treatment options for their clients. These individual contacts are valuable as a means of facilitating program access; they are also a way to get feedback on attendance status and thus can help keep a parolee in treatment. The Lincoln counselors, for example, routinely send their assessment reports to the provider prior to the parolee's first scheduled appointment after release. The intake counselor at the provider site can then use Access' record of the man's abuse history when he denies prior abuse or resists admission to a program for continued treatment. This is a simple, practical way of cutting down on parolees' tendencies to "sabotage" referrals up front.

Access managers also stress the value of in-service staff training and development, and the staff's formal site visits every month or two to different community-based providers. Arranged by the clinical supervisors from DAAA and DSAS, these visits expand counselors' referral options and serve to educate staff who may have had limited exposure to particular modalities or treatment approaches. The on-going Task Force of community-based alcohol treatment providers offers similar benefits, as well as a unique forum for discussing the range of issues affecting community-based treatment for the parolee population. Recent themes discussed in Task Force meetings have included: benefits and complications of temporary release status for CPU participants; new techniques to guarantee board-mandated treatment; the frequency of alcohol referrals among CPU graduates and current status of those referred; employment versus treatment conditions; ways to enhance communication between Access, parole officers, and treatment providers; and community provider participation at the Lincoln facility. While discussions haven't necessarily reached resolution on some of these matters, the Task Force continues to provide an unusual opportunity to share varying agency perspectives and establish some

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[6] Exceptions included the few participants (about 7%) who did not have parole board treatment mandates *and* who had FPOs who were unwilling to set their own special condition or to enforce a treatment referral in any other way.

common ground. Emblematic of this opportunity was a visit to the Task Force meeting in January from the Chairman and the Director of Operations of Parole; in our experience, it is indeed rare for representatives of local, community-based programs to have this kind of chance to interact with state agency directors, particularly when there is no formal governance relationship between them.

Two tangible accomplishments of the Task Force stand out. Discussed in the earlier section on the CPU, one of these is the ongoing series of visits to Lincoln by Task Force members to hold seminars for CPU participants. Providers on the Task Force also made themselves available to Access staff and groups of field parole officers for site visits to each of these programs (as well as to several other alcohol treatment providers) in early 1988. Most Task Force members continue to provide ready access to treatment for Lincoln participants, although the small number of Lincoln alcohol referrals limits chances to develop or even test this particular Task Force goal. In light of this lack of "business" generated by this effort, the active members are to be commended for staying with the Task Force, and particularly for their invaluable contribution to Lincoln's CPU.

In response to continued suggestions regarding the creation of a similar forum for community-based drug treatment providers, DSAS representatives indicate that gaining the cooperation of local treatment agencies is extremely difficult, pointing to the acute stress that overcrowding has already placed on these agencies. Instead, DSAS has pursued other means of meeting goals dealt with on the alcohol side by the Task Force. As noted earlier, individual community-based drug treatment providers have been recruited to give presentations on their programs at Lincoln; to date, three have done so. Additionally, in December, DSAS implemented a strategy that has been discussed since the beginning of the initiative -- forging specific individual service agreements with providers for parolee treatment slots. DSAS officials report that, by the end of February, "good faith service agreements" for 60 such slots have been developed with five local agencies. It is too early to know whether or not these verbal agreements will result in appreciably greater treatment availability for Access clients.[7]

Outlined in our last quarterly report, a tentative proposal to develop a joint DSAS/Parole pilot outpatient treatment program specifically for parolees remains

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[7] Although we have not dwelt on access to drug treatment because it is less important for Lincoln participants (for reasons noted earlier), such access is crucial to field Access' ability to serve general population parolees (and, as outpatient programs become increasingly overcrowded, it may also come to effect Lincoln cases). Parole Access administrators argue convincingly that the field office counselors tend to be judged on their ability to respond to an emergency; too often, this means trying to place a parolee in a detoxification or residential bed. Without effective service agreements (or other systemic solutions), this means putting the parolee on a long waiting list at a time of acute need. While we continue to recommend earlier, preventive outpatient referrals as a long-term answer, immediate responses must be developed for current Access needs.

dormant. However, another plan under consideration is to set aside 500 of the several thousand new treatment slots envisioned in the SFY '90 budget for parolees. This proposal continues efforts over the past three fiscal years to establish a discrete, community-based drug treatment capacity for parolees. From SFY '87 to the present, $525,000 to $700,000 have been appropriated annually, first in Parole's and then in DSAS' budget, to fund the STOP program (Selected Treatment Options for Parolees). The fund's purpose was to create additional drug treatment slots in the provider network reserved for ready access by Parole when its officers sought treatment for men under their supervision. Planning for the use of these dollars so far has not had as much effect as Parole or DSAS would like; complications include community resistance and reluctance on the part of providers.

To the extent that new parolee-targetted program slots can be developed, they would present opportunities for the kind of treatment advances we have urged in previous reports. In our view, these begin with tailoring treatment to the recently released parolee who is "clean" but at high risk of relapse. Such treatment should be better prepared and more assertive about breaking through the parolee's denial and belief that the problem is gone or can be dealt with without help. Relapse prevention techniques could also be used, along with other behavioral approaches that stress the need to develop behaviors and interests that can fill or compete with cravings for drugs, including healthier peer groups (and NA and CA). Treatment options, such as evening programs, that can fit with other demands made on the parolee are also necessary; ideally, these programs would integrate treatment with assistance in such areas as employment and family reintegration. Program counselors should also view working with parole officers as part of their job, forming a "team" that motivates and supports the parolee's continued treatment. Liberal use of urinalysis could be an important element of their common goal. Although a number of the community-based programs we have visited claimed to have some of these essential treatment components (see Appendix A), none contained all of them.

Process Interview Results: the Inmate's View. Lincoln ASAT participants were asked to evaluate the Access referral procedure in the same process interview described in the earlier chapter. The interview contained questions about post-release treatment referrals, the number and quality of meetings with Access, and inmates' perceptions of the meeting at Lincoln (if any) with their field parole officer. The data presented are from 61 interviews conducted between June 1988 through January 1989.

At the time of the process interview (usually done two to four days prior to a participant's open date), all 61 respondents had at least a general idea of their post-release treatment plans. Forty-five men (77%) reported they were being referred to a community-based drug program, and almost all of these were to outpatient programs; three men had plans to attend NA, and one planned to enter a residential TC. Alcohol referrals accounted for 16% of the group: five said they had been given an outpatient referral, four were headed for AA groups, and one planned to reside

in a halfway house. The remaining men included three who had appointments with poly-abuse programs, and another three who had no plans to attend a treatment program upon release. According to these interviews, 80% of Access referrals were to outpatient programs, 11% to AA or NA, and 3% to residential programs in the eight-month period covered by these data.[8] At the time of the Vera interview, two-thirds of the men who expected to attend an outpatient program were able to give the specific name of the program to which they were referred by Access.

Following these questions about their plans and the Access referral, each inmate was asked if he was satisfied with Access' recommendation. The majority (57%) answered that they were satisfied with Access' choice; an additional 23% said the plan was somewhat satisfactory. Only eight men (13%) expressed displeasure with their Access referral plan, and four were unwilling to pass judgment. When participants expressed opposition to the Access referral plan, it was typically because, in the words of one man, "after all the time spent in prison programs you don't want to be programming out in the streets."

On average, CPU participants reported 3.3 meetings with an Access counselor during their stay at Lincoln. Sixty-nine percent of the men reported between two and four meetings with their assigned counselor and 13% reported one such conference.

Based on their interaction with Access counselors, ASAT participants were asked to rate the counselors as "very helpful," "somewhat helpful," or "not helpful at all" in three areas: knowing about and being able to describe treatment programs in the community, understanding the inmate's needs, and arranging for post-release treatment. Between 60% and 65% of the interviewees stated that Access counselors were very helpful in all three of these areas. Most of the remaining men rated Access somewhat helpful; in each of the three areas, however, six respondents (10%) claimed their assigned counselor was "of no use at all." Again, inmate comments concerning Access referrals depended largely on how amenable a participant was to community-based treatment. Resistant inmates usually argued against a post-release program by claiming "I think they [Access] are forcing too much on me, I don't like it – they're sending me home, but I'm not really free." A typical comment from men who found Access beneficial was, "they helped in setting things up, so now my PO doesn't have to do it for me."

Unfortunately, less than half of the ASAT men reported meeting their parole officer prior to being released into the community. (The difference between this

[8] It should be remembered that these are referrals reported by the inmate. While most inmates had reached agreement with their Access counselor about the post-release referral at the time of our interview, a few men continue to insist on a program different from Access' referral choice. Almost always these are cases who persist in their desire to attend self-help groups (the 11% who report NA, CA or AA referrals), despite Access' reluctance to use these programs because of the problem they present in FPO monitoring and enforcement.

figure, derived from inmate self-reports, and the 60% figure reported from Access above may be due to a few inmates meeting their FPO after we conducted the interview.) Thus, 52% of the inmates were unable to assess the effectiveness of a face-to-face meeting with their FPO; but of the twenty-nine that did meet with their FPO, more than half (55%) said the experience was very helpful and 28% judged the meeting somewhat helpful. Two of the 29 inmates said they couldn't judge how helpful the meeting was, and four (14%) said the meeting was not helpful at all. The great majority of these respondents thought meeting the FPO at Lincoln was beneficial because it lessened their anxiety about returning to the community. Typical of these comments were, "now I know what to expect -- [the meeting] allows me to anticipate any problems or conflicts with my PO before I get out," and "its one less thing I have to worry about when I get back to the streets." Notably, when a field PO didn't keep his or her appointment with the participant, feelings of disappointment were expressed: "My PO blew off both meetings with me – it's very frustrating. It shows he doesn't care."

Although these inmates' assessments of Access at Lincoln covered a period of inconsistent program staffing (dating back through the early summer), they were favorable overall. Compared to earlier process results, participants were more knowledgeable about their post-release treatment plans (two-thirds could name the program) and reported more meetings with their Access counselor during their Lincoln stay. On specific questions about satisfaction with the Access referral and staff abilities, between half and two-thirds of the respondents gave the most positive ratings; consistently, only 10% to 15% had complaints. Finally, the fact that over half reported no meeting with their FPO at Lincoln offers further support for the new plan to assign Lincoln candidates to specialized FPO caseloads; of those who met with FPOs, the great majority saw the meeting as helpful.

Chapter Four

Alcohol, Drugs and Crime: Preliminary Pre-Incarceration Results

As an introduction to research findings presented in subsequent chapters, this chapter includes both a brief overview of the design and methods of the study, and results on measures of pre-incarceration drug and alcohol use. Useful as a means of subject "matching" for sample selection and analysis, the drug and alcohol measures are also of descriptive value; in this case, they yield estimates of drug and alcohol abuse prevalence among large groups of New York State inmates. As was done in Vera's March, 1988 Interim Report, we present results separately for the large screening sample and the selected research sample. The screening sample analyses and results are quite similar to those reported last year (the final sample reported on here is about one-third again as large as that included in the 1988 report). However, much more extensive analyses have been done on this year's research sample, which includes over twice as many subjects as last year, and for the first time includes an appreciable number of pilot participants. In addition to providing a more complete picture of these inmates' pre-incarceration abuse history, we conducted tests for differences between Lincoln participants and the selected comparison group. Moreover, we examined trends or changes in drug use patterns that occurred within this sample during the mid-1980s. Summations of all these analyses are reported below.

Research Design and Methods. Our March, 1988 report contained a detailed account of the research hypotheses, as well as the design and methods employed to address these hypotheses. A brief summary of the design and methods follows; for those interested in further detail, an updated version of the research plan is included in Appendix B of this report.

The population studied includes the pilot (or "experimental") group, composed of participants in the Lincoln CPU-Access program, 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, and extensive data obtained from DOCS files and in a face-to-face intake interview done just before release. Follow-up information is

collected in interviews with subjects and their supervising field parole officers at two and six months post-release. Finally, researchers also obtain arrest record data through twelve months post-release.

Screening and intake data collection began in the spring of 1987. These activities ceased for the comparison group in the fall of 1988, when we had achieved our original goal of including at least 300 men in this study group. Collection of intake information on pilot subjects continued through the early part of 1989, when we reached our goal of at least 150 men in this group. The following chapters present results on selected data available through early August, 1988, when these data were keypunched for computer processing. They include screening and intake results taken from interviews with 301 comparison subjects and 110 members of the pilot group. Chapter Six summarizes selected results from follow-up interviews conducted two months post-release. This sample contains 237 comparison subjects and 72 pilot participants.

SCREENING SAMPLE RESULTS

The screening interview consists of multiple measures of recent drug and alcohol abuse history, and questions on in-prison treatment participation. Obtained on a sample of 678 men passing through the Lincoln facility prior to their release, results from these interviews represent a descriptive profile of state inmates who are returning to New York City. Between the spring of 1987 and the completion of screening in mid-August, 1988, Vera staff met with 709 of these C.P.O.D. inmates to conduct screenings (to determine their eligibility as comparison subjects). Thirty-one (4%) of these men refused to participate; thus, with the exception of rare missing data, the results described below are based on a sample of 678 men.

Last year's interim report presented results from the first 455 screening interviews. Current analyses of drug and alcohol use for the total screening sample (455 plus 223 subjects screened during the past year) yield results that are very similar to those reported last year; thus only brief attention is given them in this report. To the limited extent possible, we also assessed this drug and alcohol use information for changes over time, comparing subjects screened in the earlier part of the data collection to those screened more recently.

Drug Use in the Screening Sample. Two measures of recent, pre-incarceration drug abuse were used, a frequency-of-use questionnaire (SAFQ) and an index of adverse consequences of drug use (ACQ-D).[1] The numbers did not differ from

[1]The Substance Abuse Frequency Questionnaire (SAFQ) assessed self-reported frequency of use of some 13 commonly used drugs in the year prior to incarceration. The Adverse Consequences-Drugs (ACQ-D) measure was a cumulative index of troubles due to drug use, such as loss of job, getting in fights, health problems, etc., over the same prior year. Based on similar commonly used instruments and developed and pre-tested by Vera researchers, both measures are described in detail in the appendix.

those presented in the earlier report: 58% of the screened inmates were categorized as "high frequency" drug users, 5% moderate, and 37% low frequency drug users according to the SAFQ measure. Results obtained from the ACQ-D indicated that about half the men had experienced at least one negative consequence of drug use. The SAFQ and ACQ-D measures were then combined into a simple composite measure of drug problem severity, which suggested that 65% of the screening sample had a drug problem just prior to incarceration, and that 38% had very severe problems.[2] These results are included in Table 4-A.

An analysis of the relationship between drug use and crime found that 60% of the screening sample (410 of 678) reported taking drugs on the same day as committing crimes; as expected, most of these same individuals (89%) also evidenced a drug problem on the composite measure. Conversely, of the 440 men who had a drug problem, 83% reported a drug-crime connection. Just over half the sample (54%, or 365 of 675) fell into both categories, that is, had a drug problem and used drugs during the commission of crimes.

We also assessed data available to us on changes in these men's drug use over time. On the screening data, we were limited to a rather crude analysis of differences in drug and alcohol use between men interviewed and released in 1987 (N=428), and those released in 1988 (N=250).[3] Nevertheless, on the composite drug measure, significantly more 1988 releasees had drug problems (70% as compared to 62% of the 1987 releasees), and there was a marginally significant increase in the frequency of self-reported drug use (about the same 8% increase; p=.06). The greatest difference between the two groups of releasees was evident in the drug-crime results. Seventy-one percent of the more recent releasees took drugs while committing crimes, while this was true for 54% of the 1987 releasees.

Alcohol Abuse in the Screening Sample. Like the drug use results, the alcohol use results reported below (and in Table 4-A) are virtually identical to those reported (on a smaller sample) in our prior report. The same measures were used here as were identified in that report: the Alcohol Dependence Scale (ADS), quantity-frequency (Alc-QF) and adverse consequences measures, MAST scores and

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[2] It is important to note that this composite measure (and an alcohol composite index described below) was created only for prevalence estimates for the screening sample (see Appendix B). A separate, more complete composite severity measure was created and used in numerous analyses involving the research sample; this measure is described in a later section of this chapter.

[3] Unfortunately, our screening records, not designed to address such emerging issues as crack and intravenous drug use, were quite limited in this regard. It should be remembered that inmates were reporting on drug and alcohol use in the year prior to incarceration; however, date of entry to jail or prison was not recorded at screening, so we could only divide the subjects into time periods on the basis of their release dates. Moreover, at screening we did not record drug-specific results, but only global indicators of abuse history. These caveats do not apply to the research sample; time-based analyses of this sample are presented below.

TABLE 4-A

Scores on Drug and Alcohol Measures at Screening

Scores		% of Total	(N)	Mean	(sd)
Drug Measures					
Use Frequency:	Low	37	(254)		
	Moderate	5	(32)		
	High	58	(392)		
(Totals)		(100)	(678)	1.20	(.96)
Adverse Consequences:	0	50	(339)		
	1-4	36	(241)		
	5-9	14	(98)		
(Totals)		(100)	(678)	1.75	(2.25)
Drug Composite Index:	0	35	(238)		
	1-2	27	(183)		
	3-4	38	(257)		
(Totals)		(100)	(678)	1.92	(1.63)
Alcohol Measures					
Quantity-Frequency:	Low	75	(506)		
	High	25	(171)		
(Totals)		(100)	(677)	.25	(.43)
Adverse Consequences:	0	76	(516)		
	1-4	18	(125)		
	5-9	5	(37)		
(Totals)		(100)	(678)	.74	(1.61)
ADS:	0	54	(363)		
	1-13	41	(274)		
	14-31	6	(38)		
(Totals)		(100)	(675)	2.85	(5.18)
MAST:	0-4	59	(258)		
	5-8	16	(71)		
	9-47	25	(108)		
(Totals)		(100)	(437)	6.07	(8.80)
Alcohol Composite Index:	0	67	(452)		
	1-2	18	(124)		
	3-6	15	(101)		
(Totals)		(100)	(677)	.91	(1.66)

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 be more or less than 100%.

DOCS data.[4] Based on the Alc-QF, one quarter of the sample (171 of 677) reported drinking excessive average daily quantities of alcohol. Twenty-three percent of the sample reported experiencing one or more negative consequences of alcohol use, with most of this group (18%) having more frequent difficulties. When these measures were combined to create an index of alcohol problem severity, one-third of the men showed some evidence of an alcohol problem, and 15% scored in the most severe range.[5]

An analysis of differences between men screened and released in 1987 and in 1988 reveals a significant (9%) increase in numbers of those reporting consequences of alcohol abuse, but no changes with regard to alcohol quantity/frequency or in the composite alcohol scores. As with the drug results, the incidence of alcohol use during commissions of crimes showed the greatest increase. While 28% of 1987 releasees reported an alcohol-crime connection, this figure increased to 42% in the 1988 group.

The composite drug and alcohol measures were also used to determine the incidence of poly-abuse problems. As depicted in Figure 4-A, one quarter of the men in the screening sample were found to be abusers of both drugs and alcohol. An additional 40% of the sample had drug problems exclusively, while 8% had only an alcohol problem; according to these measures, 27% did not have a drug or alcohol problem.

RESEARCH SAMPLE RESULTS

Drug Use. The Second Interim Report presented detailed data, for comparison group members only, on drug and alcohol use and on relationships between alcohol, drugs and crime; data on pilot subjects were omitted because data were available on only nine of them. We now have a sample of 411 subjects, composed of 110 pilot group members and 301 comparison group members; it was possible therefore to conduct statistical tests to assess group differences.

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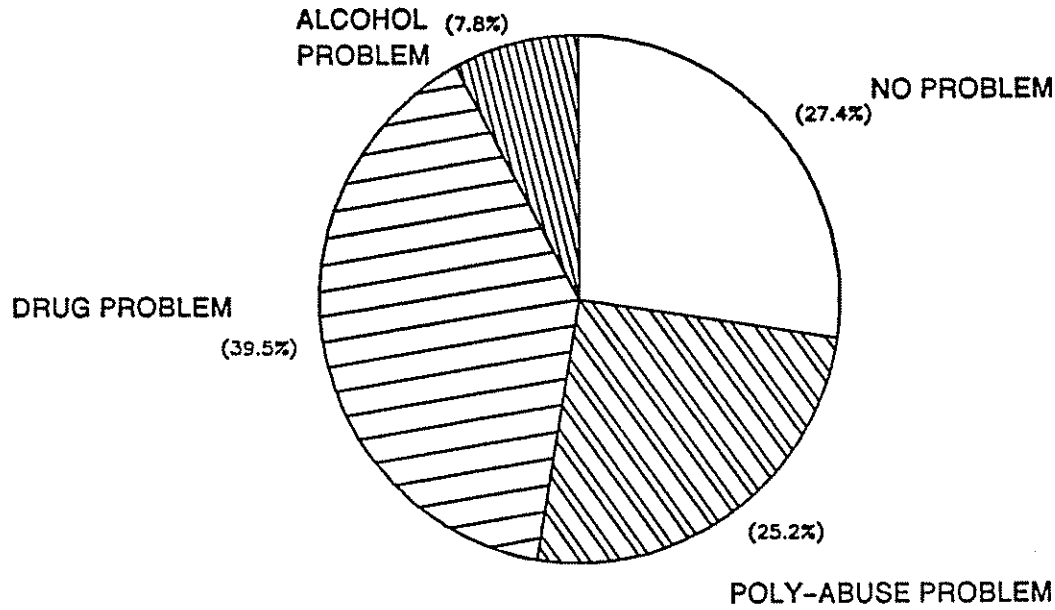
[4] The ADS is a commonly used standardized measure of alcohol dependence; the quantity-frequency and adverse consequences measures were developed by Vera staff. All three of these measures are based on self-report for the year prior to incarceration, and are administered by Vera researchers at Lincoln. The Michigan Alcoholism Screening Test (MAST) is a standardized measure administered by DOCS when inmates first enter the system. When available, MAST scores and other DOCS data on drug and alcohol use are recorded by Vera researchers from DOCS files. All instruments are described in the appendix.

[5] MAST data, collected by DOCS, were available on 437 members of the screening sample. The results of analyses on these data were consonant both with those produced by the other measures reported above and with the data presented in last year's report. Specifically, 25% of the men qualified as having an alcohol problem on the MAST (received scores of nine or more), and another 16% had scores suggestive of an alcohol problem (5-8).

FIGURE 4-A: IDENTIFICATION OF DRUG AND ALCOHOL PROBLEMS BASED ON SELF-REPORT MEASURES

(Screening Sample, N=678)



With very few exceptions there were no statistically significant differences between the two groups on their pre-incarceration drug and alcohol use. This indicates that the screening used to select comparison subjects was successful; since the pilot and comparison groups are statistically equivalent on these measures, any post-treatment group differences cannot be attributed to differences in pre-incarceration abuse history. This also permits combining the two groups to present descriptive results in this section. Thus, except for those few variables on which the pilot and comparison groups differ significantly, this discussion of drug and alcohol use and their relationship to crime is based on all research subjects, regardless of study group.

Information on drug abuse was collected from inmate records and subjects' self-reports during the interview just prior to release. Over two-thirds (68%) of the subjects' files contained references to either a history of drug abuse or drug treatment, and 16% of the files contained references to both drug abuse and drug treatment. No reference to either drug abuse or treatment appeared in DOCS files for the remaining 16% of the sample. The file data also indicated that half the men had been convicted of a drug-related crime at some point in their past.

For those subjects whose files contained some history of drug abuse, the particular drugs referenced in the files were coded. The most commonly cited

drugs were cocaine (including crack, 56%) and marijuana (45%). Heroin abuse was also referred to in over a third of the files (38%), while illegal methadone appeared in only 2% of the files. PCP was cited in 4% of the files; together, various other drugs appeared in 10% of the files. The only "minor" drug mentioned with some frequency was marijuana, which appeared singly in 13% of the files. Use of two different drugs was found in about a third of the files (34%), and use of three or four drugs was found in another 17%.

Self-reported responses to Vera researchers' questions about their use of drugs prior to this incarceration indicate that a very substantial proportion of the sample were heavy users of drugs. By combining data on the thirteen categories of drugs into a single frequency-of-use index, we find less than 8% of the sample reporting little or no use of drugs; over a third of the men were moderate (11%) to frequent (24%) users; and over half (57%) were heavy drug users prior to incarceration. Almost half of this last group (and 24% of the total sample) reported using two or more major drugs on a daily or almost daily basis.[6] Others classified as heavy users included those who used one major drug daily or almost daily, or two or more major drugs weekly (14% of the sample); daily users of a major drug and at least weekly use of a minor drug (10%); and users of one major drug daily and another major drug weekly (9%).

Figure 4-B shows the frequency of use of the most commonly reported drugs. Cocaine (not including crack) was used daily or almost daily by 35% of the sample, and once or twice weekly by 20% of the sample; another 16% took cocaine one to three times a month. Heroin was also used by a substantial proportion of the sample, with over a quarter (26%) of the men reporting daily or almost daily use, 8% reporting weekly use and 5% reporting heroin use one to three times a month. Crack was used by nearly 20% of the men in the sample, daily by 13%, weekly by 5%, and less frequently by 1% of the men. (While highly varied, on average, these men began the present incarceration in the latter part of 1985.) There was little use of other major drugs in this sample: 6% used illegal methadone; 6% took other opiates; 14% took PCP; and 12% used other hallucinogens.

Among the minor drugs, marijuana was clearly the drug of choice; 38% of the men in the sample used marijuana daily or almost daily, 15% weekly, and another 15% less frequently. In contrast, only 14% of the men used tranquilizers, the majority of whom (9%) used such drugs one to three times a month. Four percent of the

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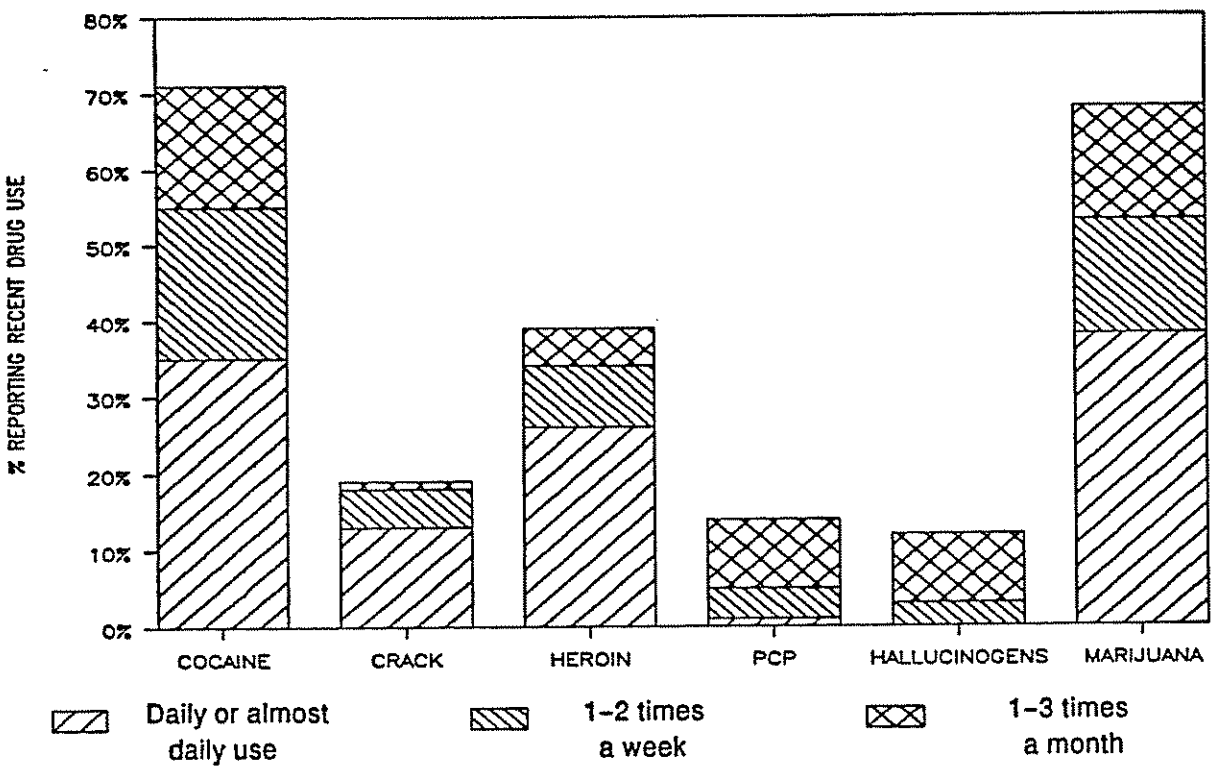
[6] We followed the D.O.J.'s Bureau of Justice Statistics' distinctions between "major" and "minor" drugs; the former group includes cocaine (and crack), heroin, other opiates (non-prescribed methadone), and hallucinogens such as PCP and LSD. The remaining substances included in our scale (e.g., marijuana, tranquilizers, barbiturates) are minor drugs. The criteria for heavy users is in the text; "frequent" users included users of a major drug weekly, or a minor drug daily, or two minor drugs weekly. Use of either a major or minor drug on a monthly basis was the criteria for "moderate" use (most of these were weekly users of minor drugs).

FIGURE 4-B: DRUG USE FREQUENCY OF MOST COMMONLY REPORTED DRUGS

(Research Sample, N=411)



sample used sedatives or hypnotics; 4% took amphetamines; 2% used barbiturates; less than 1% of the sample had ever used inhalants; and just over 1% took other minor drugs.

These data suggest that the heavy drug users (representing 57% of the total sample) were using cocaine, heroin or both of these substances daily or almost daily, while most of the "frequent" users (representing 24% of the total sample) were daily users of marijuana or weekly users of cocaine. The 11% of the sample characterized as "moderate" drug users were probably using marijuana weekly or cocaine and marijuana less frequently.

Subjects were also asked to identify their primary drug problem. Over a quarter of the sample (28%) did not feel they had "a drug problem," while 9% indicated their primary problem was marijuana. Over a fifth of the sample (21%) identified cocaine as their primary problem, and another 13% specified crack. Heroin was noted by over a quarter of the sample (26%). These results are very similar to those presented in last year's report on 114 comparison group members.

As described earlier, researchers asked a series of questions on the adverse consequences of drug abuse (ACQ-D). The scores of research subjects averaged

close to four (pilot group mean=3.7, comparison mean=3.8) on this cumulative scale, indicating that these men experienced three to four different troubles due to drug use, or frequent occurrences of two types of consequences.[7]

The data from the frequency-of-use measure and the ACQ-D were combined to yield an index of drug problem severity; scores on this measure could range from none (0) to severe (3).[8] Consistent with the results reported above, there was no significant difference between groups (pilot or comparison) in their drug problem severity. This measure categorized over two-thirds of the sample as having a severe drug problem. Sixteen percent had scores of two on this measure, and 9% had scores of one; these scores are indicative of moderate and slight problems, respectively. Only 6% of the subjects did not use drugs and had no attendant adverse consequences. The difference between the proportion of the sample identified as having a severe drug problem by this measure (68%) and that identified on the basis of use frequency alone (57%) is attributable to the inclusion of the adverse consequences due to drug use scores; the increase represents individuals who reported less than daily use of major drugs, but still experienced considerable consequences as a result of their drug use.

Changes in drug use patterns over time were assessed by dividing the subjects into groups on the basis of the date they commenced their present incarceration; this was done because the subjects were reporting on drug use just prior to incarceration (as described in Appendix B). For analytic purposes, SAFQ responses on individual drug items were compared for men who began their term of incarceration in 1985 or earlier (N=217), and those who began on or after January 1, 1986 (N=193).

As expected, differences were most striking on items regarding crack. Crack use had more than quadrupled in this sample by the end of the second period; 8% of the pre-1986 group reported any crack use, as compared with 33% of those who entered in 1986 or 1987. Very frequent (daily or almost daily) use showed the same increase, from 5% in the early group, to 22% in the more recent group. When the subjects were further divided by year of entry, a trend was obvious (see

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[7] Unlike the scoring of this measure at screening, the total adverse consequences (ACQ-D) score for research subjects included a question about how often the subjects used drugs when involved in crime. Scores for research subjects on the ACQ-D can range between 0 and 12, for screening purposes the range was 0 to 9.

[8] As noted above, the drug frequency measure (DF) ranged from 0 (none) to 3 ("heavy" use); the ACQ-D ranged from 0 to 12. On the composite, a score of 3 ("severe" problem) was given if the DF=3 or the ACQ-D was greater than or equal to 4; a 2 ("moderate") was given if DF=2 or ACQ-D=3; a 1 ("slight") was given if DF=1 or ACQ-D=1; the remaining cases were given a score of 0. This composite severity measure is used in many subsequent analyses reported in the three research chapters included here; for purposes of these analyses, the severity scores were often dichotomized into severe (scores of 3 on this composite) and non-severe (scores of 2 or less on the composite).

Figure 4-C). Three men (3%) who began their incarceration in 1984 or earlier reported any crack use. For those who entered in 1985, this increased to 12%. Results for 1986 (N=147) and 1987 (N=46) entrants were virtually identical; 33% of the former group and 35% in the latter group reported some use. In both '86 and '87 entrants, about 8% reported weekly use, and 23% reported daily use. Parallel results were found in questions about which drug subjects considered their "primary problem." No one entering in 1984 or earlier reported crack as a primary problem; 6% did in 1985; for both 1986 and 1987 entrants, this increased to 24%.

Notably, the reported use of cocaine did not show any overall increase in the analyses we conducted. When the year-by-year comparisons were done, however, an interesting pattern emerged that was most evident in the primary problem results. About one in four men who began their term in 1983 or earlier reported cocaine as their primary problem. This increased to about 38% in both 1984 and 1985, but in 1986 the proportion actually dropped to 30%, and only 20% of the 1987 entrants reported cocaine as their primary problem.[9]

Another drug use trend which approached, but did not reach, statistical significance was the extent to which heroin was reported as the subject's "primary drug problem." Overall, 31% of those entering in 1985 and before saw heroin as their primary problem, as compared with 23% of the later entrants. The yearly analyses, however, present a less clear picture. About one in three men who entered pre-1984 or in 1985 claimed heroin as a primary drug problem (about the same proportion reported daily heroin use); in contrast, this proportion was about one in five among both 1984 entrants, and those entering in 1986 and later. The rise in crack, then, appears to be accompanied by slight decreases in cocaine and heroin use (see Figure 4-C); while we cannot confirm the relationship here, these results suggest the substitution of crack for other drugs among this sample.

None of the overall drug measures (the 0 to 3 frequency-of-use scale, ACQ-D, composite drug severity index) were related to time of entry. However, a dichotomous (yes/no) item on intravenous drug use was significantly associated with the time variable, showing a solid decline from 1983 to 1987. Over half (53%) of those entering in 1983 or earlier reported intravenous use in the period prior to incarceration; this figure decreased by more than half (to 24%) in the 1987 group. From the high in the earliest group, the proportion reporting intravenous use dropped to 47% among 1984 entrants, dropped and then stayed at 38% among 1985 and 1986 entrants, and then decreased considerably to the 24% figure for 1987 entrants. The

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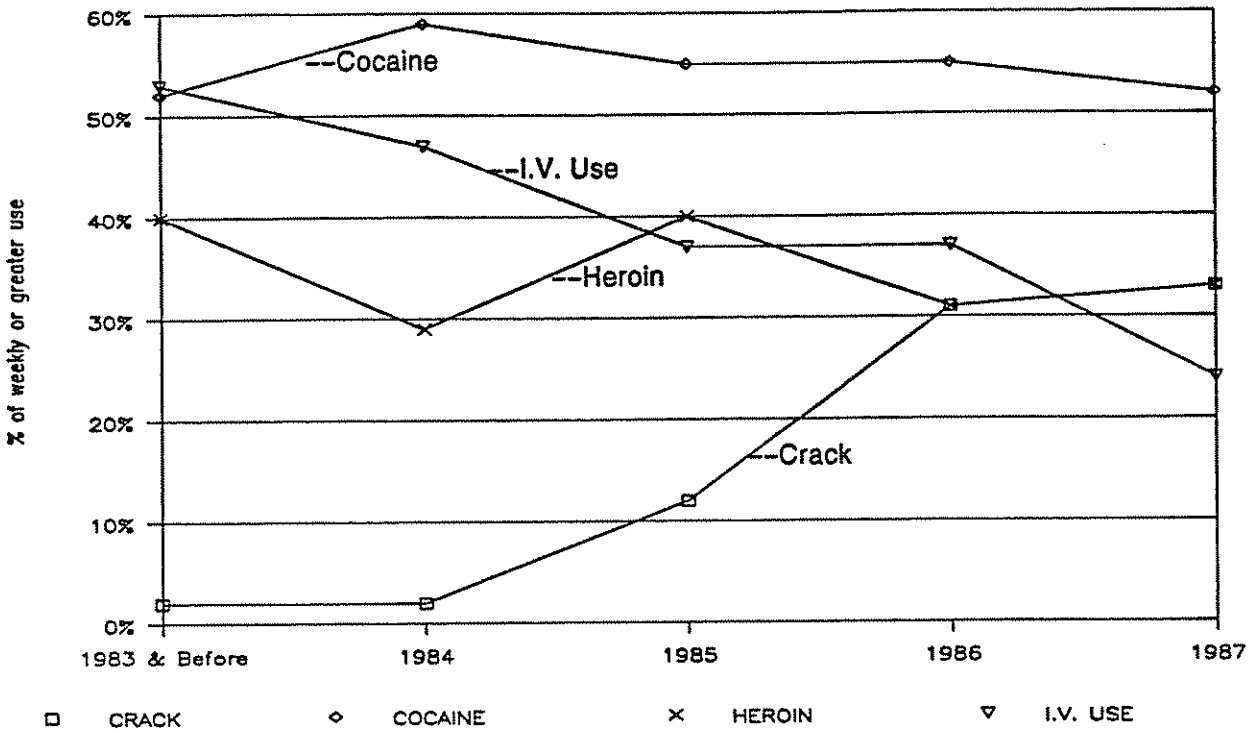
[9] A variation of this apparent trend is evident in the frequency-of-use data on cocaine. Any (at least monthly) use of cocaine clearly increased from pre-1984 to 1984 (64% to 80%), and there was a slight drop in use (75% to 68%) from 1985 to 86/87. The drop in daily use from 1985 (42%) to 86/87 (33%) however, was also accompanied by a rise in weekly use (14% to 21%) during the same period.

FIGURE 4-C: SELF-REPORTED USE OF DRUGS BY YEAR OF INCARCERATION

(Research Sample, N=411)



NOTE: These proportions represent a minimum of weekly drug use; intravenous use, however, is based on those reporting any use.

fear of contracting AIDS through intravenous use, perhaps in concert with the rise in popularity of crack, appears to have had an impact on this sample.

Alcohol Abuse. Measures of alcohol abuse were described briefly above and are discussed fully in the appendix. Scores on the MAST were available from DOCS files for 66% of the sample (272 of 411); the mean for this group was 9.4 (sd=11.2; the median was 6). Over a third (38%) of the subjects scored nine or more, the standard used to qualify a MAST respondent as an alcoholic. On the ADS (available on 410 research subjects), the mean was 5.4 (sd=7.3), and the median was 3. Using the suggested ADS scoring categories, 33% of the men showed no dependence, 55% were in the low dependence group (scores between 1 and 13), and 12% were classified as having moderate to severe dependence.[10]

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[10] As noted in last year's report, the discrepant MAST and ADS results point to the differences in these scales; the MAST is a more global indicator of an alcohol problem, while the ADS more specifically assesses symptoms of alcohol dependence. The relatively low proportion of men scoring in the moderate to severe categories of the ADS suggest that very few men in this sample have yet developed the kinds of physiological symptoms characteristic of advanced stages of alcoholism; rather those who do abuse alcohol are more likely to be psychologically dependent.

Responses to a series of questions about the quantity and frequency of use of different kinds of alcoholic beverages were used to compute a man's consumption of pure ethanol on a typical day, thus compensating for varying alcohol concentrations of different beverages. On average, these men consumed 4.5 ounces per day (sd=7.2); one can consume four ounces of ethanol by drinking about a quart of wine, eight 12-ounce bottles of beer, or nine ounces (roughly six drinks) of liquor. Although the mean was 4.5 ounces per day, half the men (53%) consumed less than two ounces per day. Seventeen percent drank between two and four ounces on an average day, and almost one-third (31%) averaged four or more ounces of pure alcohol per day, equivalent to the wine, beer or liquor quantities noted above. Subjects were also asked about adverse consequences related to their drinking. The average ACQ-A score for these men was 2.1 (sd=2.6).

Similar to the drug composite described above, a composite index of alcohol problem severity was also created for the research sample. Ranging also from 0 (none) to 3 (severe), this scale was based on the ADS, alcohol quantity-frequency (Alc-QF), and the ACQ-A.[11] On this measure, 39% of the subjects were categorized as having a severe alcohol problem; 14% had a moderate problem, 22% a slight problem, and 25% showed no evidence of a problem. As with the drug measures, we assessed relationships between our alcohol measures and the year of entry to incarceration; no relationships were found.

Subjects were also asked about how they viewed their pre-incarceration drinking problem; they were asked to categorize their drinking on a range from no problem (0) to severe problem/alcoholic (5). Half the sample felt they had no problem and about 15% responded with scores of 4 (7%) or 5 (8%). The remaining subjects responded with a 2 (16%) or a 3 (19%). The one-third who responded with a 3 or higher were asked at what age their drinking problem had begun. The average age was 19 (mean=18.8, sd=6.3), with a median of 17.

Poly-Abuse. A measure of poly-abuse was computed from the composite measures of drug and alcohol problem severity. The results of this measure indicated that 15% of the sample had neither a severe drug nor a severe alcohol problem. About a third of the sample (34%) were categorized as having a severe drug problem only, and 8% were considered to have a severe alcohol problem only. Poly-abuse was divided into severe and very severe categories: 18% of the sample

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[11] A subject was given a 3 ("severe") on the composite if he scored 14 or more on the ADS, or 4 or more (average daily ounces) on the Alc-QF, or 4 or more on the ACQ-A. A 2 ("moderate") was given if he scored 7-13 on the ADS, or 3-3.99 on the Alc-QF, or ACQ-A=3; a score of 1 ("slight") was given if he scored 1-6 on the ADS, or 1-2.99 on the Alc-QF, or 1-2 on the ACQ-A. Scores lower than these on all three measures were assigned a 0 on the composite. Subsequent analyses of alcohol problem severity often included a dichotomized variation of this scale–severe (3 on this composite) or non-severe (0-2 on the composite).

fell into the former group, and 25% of the sample were in the most severe poly-abuse category. This measure did not reveal a significant difference between the study groups.

Alcohol, Drugs and Crime. Using DOCS files and subjects' responses during the research interview, data were collected on drug and alcohol use at the time of the instant offense and while committing crime in general. DOCS files provided little evidence of alcohol use at the time of the instant offense, with 7% of the narratives indicating that the subject was using alcohol and an additional 4% using both alcohol and drugs.[12] Similarly, 13% of the DOCS files (or 15% of those with complete narratives) mentioned drug use at the time of the instant offense.

The respondents' own reports of their status provides a rather different picture, however; 41% of the subjects said they had been drinking heavily, and 69% had either used drugs or were in drug withdrawal at the time of the instant offense. In addition, 44% of the subjects indicated they were under the influence of alcohol either sometimes (16%) or frequently (29%) while involved in crime.[13] Over three-quarters of the sample disclosed they used drugs or were in drug withdrawal either sometimes (18%) or frequently (58%) while engaging in criminal activity.

Responses to two additional interview questions shed light on the relationship between drugs and crime. Subjects were asked whether they committed crimes to support a drug habit and to describe the typical connection between drug or alcohol use and crime. Over half the sample (54%) said they had committed crimes to support a drug habit. Nineteen percent acknowledged that they "sometimes" committed crimes to buy drugs, while over one-third said their crimes were motivated by the need for drugs either "most" (12%) or "all of the time" (24%).

About one-quarter (24%) of the subjects revealed having committed crimes for money to buy drugs or alcohol; an additional 9% of the men said they were typically in withdrawal while committing crimes. Nearly one-fifth of the men (19%) indicated that drugs or alcohol made them feel more courageous or made them less inhibited, and 9% said the use of these substances made them feel more aggressive or violent, which led to a crime. A few of the men (4%) committed crimes as part of

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[12] In 10% of the cases the narrative was missing or incomplete, and for those cases, drug or alcohol use remains ambiguous. Thus, of those cases with complete narratives (359 of 401), 8% mentioned alcohol use alone and 4% indicated that both alcohol and drugs were being used at the time of the instant offense.

[13] There was a significant relationship (chi square = 14.1; $p<.001$) between study group status and alcohol use while involved in crime (more comparison group members reported an alcohol-crime connection); this was the only significant relationship found between study group and the alcohol, drugs and crime variables.

a social ritual with friends that included taking drugs or alcohol, and some (8%) took drugs or alcohol to relax after committing crimes. Just under a quarter of the sample (24%) claimed no relationship between their use of alcohol or drugs and their criminal activity.

Summary. This chapter presents results of measures of drug and alcohol use in the year prior to incarceration. The screening sample data were obtained on 678 inmates about to be released from Lincoln's general population; this sample is likely representative of NYC-bound DOCS inmates. On the basis of several self-report measures, we estimated that about two out of three men in this sample had a drug problem, while one out of three had an alcohol problem. About one-fourth of the sample abused both drugs and alcohol; 40% had a drug problem exclusively, and 8% had an alcohol problem only. Overall, 58% were heavy users of drugs--often using cocaine, heroin, crack or a combination of substances on a daily basis. One-fourth of all subjects reported substantial consumption of alcohol on a daily basis. Analyses indicated that the proportion of inmates with drug problems increased about 8% over the period of our data collection. Increases in the proportion of inmates using drugs or alcohol while engaged in criminal activity were even more dramatic; drug use rose from 54% to 71%, while alcohol use went from 28% to 42%.

Compared to the screening sample, more complete drug and alcohol results were available on 110 Lincoln pilot participants and 301 comparison group subjects. While not yet proven, it is thought that these men are representative of city-bound inmates with drug and/or alcohol problems. Initial tests comparing the two study groups revealed that, on the basis of responses to the various self-report measures, the groups were comparable on pre-incarceration drug and alcohol history. This not only suggests that the screening procedure was successful, but also permits us to combine the groups to compile the present drug and alcohol results. In capsule form, these are as follows:

- Ninety-two percent of the men reported using drugs at least once a month, and 68% were classified as having a severe drug problem.

- Fifty-seven percent reported very heavy use of drugs, that is, using a "major" drug such as cocaine, crack, or heroin on a daily or almost daily basis, or using two or more of these drugs weekly; and almost half of these (24% of the entire sample) reported use of *two* or more of these major drugs per day.

- Cocaine was used daily or almost daily by 35% of all subjects, heroin by 26% and crack by 13%. Despite the heavy use of cocaine, 21% identified cocaine as their primary drug problem, while 26% said heroin was the problem, and 13% pointed to crack as their primary problem.

- Crack use more than quadrupled over time, from 8% among subjects who began incarceration in 1985 or earlier, to 33% of those entering in 1986 or 1987. Proportions reporting daily cocaine use went from 28% among the 1983 and earlier entrants, to about 42% among the 1985 entrants, and back down to 33% in the most recent entrants. Daily heroin use showed a similar 10% drop between 1985 entrants and more recent cases. Taken together, these findings suggest crack may be taking the place of cocaine and heroin among some users.

- Proportions of men reporting intravenous drug use also dropped significantly, from a pre-1984 high of 53% to 24% among the 1986-87 entrants.

- Thirty-nine percent of the sample were judged as having severe problems with alcohol. Almost one-third reported consuming an average daily amount of alcohol at least equivalent to a quart of wine, eight bottles of beer or six drinks of liquor.

- Many of these men abused both alcohol and drugs: about one-fifth of the men showed some evidence of poly-abuse, and another 25% were found to have severe problems with both.

- Three-fourths reported some use of drugs, and 44% reported drinking heavily while committing crimes. Over half reported ever committing crimes to support a drug habit, while one-third said their crimes were nearly always motivated by a need to buy drugs.

Chapter Five

Prison Treatment Participation and Drug- and Alcohol-Related Parole Conditions

Although primarily designed to evaluate the effectiveness of the pilot CPU and Access programs, the research was also planned to provide State policymakers with information not previously available, such as the findings on pre-incarceration drug and alcohol use presented in the previous chapter. This chapter addresses two other distinct areas of interest – inmate participation in DOCS drug and alcohol programs, and the setting of drug- and alcohol-related conditions by State Parole Boards. In both cases, data obtained from inmate files and Vera intake interviews were used to construct a descriptive account of the options available (types of programs and conditions set), the distribution of these options among inmates, and in the case of the treatment programs, how inmates judge their effectiveness.

Our examination of prison treatment and parole conditions was taken a step further. Studies have consistently found that drug and alcohol abuse history is the best predictor of future abuse; that is, individuals with the most severe histories are most prone to relapse, while those with more moderate histories of abuse are most likely to recover, and, in many cases, recover without treatment. With this principle in mind, further analyses were conducted to assess whether inmates most in need of treatment (based on our measures of abuse history) were "matched" to prison treatment, and to parole mandates that encouraged post-release program participation.

ATTENDANCE IN PRISON TREATMENT

Information on the subjects' participation in alcohol and drug treatment during the current incarceration was obtained from interviews and reviews of individual DOCS files. Data from the screening sample and the comparison group are of particular interest, because both these samples are likely representative of a large population of state inmates. Screening sample subjects are likely typical of all inmates returning to the NYC area; the comparison subjects, selected for the study on the basis of the severity of their drug/alcohol problem, are likely typical of city-bound DOCS inmates with histories of drug or alcohol abuse.

Virtually all DOCS facilities offer some type of drug or alcohol program. It is not surprising, then, that three out of four (74%) of the 678 men we screened reported attending some kind of in-prison treatment. Of those who participated in

one or more programs, the median time spent in treatment was about four months.[1] Compared with the entire screening sample, a slightly greater proportion of comparison group subjects attended one or more programs (79%), and their attendance was typically for longer periods (the median was six months). Pilot subjects, all of whom had attended in-prison treatment, spent a median of eight months in these programs, excluding their time in the Lincoln CPU.

With the more complete information collected on subjects selected for the research, we were able to determine how many in the comparison and pilot groups successfully completed in-prison treatment. With a criterion of 12 or more weeks of program attendance coupled with successful termination, 61% (184 of 301) of the comparison group satisfactorily completed some kind of drug or alcohol treatment program.[2] Virtually all the pilot subjects met this criterion since it was part of the eligibility criteria for Lincoln CPU participation.

When comparison group men who didn't attend any program were asked why they didn't go, the most common response, given by 44%, was that help wasn't needed -- that they had no drug or alcohol problem. Another quarter of non-attenders said they had been placed on a program waiting list, but had never had the opportunity to participate. Those who did attend were asked why they had participated. Although the most common answer, given by 61% of the men, was the belief that treatment program participation led to earlier release on parole, almost as many (52%) said they went to get help with a drug or alcohol problem (each subject could give more than one reason for participating). About one-quarter said they went initially because of encouragement from correctional staff, and one-fifth traced their motivation to there being no better program option available.

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[1] The median represents the mid-point of the distribution of weeks in treatment, that is, 50% of the sample spent four or more months in treatment, and the other half attended less than four months. On some occasions, the median is a more accurate representation of a group's behaviors or experiences than the group mean (or average). Group means are less representative if the distribution is skewed by a few cases who are very atypical ("outliers"). For example, while the median months in treatment was 4.1, the mean was 6.2 months (standard deviation=5.9); this is greater than the median because eight of the 678 men reported spending two or more *years* in treatment.

A second point to be noted is that weeks in treatment is a cumulative total across all programs attended. Most DOCS inmates are transferred several times during their incarceration, and will attend programs at different institutions. Thus, the four months in treatment reported as the median here does not necessarily refer to four months in a single program.

[2] "Successful termination" can mean formal graduation from a program which confers this status on those who complete, or, for many programs in DOCS facilities, it can simply refer to the absence of an unsuccessful termination. The notion of graduation is inconsistent with the tenets of self-help groups (AA, NA, CA) and many programs aligned with their treatment approach. Therefore, individuals counted as successful completers include many who accumulated 12 or more weeks of attendance in self-help groups in one more facilities over the present incarceration.

Participation in Non-ASAT Programs. In keeping with DOCS' own system of classifying drug and alcohol treatment programs, we distinguished subjects' participation in the Department's ASAT programs from participation in other less formal, inmate- or volunteer-run treatment programs. Most attendance in drug or alcohol treatment by comparison group men was in non-ASAT programs (including self-help groups). Two-thirds of this group (and 35% of the pilot subjects) spent some time in such programs. Using the same criterion described above, just over half of the comparison group (52%) successfully completed non-ASAT programs. These programs are ubiquitous in the DOCS system; the comparison group attended programs located in 38 different correctional facilities.[3]

The most common type of non-ASAT program was those with a drug-abuse treatment orientation; 30% of the comparison group attended these programs. Other non-ASAT programs included AA meetings, attended by 16%; NA groups, attended by 14%; and programs that addressed both drug and alcohol problems, attended by 8%. Participants spent about five months in these programs, and had last attended treatment three months before coming to Lincoln, thus leaving an approximate four-month lag between treatment and release.

Most participants offered favorable assessments of these programs' effectiveness. Using a 1-to-5 rating scale, with 1 being "extremely helpful" and 5 "of no use at all," half of the men gave the highest score to the program's potential for helping them "to stay straight or sober" after release; another 20% judged the program a 2, whereas 9% judged the program a 5. Participants gave similar opinions on the utility of the program in helping them obtain earlier release on parole.

Participation in ASAT Programs. About one-quarter (24%) of the 301 comparison subjects attended an ASAT program during their incarceration; most of these (20% of all comparison group men) completed them. The ASAT programs they attended were located in 16 different institutions (the greatest number attending any one program was eight, at each of the Woodbourne, Greene, Hudson and Otisville ASATs). Twenty-one of the 73 ASAT participants had attended one of DOCS's "residential" ASATs (at Greene, Mt. McGregor, Tappan or Collins). Similar to the less formal programs described above, the median length of ASAT participation was five months, and the median time period between last attending the program and coming to Lincoln was about three months.

More detailed analyses of ASATs revealed that the mean number of weekly activities reported by residential ASAT participants was about nine. Group counseling sessions and meetings directed at drug and alcohol education accounted for

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[3] Most of these 38 programs had been attended by five or fewer men in the comparison group. Programs in the following facilities were attended by ten or more comparison subjects: Fishkill (20 men); Washington (13); Mid-Orange (12); Watertown (11); Groveland (10); and Greene (10).

over half of these activities; on a weekly basis these men averaged 3.4 group sessions and 2.8 educational meetings. The next most common activity was attendance in AA, NA or CA meetings; residential participants averaged just under one meeting of each type per week. In contrast, they only averaged from one to two individual counseling sessions during their entire stay in the program.

Graduates of non-residential ("modular" or "drop-in") ASATs reported attending about half the number of activities reported by men in residential programs (a mean of 4.7 weekly). Again, group counseling (mean=1.8 weekly) and educational meetings and seminars (mean=1.4 weekly) were the predominant activities. In these programs, the men averaged under one AA and NA/CA weekly meetings (.68 and .35, respectively); individual counseling sessions were similarly rare.

Because the comparison and pilot group ASAT participants did not differ (on the basis of statistical tests) with regard to their judgments about program effectiveness, we can report these results for this combined sample (N=179). Using the same 1-to-5 scale noted earlier, ASAT participants rated their programs slightly higher than those in non-ASATs; 61% of the participants (vs. 50% in non-ASAT programs) judged the program "extremely helpful," and a similar number, 17%, rated the program a 2. As was the case with the non-ASAT attenders, only 8% offered a 5 response. Similarly positive ratings were given in response to specific questions about the quality of the ASAT staff in terms of getting the inmate "really involved in the program," and "understanding [his] problems." The staff's ability to "educate about alcohol and drugs," and to "stimulate communication among inmates" in meetings and groups elicited even more positive ratings. In both these categories, about 70% judged the staff "very good" (a 1) and less than 15% offered neutral to negative evaluations.

Matching Inmates to Treatment: Who Attends Which In-prison Program?

Information on in-prison treatment participation was linked to data on pre-incarceration drug and alcohol history to assess several research questions: Are individuals with the most severe drug and alcohol histories more likely than those with less severe problems to attend programs, and thus get the treatment they need? Are those with severe problems more likely to be targeted to the more intensive and professionally-run ASAT programs? Once in programs, are the severe cases more likely to complete programs? Finally, are the ASATs better at graduating men with more severe abuse histories?

Data available from screening interviews (N=678) indicate that four out of five men (81%) who met Vera researchers' criteria for having a recent drug or alcohol problem attended a treatment program during the present incarceration; a smaller, but still sizable, proportion (54%) of those who did not meet these criteria also attended programs. The more detailed data obtained from the comparison group (N=301) revealed the same pattern with regard to drug problems. Overall,

men with more severe drug abuse histories were more likely to attend treatment during the present incarceration than those with less severe drug histories. However, although this relationship (between drug abuse severity and prison treatment attendance) was statistically significant, its magnitude was modest. Eighty-three percent of those with severe drug problems had attended some kind of substance abuse treatment; 70% of those with less severe drug problems had also done so. No attendance difference was observed for those with alcohol problems; 83% of those in the most severe categories went to a program -- as did 77% of those without a severe alcohol problem. These results are summarized in Table 5-A.

Further analyses revealed that abuse severity was related to attendance of non-ASAT programs, but bore no relationship to ASAT attendance. Almost three-fourths of the most severe drug abusers attended a non-ASAT program, compared with 58% of those in low severity categories. This difference was not evident in ASAT programs, where about one-fourth of those in both the low and high severity groups attended. Again, alcohol problem severity was unrelated to attendance in either non-ASAT or ASAT programs.

TABLE 5-A: PARTICIPATION IN PRISON DRUG AND ALCOHOL PROGRAMS BY PROBLEM SEVERITY

(in percents)

	DRUG PROBLEM		ALCOHOL PROBLEM	
PROGRAM STATUS AND TYPE	Severe (N=204)	Non-Severe (N=97)	Severe (N=123)	Non-Severe (N=178)
PARTICIPATION				
NONE	17	30	17	23
ASAT	25	22	24	25
NON-ASAT	72	58	72	65
ANY PROGRAM	83	70	83	77
COMPLETION				
NONE	35	43	34	40
ASAT	21	18	20	20
NON-ASAT	54	47	55	49
ANY PROGRAM	65	57	66	60

NOTE: Some inmates participated in and completed both ASAT and non-ASAT programs, thus the "any programs" percents are less than the sum of the ASAT and non-ASAT percents.

Completion of prison treatment programs was also found to be unrelated to pre-incarceration abuse severity; this held true for both non-ASAT and ASAT programs. Of those without severe problems, about 48% completed non-ASAT programs, while 19% completed ASATs. These completion rates were no different for inmates with severe problems; in this group, 54% completed a non-ASAT, and 21% completed an ASAT program.

Summary and Conclusions. Taken together, these results demonstrate mixed success; inmates most in need of treatment attend programs in prison more frequently than those not in need. On the other hand, the matching of inmates to treatment could be much improved. We don't think this will come as a surprise to DOCS officials; rather than trying to tailor programs or screen inmates for participation, most recently the Department has focused on expanding ASAT programs to all facilities and on enhancing extant programs. This seems an appropriate policy direction, particularly given that inmates in need of treatment permeate the entire system, as our results confirm.

The present results point to a possible next step. Allocating ASAT resources could be done more efficiently if treatment need was routinely identified, and then used to select inmates for participation. It is notable that non-ASAT programs appeared to be more efficient in serving those in need -- the findings suggest that abuse history is related to attendance in these programs, but not ASAT attendance. One explanation for this could be that ASATs are both less available and more attractive to inmates. While those less in need might stay away from a non-ASAT program, the (at least perceived) higher quality of ASATs may generate more interest, regardless of need; relative to less formal, inmate- and volunteer-sponsored programs, ASATs tend to have a "high profile" in facilities where they are available, and virtually always have waiting lists. Given this demand, DOCS could afford to better tailor the supply to those who most need it.

Improvements in administration of the MAST at inmate classification and in documentation of treatment need represent progress here. We hope to work more closely with DOCS officials over the next year to investigate other means of improving this system, particularly with regard to drug history assessment and systematic screening and selection of candidates for ASAT programs.[4]

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[4] As a springboard for that collaboration, we spent a day at the Downstate Correctional Facility in Beacon this past December. Downstate's role as the classification point for all inmates entering DOCS' system from the NY metropolitan area makes it the place to begin sorting out drug and alcohol treatment needs among state prisoners. Downstate's present classification scheme is focused, understandably, on inmate characteristics (such as mental health status) that have a direct bearing on security. While it remains to be seen if drug and alcohol assessment can or should be raised to the level of attention and discrimination presently afforded security variables, Downstate potentially offers the apparatus necessary to examine prisoners' abuse histories and bring differential evaluations of their treatment needs more prominently into the facility placement decision.

DRUG- AND ALCOHOL-RELATED CONDITIONS OF PAROLE

As noted in our last interim report, parole boards in New York State use a broad range of conditions in their attempts to curb parolees' continued abuse of drugs and alcohol after release. Those preliminary results indicated that these attempts are, at least in part, successful: Relative to the comparison group as a whole, comparison parolees with treatment conditions were almost twice as likely to be attending programs at the two-month follow-up point.[5]

In addition to describing the frequency with which particular types of board conditions were set for the study sample, we explored the numerous combinations of conditions set for men in the research, and the link between the conditions chosen and our measures of pre-incarceration abuse severity. Again, because comparison group results are most likely representative of NYC-bound inmates with drug or alcohol problems, we first discuss findings for this group. The end of this section delineates differences between the comparison and pilot groups.

Though it is evident that parole board members vary considerably in their terminology and choice of conditions, the majority of mandates specify treatment for either a drug or alcohol problem, and/or "drug testing" (urinalysis) for those seen as having drug problems, and/or "alcohol abstinence," for those with alcohol problems. Notable exceptions to this drug-alcohol dichotomy are use by some board members of the term "substance abuse" in specifying a treatment mandate and, additionally, the application of both drug- and alcohol-related conditions in a single case.[6]

One quarter of the men in the comparison group had no conditions relating to drug, alcohol or poly-abuse. More than half of the remainder (about 40% of the total sample) had exclusively drug-related conditions; about half of these (20% of the sample) had two or three conditions. Most commonly, multiple drug conditions included a mandate to attend treatment and a requirement for drug testing (urinalysis). Considerably fewer men (12%) were given conditions exclusively dealing with alcohol, but almost all of these received multiple conditions. This reflects parole boards' tendencies to couple alcohol abstinence with a mandate for AA attendance

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[5] At that time, 19% of comparison group subjects reported participating in treatment at the two-month point; among those with treatment conditions, 34% were participating. The attendance rate rose to 55% for those with FPOs who had followed up on treatment conditions by making program referrals. Similar findings are evident in the larger, updated sample analyzed in the next chapter.

[6] For subsequent analyses the study sample was divided into four mutually exclusive groups: men with no drug- or alcohol-related conditions; those exclusively with one or more alcohol-specific conditions; those with only drug-related conditions; and those with conditions relating to poly-abuse (including individuals who had received both drug- and alcohol-related conditions, or the "substance abuse" condition in the absence of another condition that specified a particular problem).

or outpatient treatment. Finally, just under one-quarter of the group were given a poly-abuse condition, including 10% with multiple conditions (typically substance abuse counseling and urinalysis, or both a drug- and alcohol-specific condition).

More specific analyses of these data revealed that 60% of the comparison group received mandates to attend treatment of some kind. The substance-specific breakdowns yielded about the same proportions noted above: 30% specified drug treatment, about one-fifth identified "substance abuse" (or a combination of alcohol and drug) treatment, and 13% specified alcohol treatment. Other drug and alcohol conditions appeared less frequently, and were almost always paired with a treatment condition. Mandates for "drug testing" or urinalysis were set for about one-third of the comparison group. "Drug alert" conditions, which are simply a means for the board to "alert" field parole officers and their superiors to a parolee's drug abuse history, were specified for 22% of the men.[7] A mandate to abstain from alcohol was given to 13% of the men, typically in conjunction with an AA attendance condition.

We were somewhat puzzled by the boards' use of the term "at the parole officer's discretion" in specifying many conditions. Given the high degree of discretion field parole officers already have in enforcing parole conditions, we did not expect to find board members explicitly recognizing and possibly extending that discretion. Specifically, in about one-third of the treatment conditions set for these men, boards added the phrase "at the PO's discretion." Particularly confusing was the addition of this phrase to about 20% of cases specifying the "drug alert" condition.

These comparison group findings were compared to those for the Lincoln pilot group; although the groups were found to be similar on many parole conditions, a few differences did emerge. Perhaps because pilot participants are more salient to the parole boards, a higher proportion of pilot (91%) than comparison group men (76%) were given some drug- or alcohol-related conditions. Similarly, significantly more pilot participants (83%) than comparison men (63%) got treatment-specific conditions.

Even though mandates were more common in the pilot group, we did not expect to find different proportions of each group getting drug, alcohol and poly-abuse conditions; after all, the incidence of problems was equal for both groups (see Chapter Four). However, this was not the case. While equal proportions of pilot and comparison subjects were given alcohol and poly-abuse conditions, significantly more pilot men were given drug-related conditions. Over half (54%)

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[7] To our understanding, a "drug alert" is regarded and recorded by the Division of Parole as a "condition" but does not specify a mandate to the parolee; rather, it is the boards' documented acknowledgement (to the field and senior parole officers) of the parolee's past (and potentially continued) abuse problem.

the pilot group were given mandates to attend drug treatment, compared to 30% of the comparison group, and twice as many pilot men (41% versus 21% of the comparisons) received multiple (two or more) drug-related conditions.

Parole Conditions and Substance Abuse History: How Well Matched? We presume that parole boards' decisions are determined by an assessment of the special risks and needs of each individual. Because an individual's abuse history is generally recognized as the best predictor of whether or not that person's drug or alcohol problem will recur, we expected to find a strong relationship between a parolee's abuse history and the setting of drug- and alcohol-related conditions. We also expected to find that boards would be more likely to set these conditions when there was evidence of the parolee's drug or alcohol abuse during previous commission of crimes. Our data were analyzed to investigate these expected relationships.

It is evident from the results already presented that the overall conditions set by parole boards reflect the abuse history of the research sample: Three-fourths of the comparison group (selected because they were found to have an abuse history) received drug or alcohol-related parole conditions, and 60% were given mandates to attend treatment. Using the abuse severity measures described in Chapter Four, additional analyses addressed whether the boards made further discriminations within this group. In general, those with severe histories were more likely than men with less severe abuse histories to be given some drug- or alcohol-related conditions by the boards and, specifically, to be given treatment mandates.[8]

However, while these results suggest the boards appropriately differentiate among individuals in setting conditions, more detailed statistical analysis suggests this process could be improved. As shown in Table 5-B, for example, while approximately 72% of the men with severe drug histories were given one or more drug/poly-abuse conditions, about 44% of those in the less severe group also got such conditions. Therefore, although men with more severe histories were more likely to get "appropriate" conditions, over one out of four with severe drug problems *did not* get a condition, and a little less than half (44%) of those without severe problems *got* conditions. Similarly, conditions specifically for treatment were not given to 44% of those with severe histories, and were given to 32% in the less severe group.

In addition to analyses using the severity measure, we explored other variables the board may use in setting conditions. These included inmates' histories of drug-related crimes as well as other evidence of drug-crime connections (either self-reports that that they were typically "high" when committing crimes, or documentation in DOCS files to this effect). These analyses revealed a pattern similar to

[8] These relationship were statistically significant in drug-related analyses, but not alcohol-related analyses.

TABLE 5-B: DRUG- AND ALCOHOL-RELATED CONDITIONS BY PROBLEM SEVERITY AND CRIMINAL ACTIVITY

(in percents)

PAROLE BOARD CONDITIONS	DRUG PROBLEM		DRUGS AND CRIME		ALCOHOL PROBLEM		ALCOHOL AND CRIME	
	Severe (N=204)	Non-Severe (N=97)	Yes (N=167)	No (N=134)	Severe (N=123)	Non-Severe (N=178)	Yes (N=80)	No (N=221)
ANY DRUG OR POLY-ABUSE CONDITION	72	44	72	52	---	---	---	---
ANY ALCOHOL OR POLY-ABUSE CONDITION	---	---	---	---	42	31	46	32
DRUG OR POLY-ABUSE TREATMENT CONDITION	56	32	56	38	---	---	---	---
ALCOHOL OR POLY-ABUSE TREATMENT CONDITION	---	---	---	---	39	26	43	27

NOTE: The "Drugs and Crime" and "Alcohol and Crime" columns represent proportions of subjects indicating they were frequently under the influence of drugs or alcohol (or in withdrawal) while committing crimes.

the severity results. About three-fourths of those with a drug-crime history were given drug/poly-abuse conditions, as were about half of those without this history.

Examination of alcohol history variables and alcohol and poly-abuse conditions uncovered some notable contrasts to the drug-related results presented above. In general, alcohol history appeared to be of less significance -- analyses suggest no relationship between alcohol history and whether alcohol or poly-abuse conditions were set (see Table 5-B). For example, 42% of the men with severe alcohol problems were given alcohol or poly-abuse conditions, compared to 72% of those with severe drug problems who were given drug or poly-abuse conditions.[9] Moreover, men without severe alcohol histories were almost as likely as those with severe alcohol histories to get alcohol or poly-abuse conditions (31% in the non-severe as compared

[9] An exception occurred when there was evidence of drinking at the time of the instant offense. A significantly greater proportion (20%) of those reporting this alcohol-crime connection were given conditions, compared to those who did not report this connection.

to 42% in the severe group). This suggests boards may not be able to distinguish successfully between men most in need of alcohol or poly-abuse treatment and those who are less in need (at least as indicated by their abuse histories). This may reflect the greater salience of drug histories in the eyes of board members. For example, when a man with a severe alcohol problem also has a severe drug problem (as is the case for about 75% of those subjects with severe alcohol problems), the man is much more likely to be given a drug-related condition by the parole board.

Summary and Conclusions. Initial interpretation of these results leads to conclusions similar to those we drew earlier in discussing the match between abuse severity and participation in prison treatment programs. The overall picture suggests that "appropriate" matching is occurring, as individuals with the greatest need for treatment and who pose the highest risk of relapse are typically assigned drug-related conditions. However, between 20% and 30% of those given these conditions show a less obvious need for them based on their abuse history. Furthermore, 44% of those with evident need – those judged as having severe drug problems -- did not get a treatment condition of any kind.

Several possibilities for improvement deserve further investigation. Paralleling potential advances in the allocation of prison treatment, a better means of identifying parolees' need for treatment -- and assuring parole boards' acceptance of that identification -- should be part of the solution. Over the next year we hope to examine with Parole possible steps in this direction. For example, institutional parole officers routinely prepare reports for board hearings and make recommendations for conditions; comparing a sample of these reports with conditions actually set by the board reviewing the report would indicate if attention should be focused on more appropriate recommendations or on increasing boards' conformity with recommended conditions. Our preliminary findings already affirm the importance of parole conditions on post-release treatment participation; a superior method of matching board mandates to parolees' needs should not only make the difficult tasks of Parole Board members and parole officers easier, but it may also contribute to reductions in both relapse and criminal recidivism.

Chapter Six

Preliminary Follow-Up Results

The results presented in this chapter include outcomes on a selected set of measures indicative of post-release success or failure: re-arrests and violations; post-release drug and alcohol use; and participation in community-based treatment. Where appropriate, results for the combined comparison and pilot groups are presented for descriptive purposes; in all analyses, the two study groups are then compared on these outcomes.

The present results are based upon two-month follow-up interviews with subjects and their supervising field parole officers (FPOs). The data consist of all interviews completed through early August, 1988.[1] Almost 80% of the comparison sample (237 of 300+) and about half of the pilot sample (72 of 150+) are included in these analyses, in data obtained either through face-to-face parolee interviews, or through telephone interviews with their field parole officers. In most cases, both the parolee and FPO were interviewed; however, in one-third of the cases only the FPO participated, and in rare cases (<4%) the parolee was interviewed but not the FPO. No follow-up interview (with either the parolee or FPO) was conducted for six percent of the sample cases who had reached the two-month follow-up point. Most of these men had moved out of the New York City area and were no longer under local parole supervision; a few had indicated their unwillingness to continue in the research.

As noted earlier, the content of the parolee and FPO interviews overlaps considerably. Although time constraints did not allow a systematic analyses of parolee-FPO response discrepancies in this interim report, the present narrative includes non-statistical comparisons where appropriate. The possibility of "response bias" raises an additional caution in interpreting these initial results. While the participation of 68% of the parolees eligible for the two-month inteview represents a very good response rate for this type of population, we have not yet analyzed what non-random differences exist between the parolees who chose to participate in the follow-up interview and the one-third who did not. Examination of this

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[1] Most of the subjects not included in these analyses had not reached the two-month post-release point (the last comparison subjects reached this point near the end of the 1988 calender year, and the last pilot subjects won't reach this point until May, 1989). As noted previously, time constraints in the processing of interview data necessitate limiting these interim analyses to the two-month rather than the six-month follow-up period. In addition, over half of the subjects in the study had not reached the six-month post-release point by the time the data were analyzed.

issue is planned for the final report; until then, the post-release findings reported here must be regarded as preliminary.

Finally, it should be noted that the "two-month" interviews were conducted anywhere from 7 to 14 weeks post-release. Although all interviews were scheduled for exactly eight weeks after the subject's release, the actual interview date varied, averaging about ten weeks after release (mean number of weeks since release for parolee interviews was 9.9; mean weeks since release for FPO interviews was 10.2). Therefore, while we continue to use the "two-month" phrase in discussing these post-release outcomes, the results reflect a variable time period, most typically between 8 and 11 weeks post-release.

Post-release Status and Self-reported Criminal Behavior. Overall, 17% (51 of 309) of the men had been either arrested for a new alleged offense or otherwise violated by Parole at the two-month point.[2] The study groups differed slightly (non-significantly) with regard to these outcomes -- 13% of the pilot group were arrested or violated, as compared with 19% of the comparison group. For both groups, about one-third of these arrests or violations were described by the FPO as drug-related.

We also asked the parolees and their field officers about any crimes the parolee committed since his release for which he had not been arrested. Of the 83% of all subjects who were not arrested or violated, 9% said they had committed one or more crimes, and 4% reported committing nine or more crimes since release. The slight, non-significant difference between the study groups held also for the self-report data; 7% of the pilot group who hadn't been arrested or violated reported committing crimes since release, compared with 13% of comparison subjects. When we asked the parole officers the same question, 3% suspected the parolees under their supervision had committed crimes for which they had not been arrested or violated; study group differences could not be assessed on the FPO responses, given these small numbers.

Self-reported Drug and Alcohol Use. Most measures used at research intake to assess pre-incarceration substance abuse were also used to assess post-release abuse in the follow-up interviews (see Chapter Four and Appendix B). Men were asked about their frequency of use of several commonly-used drugs, and about the adverse consequences they experienced from drug use (such as job loss or fights with family or friends). To estimate the prevalence of post-release drug problems in

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[2] For purposes of these results, a man was considered to be a parole "violator" if the supervising FPO was in the process of a violation proceeding; just as all arrests do not result in convictions, it is always possible the parolee will not be "convicted" of the violation. In addition to the FPO/parolee-reported results presented here, we are obtaining official post-release arrest record data ("rap sheets") on all subjects through 12 months post-release. These data will be assessed in our final report.

this sample, the frequency-of-drug-use and problems-due-to-drug-use measures were combined into a single severity index. Of the 209 men in both groups responding at the two-month point, 13% of the subjects fell into the most severe category, and 8% into the moderate problem group.

On the basis of the frequency scale alone, 40% of these men reported any use of drugs during this post-release period. Eleven percent scored as heavy users (a 3) on our frequency measure, indicating that they reported daily or near daily use of a "major" drug (cocaine, crack, or heroin), or at least weekly use of two or more of these substances. Cocaine use (not including crack) was reported by 16% of the men; 7% said they were using cocaine daily, and 5% one to two times a week. Eight percent reported any heroin use, with half of these using at least weekly. Three precent said they had tried crack, but none reported using it weekly or more. About one-third of the men reported use of marijuana since release, with 13% reporting use once or twice a week, and 10% reporting daily or almost daily use. Less than 2% of the subjects disclosed use of any other drug. Six percent of the men reported intravenous drug use since release.

When asked to estimate the extent of their parolee's drug use, about 40% of the FPOs claimed they had too little information to provide a reliable estimate. Those FPOs who felt they could judge the parolee's drug use offered assessments similar to parolee self-reports; overall, FPO estimates were about two to three percentage points below those reported by the parolees. The notable exception was crack use; whereas 7% of the FPOs said their parolees were using this drug at least daily, none of the subjects reported daily crack use and only 3% reported any use. We also asked parolees to assess the extent of their own post-release drug problem. Fourteen percent acknowledged an ongoing drug problem; cocaine was cited most frequently (6%) as a "primary problem," followed by crack (3%) and heroin (3%).

As described previously, the alcohol indices included the Alcohol Dependence Scale (ADS), a quantity/frequency measure of alcohol use (AQF), and an adverse consequences of alcohol scale (ACQ-A). As was done with the intake data, a composite index of alcohol problem severity was created from these measures for the two-month post-release period. On this composite scale, 6% of the men evidenced a severe problem (with the highest possible score of 3), and 8% were in the next "moderate problem" group, with scores of 2. Although almost half of the parole officers said they could not judge their parolee's pattern of alcohol use, the results from those that did respond followed the pattern observed in the previous drug analysis. Overall, FPOs offered slightly lower estimates of use: 9% said their parolees were drinking "very heavily" or with some loss of control (compared to the 14% who fell in the moderate and severe groups based on parolee reports).

Although *not* statistically significant, a consistent pattern of differences between the study groups emerged, with the pilot group reporting less severe levels

of abuse on both individual and composite measures of abuse. With respect to post-release drug-use frequency, 12% of the comparison men and 7% of the pilot group fell into the heavy user category. Similar proportions were found on the composite measure of drug problem severity. In addition to these "objective" measures, we asked each parolee to categorize his use of drugs since release. Again, 17% of the comparison group viewed their drug use as a problem, but 7% of the pilot group said this was the case.

On the alcohol quantity/frequency measure, 7% of the comparison group reported average daily consumption equivalent to two or more ounces of pure alcohol (e.g., four bottles of beer, half a bottle of wine, or three drinks of liquor), as compared with 2% of the pilot men. Similarly, on the alcohol composite, 15% of the comparison group were classified in the moderate or severe problem categories compared to 9% of the pilots. Finally, when asked to assess their drinking patterns, 19% of the comparison group described it as heavy or problem drinking, while 11% of the pilot group gave this description.[3]

However, these small but consistent differences between the two study groups in parolees' responses were not evident in FPO interviews. While two out of five FPOs could not estimate their parolee's drug use, and half couldn't judge alcohol use, according to those who did respond, the pilot group did not fare better on either the drug or alcohol composites developed from FPO estimates.

Post-Release Drug and Alcohol Treatment Participation. Interviews with comparison group parolees indicated that 41% (65 of 164) had been referred to a specific drug or alcohol treatment program (including self-help groups like NA, CA and AA) after their release.[4] Most of these (47 of 164, representing 28% of the entire comparison sample) were to drug treatment programs. Five men (3% of the comparison group) were also referred to a second drug program during the two-month period, and one was referred to three different drug programs. About 62% of the drug program referrals were to outpatient drug-free programs, and another 19% were to NA or CA groups. Eleven percent said they were referred to a residential program (typically TCs), and the remainder reported a referral to methadone maintenance, drug detoxification, or some other drug treatment program.

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[3] The discrepancy between average daily alcohol consumption (overall, about 6% report two or more ounces) and these self-assessments (17% describe their drinking as heavy or problem drinking) is not readily explained. One possibility is that many of the men who report heavy or problem drinking are "binge drinkers;" in their self-descriptions they could be focusing on the loss of control associated with these binges, but because the binges are infrequent (e.g., once weekly), average daily consumption would still not be very high.

[4] We counted a referral as occurring only if the respondent could be specific about it (e.g., name the program and its location). An ambiguous reference, such as "yes, I'm planning to get myself in a program," or the FPO saying "you should go find yourself a treatment program" (with no follow-up by the parolee or FPO) was not counted as a referral.

A total of 21 men (13% of the comparison group) had received an alcohol treatment referral; none of them said they'd been referred to two or more programs. More than four out of five of these referrals were to AA. Three men had been given referrals to outpatient treatment, while one man reported an inpatient alcohol treatment referral.

The majority (60%) of these post-release drug and alcohol treatment referrals came from the subjects' field parole officers. Fifteen percent of the drug referrals were reported to come from the parolee himself (although many of these self-referrals occur after considerable encouragement by the FPO). Self-referrals accounted for considerably more (30%) of the alcohol referrals. Equally small proportions of drug and alcohol referrals came from other sources, such as family, friends and personnel in other types of programs.

In addition, Access counselors in Parole district offices were responsible for five of the drug treatment referrals (and no alcohol program referrals). These referrals, which would have occurred via an initial referral to field Access from the man's field PO, accounted for 11% of all comparison group drug referrals made over the two-month follow-up period. This figure is an important indicator of Access' degree of impact on the general parolee population during this period. It should be kept in mind that field Access was not operating during much of the period covered by these data (as summarized in our earlier reports); it will be important to compare this result with those obtained after Access' expansion in late 1988.

Of the 47 comparison group men referred to drug programs, over half (25, or 53%) reported regular attendance in a program at the time of the follow-up interview. These 25 men comprise 15% of all comparison group parolees interviewed at the two-month point. Three others (6% of those referred) reported irregular program attendance. About one-fifth of those referred reported never following up the referral, or dropping out after a single visit to the program. Another five men were pending placement in a program (had intake appointments scheduled or were on a waiting list), and four said they had been denied admission to the program to which they had been referred. A total of 28 men reported two or more weeks of attendance in drug programs; 17 attended from two to seven weeks, and 11 reported eight or more weeks in attendance, indicating steady participation since release.

Further analyses examined the relationship between these outcomes and type or modality of treatment. These results are presented for descriptive purposes only because the numbers are too small to represent stable findings. The outcomes of outpatient referrals parallel total referral outcomes for all types: about half the men with outpatient referrals report attendance, and one-quarter reported no follow-up or dropping out. All but one of the men pending placement were waiting to attend outpatient programs. Of all the treatment modalities, NA and CA were associated with the highest proportion of favorable outcomes; of the ten men with NA/CA

referrals, six said they were regularly going to meetings, and two reported irregular attendance.[5] One of the five men with residential drug referrals was in treatment; three men never followed up on the residential referral, and one was denied admission for lack of space.

The self-reported outcomes of alcohol treatment referrals were similar to the drug program results, but the proportion of men reporting attendance in these programs at the two-month point was slightly higher. Twelve of the 21 men referred to alcohol programs reported regular attendance; while these participants account for 57% of those referred, they represent only 7% of the entire comparison group. Paralleling the drug referrals, a few men (2 of 21) reported irregular attendance, about one-fourth "did not show" for the program or dropped out, one man was pending placement, and another was denied admission to a program. Overall, six men said they had attended alcohol programs for two to seven weeks, and eight said they'd been attending for eight weeks or more since release. Because 17 of the 21 alcohol referrals were to a single "modality" (AA groups), the numbers in other program types were too small to investigate outcome differences based on modality.

Vera researchers also asked supervising field parole officers about their parolees' referrals to and participation in post-release drug and alcohol treatment. Viewed in the aggregate, FPO accounts were consistent with the results reported by parolees, particularly with regard to reports on referral outcome. Of the 225 FPOs interviewed who supervised comparison group subjects, 55 reported their parolee had had one or more drug treatment referrals. This represents 24% of the entire study group; the comparable figure for parolee self-reports was 28%. According to the FPOs, 25 men (11%) had received alcohol treatment referrals (versus 13% reported by parolees).

The FPO and parolee results on treatment outcome were even more consistent. Of the total drug program referrals, 53% of the FPOs reported regular attendance in the program at the time of the interview, and 9% reported irregular attendance (the comparable figures from the parolee reports were 53% and 6%, respectively). FPOs reported "no shows" and program drop-outs for 23% of the drug referrals (22% according to the parolees), and 12% of the men were pending placement in a drug program (10% reported by parolees). Only 3% of the FPOs said the parolee had been denied admission to a program; 8% of the parolees reported this outcome.

Overall, FPO accounts of alcohol treatment outcomes were also quite similar to the parolee reports. Just over half (52%) said the parolee was regularly attending,

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[5] Because of the explicitly "anonymous" nature of these self-help groups, self-reported participation in them is difficult to confirm. According to Parole officials, this explains (in part) the relative popularity of these programs among parolees, as well as the reluctance of Access and many FPOs to make referrals to them; this should be kept in mind in interpreting parolee self-reports.

and 12% reported irregular attendance in alcohol programs (as compared with 57% and 10%, respectively, for parolees). Twenty percent of the FPOs (compared with 24% of the parolees) reported no referral follow-up or early drop-out from the program. As was the case in the parolee results, small proportions were said to be pending placement or denied admission.[6]

Post-Release Treatment Participation in the Pilot Group. As expected, almost all (42 of 45) pilot men interviewed at the two-month point reported one or more referrals to treatment. Approximately three-quarters of them reported drug treatment referrals, while the remaining were referred to alcohol programs (a few men reported both an alcohol and drug program referral). In addition to the initial referrals made at release, pilot men were more likely than comparisons to report subsequent program referrals. Five of the 33 men referred to drug programs (11% of the entire pilot group as compared with 3% of the comparison group) reported an additional referral and one pilot subject reported three subsequent referrals. Second referrals to alcoholism treatment programs were reported by six men, and one man reported four referrals (no comparison subjects reported any re-referrals to alcoholism treatment). These men represent more than half of all those (7 of 13) with alcohol referrals; most of these additional referrals were to AA, and followed an Access outpatient program referral.

Although the two study groups differed significantly as far as the number of referrals received, once referred, pilot participants were no more likely than comparisons to be enrolled in drug or alcohol programs at the two-month follow-up

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[6] The FPO results presented in this section summarize findings from the 225 parole officer interviews with comparison group cases. Thus, they are derived from a larger, and somewhat different sample than the parolee results (based on 211 face-to-face parolee interviews). To further assess consistency, we examined post-release treatment participation results of the 197 interviews that "overlapped," i.e., where both the FPO and parolee interview was done. All subjects for whom both interviews had been conducted were used in this analysis, without regard to study group.

As expected, more discrepancies were evident when the FPO and parolee results were compared on a case-by-case basis. On the drug referrals, there was agreement on 174 of the 197 cases (88%), including 127 instances where both the parolee and FPO reported no referrals. Of the 77 cases where one or more referrals were reported by either the parolee or FPO, the number of referrals matched in 47 (61%) instances. There were ten cases where the parolee reported a referral and the FPO reported none, and three cases of a FPO-reported referral and none by the parolee. In ten other instances, the FPO and parolee reported a different number of referrals (almost all of which were a discrepancy between one and two referrals).

FPO and parolee accounts of program attendance were also compared for the 197 cases where both interviews had been conducted. There were 52 instances of drug program attendance reported in one or both of these interviews. In 39 (75%) of these cases, the FPO and parolee both reported the man was attending at the time of the interview. In seven cases the parole officer reported attendance while the parolee did not, and in the six remaining instances, the parolee said he was attending and the FPO did not. Although these numbers are too small for conclusive interpretation, they suggest that there is no consistent bias in either the FPO or parolee reports, and that they are equally valid sources for these results.

point. About half the pilot group referred to drug programs (17 of 33, or 52%) reported regular attendance at the time of the interview, a figure nearly identical to the 53% reported for the comparison group. Another four pilot men (12%) reported irregular attendance (compared with 6% in the comparison group). As with the comparison men, about one-fourth of the pilot group reported no follow-up or early drop-out from the program.

When only men with referrals are considered, then, similar proportions of pilot and comparison men report regular participation in a drug program at the two-month point. However, the referral differences are critical. Almost three-fourths of the comparison group had received no drug referral; thus the 25 men in this group who were attending programs represent only 15% of the entire group. About two and a half times that number -- 38% (17 of 45) of the pilot group -- reported regular attendance in a drug program. This same (statistically significant) study group difference is further reflected in the length of post-release drug treatment attendance. Twenty-seven percent of the pilot group reported attending drug programs for eight or more weeks since release, compared with 7% of the comparison sample. In all, 53% of the pilot men attended programs for at least two weeks during the post-release period, while this was true for 17% of the comparison subjects.

The alcohol treatment results echoed the drug program findings. While seven pilot men reported regular attendance in alcohol programs (representing 54% of all pilot men who were given an alcohol referral), 57% of the comparison subjects with alcohol referrals reported regular attendance. Nonetheless, although there is no difference between the study groups on these outcomes, pilot participants were significantly more likely than comparison men to be given a referral. Thus, proportionally more pilot men are in treatment: the seven pilot subjects in alcohol treatment account for 16% of this group, in contrast to the 7% of comparison subjects in alcohol programs. Four pilot men (9%) reported eight or more weeks of attendance in these programs since release, as compared with only one (<1%) comparison subject. About one-fourth of the pilot men attended alcohol programs for two weeks or more; 9% of the comparison group attended for at least this long.[7]

Although FPO and pilot group parolee reports of post-release treatment outcomes were generally in agreement, they were somewhat discrepant with regard to total referrals reported. In an earlier section it was noted that almost all pilot men

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[7] An additional analysis of the study groups' aggregated treatment participation results focused on the effects of parole conditions, as well as referrals. Updating an analysis done for last year's report, we found that 28% of the parolees interviewed at the two-month point reported attendance in a drug or alcohol program at the time of the interview. When only men with parole conditions for treatment are considered, this participation rate increases to 41%. Finally, of all men who were referred to a program, 55% report attendance.

reported one or more post-release referrals (approximately 75% with one or more drug treatment referrals, and 25% with alcohol referrals). These figures dropped in the FPO accounts to 63% for drug referrals, and 18% for alcohol referrals. Apparently, about one in five (13 of 70) FPOs supervising pilot participants did not include the Lincoln Access referral in reporting these data to Vera interviewers, or were not aware of the referral.[8]

In comparison to reports of referrals, discrepancies between FPO and parolee accounts of the outcomes of referrals were of a smaller magnitude, and showed no consistent pattern. Forty-seven percent of FPOs said the parolee was regularly attending drug treatment at the time of the interview, in contrast to 51% according to parolees. Compared with parolees, more field officers reported favorable outcomes of alcohol referrals; FPOs said that 8 of 13 (62%) pilot group parolees with alcohol referrals were attending treatment at the two month point, whereas 54% of parolees with alcohol referrals reported attendance.

Pilot Group Treatment Participation: Follow-up Log Results. In addition to recording data from post-release interviews with parolees and FPOs, we have continued to track pilot participants' treatment referrals and outcomes on a follow-up log. Part of the log includes program outcomes according to Access' own case tracking records (made available to us by Access adminstrators). When we compared the logged data (on 101 cases with complete data through mid-January) to both the parolee and FPO interview results presented above, referral information was consistent; Access reports on treatment outcomes, however, were not as consistent with those reported in interviews. Specifically, 26% of the pilot men were attending treatment at 3.5 months post-release according to Access records; this contrasts with the parolee and FPO reports, which indicated that just over 50% were in treatment at the time of the two-month interview.[9]

There are several possible explanations for this discrepancy. The most obvious is that the follow-up period is different -- some program attrition would be expected between the time of the interview (which averaged ten weeks post-release) and the 14-week point used in the log tabulations. In addition, past research suggests that individuals who continue to participate in follow-up studies after

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[8] While we have not had the chance to further investigate this discrepancy, we suspect most of these cases are pilot men who were not given treatment mandates by the parole board, but were given Access referrals. If so, this would be further evidence of the importance of explicit conditions in gaining the attention and cooperation of field officers in treatment enforcement and monitoring.

[9] Follow-up data were recorded on the log for two periods corresponding with the outside limits of our post-release interviews -- from release to 3.5 months, and from 3.5 months to 7.5 months post-release. To compare with the interview results, the present analysis was limited to the 3.5-month log data.

treatment tend to be doing better than those who drop out of studies; thus, our interview results may exaggerate the attendance rate of the entire group because those participating in two-month interviews were more likely to be in treatment than the one-third who didn't participate in the interview. Access (and treatment programs which provide attendance information to Access) may also use a stricter criterion for "regular attendance" than do either the parolees themselves or their FPOs. Other explanations for this discrepancy would be more difficult to confirm; these include the likelihood that parolees and FPOs inaccurately report higher attendance, that Access' follow-up documentation reports lower attendance than is the case, and/or that the treatment providers inaccurately relate attendance information to Access counselors.

We have not yet had the opportunity to investigate this discrepancy further; a case-by-case comparison of log and interview results, assessed at the same post-release date, will be done and should suggest specific reasons for the discrepancy. Until then, however, the interview findings which indicate a 50% attendance rate for individuals with referrals should be viewed as a possible over-estimate. Nonetheless, there is no reason to assume that, even if adjustments are made in these figures to improve their accuracy, there will be a lower rate found for pilot men but not for comparison men. Thus, our central preliminary finding -- that different *rates of referral* for the two groups result in more treatment participation by pilot participants -- would not be affected by this further analysis.

Drug and Alcohol Treatment: Parolee and Parole Officer Perspectives. Each parolee who attended a post-release program was asked to judge the program's effectiveness in terms of "keeping [him] straight or sober." Of the 60 men who felt they could assess the drug program to which they had been referred, 60% gave a positive assessment (1 or 2 on the 1 to 5 scale), while 20% gave negative ratings of the program (4 or 5 on the scale). Respondents willing to judge the effectiveness of alcohol programs were similarly favorable. Half the 30 men rated the program "very helpful" in terms of keeping them "straight and sober," while another one-fourth gave the program the next highest rating (2 on the scale). Six men (20%) gave negative ratings. There were no differences between the pilot and comparison groups on either these drug or alcohol program assessments.

Pilot and comparison subjects did differ, however, in their responses to another set of questions about their own thoughts or suggestions from others about attending treatment since release. Over twice the proportion of pilot men (63%) than comparison men (27%) reported considering drug or alcohol treatment on their own. More pilot participants also said they'd gotten advice and suggestions for treatment from family members since release (33%, as compared to 12% of the comparison group). Few subjects in either group reported encouragement from friends to seek treatment.

We also probed the men's motivations for attending treatment after release. By far the most common response, offered by 62% of the men, was that "it's a condition of my parole." Approximately one-fourth also attributed their attendance to needing help with drinking or drug problems. It is notable that pilot men were no more likely than comparison subjects to offer this latter reason for attending treatment.

Field officers were also asked to assess each of a number of treatment modalities on a 1 to 5 scale (most positive to most negative). Their opinion of the effectiveness of drug and alcohol programs in the State prison system might be characterized as lukewarm; 31% rated these programs a 3 (the midpoint), and 28% a 2.[10] About 15% of the FPOs gave these programs the lowest score, and 12% the highest. Evaluations of the Access program's effectiveness were somewhat more positive. Half of the FPOs gave Access a positive rating (1 or 2), and one-fourth gave it the highest rating; another one-fourth judged Access negatively, with scores of 4 or 5.

Questions on self-help groups (AA, NA and CA) elicited divergent responses from FPOs supervising pilot and comparison men. Apparently indicative of the influence of Access staff (whose policy is to avoid referrals to self-help groups in preference to outpatient programs), over one-fourth (27%) of the comparison group FPOs rated these groups a 1, while 8% of the pilot FPOs gave them the highest rating. In general, the pilot FPOs rated self-help groups in the middle of our scale (85% gave them scores of 2, 3, or 4); 56% of the comparison FPOs gave them these scores.

Effectiveness of and access to community-based treatment programs were addressed in separate questions. The FPOs were quite favorable regarding these programs' effectiveness, with about 40% rating them a 2 and another 18% assigning the highest rating; only 11% gave negative scores to the programs on effectiveness. The question on accessibility of community-based treatment was the only item that yielded a significant difference with respect to drug and alcohol programs. Not surprisingly, negative ratings were more common when drug program accessibility was evaluated; one-fourth of the FPOs rated these programs a 5 on access, and another 17% rated them a 4. In contrast, one-fourth of all FPOs rated alcohol programs a 4 or a 5 on this scale. On the other hand, several FPOs gave positive ratings to drug programs, with scores of 1 (14%) or 2 (27%); on the accessibility of alcohol programs, 23% gave a response of 1, and 35% a response of 2.

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[10] With the exception of their ratings of self-help groups' effectiveness, FPOs supervising comparison and pilot participants did not differ in their judgments; in all but this one case we do not distinguish between the results of the two groups. In addition, for each "modality" (e.g., prison programs, self-help groups, community-based providers) we posed separate questions regarding alcohol and drug programs. With the exception of a question about access to community-based treatment, no significant drug-alcohol differences were observed, so in all but this one case, these responses were aggregated for presentation.

Summary and Conclusions. Results from two-month follow-up interviews[11] with 309 parolees and/or FPOs were presented on three measures of post-release outcome: rearrests and parole violations; drinking and drug use; and drug and alcohol program participation. Seventeen percent of the subjects had been rearrested or violated during this follow-up period; in addition to this group, 9% reported in their interviews that they had committed crimes for which they had not been arrested. No significant difference was found between the pilot group (13% of whom were rearrested or violated) and comparison group (19% rearrested/violated) on these recidivism outcomes.

Forty percent of the men acknowledged some drug use since release; our measures indicated that 13% had already developed a severe drug problem, and 8% a moderate problem. Cocaine use was most common, with 7% reporting daily or almost daily use, and another 5% reporting use once or twice a week. Eight percent reported heroin use (4% using it at least weekly) and 3% had used crack. On a composite scale of alcohol severity, we found that 6% of the men had developed a severe problem and 8% a moderate alcohol problem by the time of their interview. Similar to the recidivism results, the two study groups did not differ significantly on these drug and alcohol measures, although the pilot subjects consistently demonstrated more favorable outcomes.

A significant difference was observed between the groups on post-release participation in drug and alcohol programs. On the basis of reports from parolee interviews, the proportion of pilot men regularly attending treatment at the time of the interview was about two and one-half times the proportion of comparison men in programs. Further analyses suggest this disparity largely reflects differences in referral rates between the two groups. While about two of every five comparison subjects were referred to treatment programs, over nine out of ten (93%) pilot men were referred. Once a referral was made, however, comparison subjects were just as likely as pilot men to follow it up and continue participation.

Through the course of our data collection a question arose as to the actual number of men in attendance at treatment programs at the two-month follow-up point. Overall, 54% of the pilot men reported participation at the time of the interview, as did 22% of the comparison men. Results from FPO interviews were generally consistent with these parolee reports. However, Access case records, tabulated at the 3.5 months post-release, indicated that attendance for the pilot men was half that (26%) reported in our interviews. Further analyses are planned to examine possible explanations for this discrepancy.

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[11] It should be remembered that, although these interviews were scheduled to occur exactly two months post-release, on average they occurred ten weeks post-release, and a few were done as late as fourteen weeks post-release. This was due to problems in contacting FPOs and the fact that many parolees were late in arranging and arriving for interviews at Vera.

Regardless of what the analysis of these discrepant reports shows, they are not likely to obviate the group difference on treatment participation. This is because differences in the two groups' rate of referral appears to account for the overall differences in treatment participation, and these referral rates are not in question. To the extent that these findings are confirmed as additional data are collected and analyzed, they point to the importance of Access as a referral agent, and thus as a major influence on post-release participation in treatment. Our preliminary results indicate that field parole officers can have a similar impact on participation, *if* they make a treatment referral. In this respect, it is notable that while three-fourths of the comparison men had drug- or alcohol-related parole conditions (60% to attend treatment), 41% were actually given referrals. The data suggest parolees are unlikely to attend treatment programs on their own -- they must first be referred.

Appendix A

Serving the Ex-offender: Community-based Treatment Issues

Previous Vera reports have discussed ASAT programming in upstate facilities and all aspects of the Lincoln pilot through the point of release and referral to post-release treatment. To date, however, we have not looked in any detail at the universe of treatment programs to which research subjects are referred. Although we have examined data on the frequency and type of program referrals made for parolees, this quantitative database does not provide detailed information about the characteristics of treatment programs used for these referrals.

To develop a more comprehensive understanding of these programs and the issues surrounding treatment access and retention for study subjects, Vera staff employed a variety of qualitative data collection methods. Most important to the discussion that follows were in-depth interviews at a small number of outpatient treatment programs that project staff conducted in the latter part of 1988 and into 1989. The majority of these were with drug programs and were selected because research subjects had been referred to them with some frequency. To a lesser extent, some of the information we gathered came from site visits made over a year ago during the formation of the Task Force of alcohol treatment providers. In addition, we conducted interviews with Access and other state agency staff who were familiar with local treatment programs.[1] Apart from these various interviews, Vera staff also administered brief questionnaires to a small group of research subjects who had attended treatment programs, examined previously completed interviews with field parole officers to ascertain their sentiment toward local treatment provision, and reviewed research literature on substance-abuse treatment.

Collectively, these efforts focused on a number of issues relevant to the research: the ability of treatment providers to meet the various needs of the criminal justice client; the interaction between program staff and parole officers; the efficacy of outpatient programs in treating multiple drug and alcohol dependencies; the ways in which programs have adapted treatment to the recent crack crisis; and perceived gaps in the service delivery system.

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[1] Over the summer of 1988, Vera staff also gathered basic information about a substantial number (N=33) of local drug treatment programs that serve criminal justice clients; this review focused on program availability (hours, fees, waiting lists), client characteristics and requirements for admission. Although not as specifically focused on programs utilized by Access and research subjects, the results of this survey are incorporated here where relevant.

We came away with a more complete picture of the post-release referral process and the characteristics of community-based treatment used by parolees. Although focused primarily on treatment for parolees, the information gathered also raised more general issues regarding treatment for drug and alcohol abuse in New York City, and illuminated some underlying controversies about how best to approach treatment for the larger criminal justice population. This chapter reviews these various issues.[2]

Referral and Access to Treatment. Despite a range of treatment approaches expressed by community-based programs, we discovered that decisions on referrals are largely dictated by practical considerations. One of the more seasoned clinicians we spoke with said that trying to match individual clients to a particular "treatment philosophy" was, at best, very difficult, and that even if the grounds for such a match could be established, there would be no way to guarantee that space would be available.[3]

The lack of available treatment slots in New York City is a theme that ran throughout our interviews. The preponderance of outpatient referrals for research subjects reflects both this concern with treatment access and a clinical factor cited in several of our interviews. Most practitioners involved in the referral process asserted that parolees just released from prison would strongly resist residential treatment, and that most "deserved the chance" to see if they could succeed in an outpatient program or self-help group. Even more salient, however, is the simple fact that (low-cost) residential drug treatment in New York is virtually inaccessible today due to overcrowding. Access to inpatient alcohol programs is easier, but because most releasees lack medical insurance, acute need has to be demonstrated or long waiting periods are the norm.

Getting into outpatient drug programs can also be problematic. Without exception, each of the ones we spoke with were operating at capacity or over capacity, and a number had waiting lists of varying lengths. It was not surprising, then,

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[2] A brief explanatory note needs to be reiterated: because the vast majority of Lincoln Pilot inmates receive drug referrals, the discussion here focuses on drug treatment issues.

[3] In fact, the research literature throws little light on the efficacy of any approach to matching individual clients to a specific treatment philosophy. Instead, research on programs designed for heroin addicts (Jaffe, 1984; Ludford, 1984) has consistently found little difference in outcome according to treatment modality (methadone maintenance, therapeutic community, outpatient drug.)
These findings are not strictly applicable, of course, to differences between various types of outpatient drug programs or to differences between program modalities for other types of substance abusers. Yet the research does reveal a lack of consensus over which type of program works best for which type of client.

to hear Access counselors (and occasionally IPOs) express excitement over discovering a new program without a waiting list, or even for them to scrupulously keep such information to themselves. Outpatient alcohol treatment programs do not appear to share these overcrowding problems. Although a few were at or near capacity, none had waiting lists.

Apart from the issue of space, three other characteristics were deemed central considerations in making a post-release referral -- cost, location and schedule.[4] While many drug treatment programs in New York City have always had sliding fee schedules, it is only within the past two to three years that these have been enforced. Even though our visits were limited to programs charging little or nothing, a few drug treatment programs reported that employed parolees might be required to pay as much as $35 a month, based on a sliding scale. In addition, some programs charge clients anywhere from $4 to $12.50 per test for urinalysis. These costs can be especially distressing to someone who has received treatment for free in the past. As much as any segment of the population, recently released parolees generally have difficulty paying these fees to drug treatment programs, even if they are employed, because of their generally low wages. It is not surprising, therefore, that Access counselors, along with many parole officers and parolees, have quickly become experts on which programs charge, which do not, and which are willing in certain circumstances to overlook costs. This is borne out by the fact that most programs to which pilot subjects were referred with relative frequency actually reported a large degree of flexibility in the enforcement of fees.

There is some controversy about the utility of such fees.[5] A state official and at least one treatment provider argued that charging minimal amounts can promote client motivation. Not surprisingly, many others we interviewed considered fees

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[4] Referral decisions were little influenced by program-specific admission criteria; most of the programs interviewed actually had few criteria for entry, other than a minimum age requirement (ranging from 13 to 18.) One of the programs reported that parolees were expected to bring release papers to intake interviews. Another program (one of the few that required payment and did not employ a sliding scale) required a birth certificate, social security card, medical exam, proof of address and proof of income. Mental illness and/or violent behavior were cited frequently as reasons for non-admission; some programs claimed that they referred these clients to mental health facilities. Program staff generally concede, however, that it can be difficult to distinguish between drug-induced psychosis and underlying mental illness. Surprisingly, the majority of programs interviewed did not mention criteria related to substance abuse. There were two exceptions: an alcohol treatment program required that new clients be "demonstrated alcoholics" who were not in need of detoxification; one drug program also required that new clients not be in need of detoxification.

[5] It should be pointed out that all these programs receive public funds through DSAS and therefore are not in a position to use the fees to pay for program improvements. Instead, whatever they collect from individual clients, theoretically, is subtracted from the DSAS funding.

counter-productive, serving as a disincentive to continuation in treatment. Some particularly pointed to the inappropriateness of charging men who were attending treatment because of a legal mandate set by the parole board.

The importance of location in influencing referrals is obvious. It almost goes without saying that the fewer transportation hassles one has getting to a program, other things being equal, the greater the likelihood of staying in treatment. Proximity to home, we discovered, was one of the most important criteria for matching parolees and treatment providers.[6]

Because many parolees have conditions mandating employment, and because many work or look for work during the day, treatment programs with evening hours are generally preferred for the parolee population. In the programs used frequently by Access, at least partial treatment (generally group therapy, if not individual counseling) was available in the evening. This contrasted with the majority of programs, many of which offered weekday programming only or required lengthy weekday orientation sessions before clients could enter evening treatment. Programs offering weekend hours were few.

A final factor that appears to have some influence on where research subjects are referred is the willingness of programs to provide information on client status to Access and Parole. Perhaps unfortunately, it is for this reason that both Access staff and parole officers steer away from referrals to self-help groups (AA, NA, CA), as the "anonymity" they guarantee generally precludes interaction with parole officers. In their interviews, FPOs often complained that they ordinarily "can't verify attendance" at these self-help meetings without some arrangement by which notes are signed and passed on to them.[7] Among outpatient programs visited, there is generally greater receptivity to Access/Parole involvement. For example, one Access staff member spoke highly of a particular program that "always keeps in touch ... if the program doesn't seem appropriate for the client, [they'll] get back to

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[6] This does not preclude other considerations, of course. In fact, a few of the research subjects who completed detailed interviews reported having requested a second treatment referral to a program which was *less* geographically convenient. There were several reasons for this: a preference for a night program in contrast to a day program, a desire for a program in which there was a higher proportion of ex-offenders, and a perceived need for "more specific help with a drug problem" than has been offered by the original referral.

[7] Avoiding referrals to self-help groups is unfortunate simply because they may provide the best resource for many offenders who are released to the community "clean" from drugs or alcohol, but have had extensive abuse histories. This would be particularly true of individuals who have been active in AA, NA or CA during incarceration, and show genuine motivation to continue that involvement. The relative value of self-help groups also increases as outpatient programs get overstressed and begin to offer very loose, unstructured and less frequent programming. Parole may have to consider better means of enforcing self-help participation through a specially developed record system (such as that being tried in New Jersey).

me. I can talk to any of the counselors at any time. They make themselves available." Such close relationships, by allowing for the easy exchange of information, are highly valued by Parole and especially Access.

Treatment Structure and Retention. Some supervisors spoke of not actively enrolling clients in treatment until a mandatory orientation period had been completed, but most such periods were not extensive. There were a few exceptions, however. One program set aside one night a week for orientation groups; clients, though, were actively enrolled during this time. Two other programs, neither of which was DSAS funded, had extensive education-oriented orientation periods (two to three months) which served as a preliminary to treatment. Some alcohol treatment providers had "evaluation" periods which resembled the orientation stage in the drug programs.

The issue of keeping clients actively in treatment is complicated by the fact that being an "active" client does not necessarily entail regular attendance at all scheduled sessions. Most outpatient treatment programs expect clients to appear one to three times a week for a group session which can range from one to two hours each. Scheduling individual counseling sessions varies considerably by program, with some scheduled weekly, and others only on an "as needed" basis. Some program operators were less specific about how frequently clients were expected to attend, claiming it was tailored to individual needs. In recognition of this fact, and also that some clients lapse temporarily in their attendance, most programs generally keep clients enrolled as active participants if they attend at all in a given month. In general, drug programs appeared more lax with regard to these criteria for maintaining an active client than alcohol providers.

The time that clients were expected to remain in treatment also varied. One program expected clients to attend 36 counseling sessions over nine months for successful program completion. Other programs spoke of treatment periods ranging from one to two years, and those with strong Twelve Step orientations expected treatment to continue indefinitely, although this did not have to include formal outpatient participation. Generally, programs did not distinguish carefully between these "optimal" treatment durations and estimates of the "average" treatment length of clients. Although several programs acknowledged that many individuals entered treatment but stayed only briefly, they did not appear to consider such "early drop-outs" in their estimates of average time in the program.

All the alcohol and drug programs we visited emphasized the frequency of relapse; because of this, they were unlikely to drop someone for an isolated recurrence of abuse. Only a few expected clients to be abstinent from the first day of treatment. Staff in alcohol programs generally felt they could identify relapse from clinical signs, while several drug programs use urinalysis under varying conditions and schedules. Most of the latter appeared willing to continue treating clients after one or two dirty urines--as long as the clients themselves demonstrate a desire to

stay enrolled. Several, however, did report that clients would be terminated after two or three dirty urines.

Responding to Crack and Cocaine. In addition to its influence on system overcrowding and attendant waiting lists, the crack epidemic has markedly changed the characteristics of the client population. Treatment providers reported that crack users were more resistant to treatment than other users, in part because of the rapidity with which crack addiction can develop. They also related that crack users were more erratic, more anxious, and had shorter attention spans than other clients, specifically heroin addicts. Finally, minimum age requirements had fallen as a result of the epidemic--some had clients as young as 13 in attendance. On the other hand, most programs did not report a change in treatment approach to respond to this new population; crack abuse, rather, was dealt with "just like any other addiction."[8] The only consistent variation was in programs based on the therapeutic community model, where staff felt a "less confrontational" approach was desirable when dealing with the volatility of crack abusers.

A few programs reported devoting considerable effort to placing clients in residential facilities as a result of the crack epidemic and general system overcrowding. Across the board, there was a feeling of being overwhelmed by clients whose problems were severe enough to merit residential treatment, but who were unable to find space there (one outpatient program estimated that 60% of their clients needed residential care). In many interviews, program staff explained that outpatient drug treatment had been originally designed for individuals who had graduated from TCs and were returning to the community, or for individuals with relatively mild patterns of drug abuse. Faced with clients that are much more difficult to handle, some agencies have developed day programs, with more intensive and more frequent outpatient sessions. Others have developed extensive networks in other regions of the country (New England and some southern states were mentioned in interviews) where residential programs have available treatment slots. Thus, outpatient programs will often try to keep a client until an arrangement can be made to enroll him in residential treatment elsewhere.

Referring and Treating the Criminal Justice Client. The programs to which research subjects were frequently referred reflected a wide range of contact with parolees and other criminal justice populations. Although one program treated criminal justice clients exclusively, more commonly programs estimated that approximately 33% to 60% of their client population were parolees. Conversely, one

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[8] Research literature (DeLeon, 1986; Gawin and Ellinwood, 1988) argues that stimulant abuse requires treatment that is specifically adapted to the unique characteristics of stimulant addiction, particularly the intense depression experienced by chronic cocaine abusers during an extended withdrawal. Gawin and Ellinwood find it unfortunate that "much current treatment is patterned after treatment for alcohol or opiate abuse and is applied without adaptation for stimulant abuse." (1988; p. 1177)

reported efforts to "steer clear" of the criminal justice population, while still another (the only program to support itself through client fees) estimated that only 10% of active clients were criminal justice referrals, although a large number of parolees were referred there for treatment but had dropped out on their own.

An important question that surfaced repeatedly was whether having mandatory treatment conditions set by parole boards made criminal justice referrals intrinsically different than other clients. In one sense, the fact of compulsory attendance was not unique to this population. Many programs, for instance, treat women referred by Special Services for Children (SSC) or the Bureau of Child Welfare (BCW)--women who might risk losing their children if they were not in treatment for drug abuse. Other clients had been pressured by family members or employers to enter treatment. Because of these other possible treatment "conditions," a number of program operators did not perceive substantial differences between parolees in attendance and other typical clients, most notably in terms of their initial motivation to attend treatment.

On the other hand, program operators generally agreed that recently released criminal justice clients share several distinctive features. First, they are seen as particularly resistant to treatment in contrast to "voluntary" or self-referred clients. Treatment staff said that many parolees claim not to have a substance-abuse problem (they had, after all, generally been "sober" for a lengthy period of time while incarcerated), and were seen as participating minimally ("they stroll in and out"). Those who do continue in treatment were often seen as "going through the motions" to satisfy parole: "Once the condition is gone, they're gone."

The issue of motivation was raised frequently in connection to criminal justice clients. Most programs contended that motivation was particularly low among criminal justice referrals, who were seen not only as "very unmotivated" but "very guarded" as well--"they don't want to be here" was one comment. One interviewee suggested that criminal justice clients were hostile and resistant because "having to deal with a variety of conditions leads to frustration." Another program operator suggested that younger parolees appear more motivated because they see a greater need to "get their life together;" in his view, older parolees attend treatment primarily because they are required to, thus their participation is generally minimal.

Because most criminal justice clients, particularly those recently released from an incarcerative facility, are emerging from an extended period of sobriety, one of the programs interviewed saw its mission as one of "relapse prevention," rather than the treatment of an active addiction.[9] Treatment, in this case, focuses on

[9] This approach does not appear to reflect the clinical model of relapse prevention (Marlatt and Gordon, 1985) which is based on a rejection of the "disease model" of addiction and a behavioral approach to treatment. Instead, in this instance, the concept of relapse prevention appears to have been adapted to complement an AA/NA orientation.

how "not to use" drugs and alcohol. Although a few other programs spoke of the value of a "preventive" approach for this population, they did not appear to have a clearly delineated model in mind. One program, in fact, denied that such an approach would work: "A preventive approach can work in a prison setting . . . [but by the time they come to us] most have already reverted to drug use."

Another frequently cited point was the high drop-out rate among criminal justice referrals, in spite of parole conditions mandating continued attendance.[10] Many, in fact, even with specific treatment conditions, do not return after their initial intake interview. One program estimated that only 20% of criminal justice referrals stayed in treatment three months or longer, while at another the "gradual attrition" of criminal justice clients was a recurring problem. Yet one program director offered an alternative perspective on the common sentiment that those mandated to attend treatment lack motivation and are therefore worse clients. He said that it is difficult to read beneath the surface to fathom an individual's actual reason for continuing in treatment; the fact of attendance is important in itself. In his view, retention in treatment by compulsory means could permit individual motivation to develop as treatment proceeds.[11]

A few programs raised concerns about one aspect of the criminal justice population: drug sellers who are not necessarily drug abusers but still have parole conditions mandating drug treatment. These clients were seen as particularly resistant and often disruptive in group settings.

There also appeared to be considerable diversity among programs in the intensity of their effort to keep clients in treatment if they failed to appear regularly. Some programs reported regularly making follow-up phone calls and sending letters to clients who failed to attend. At other places, attempts at improving client retention in treatment appeared to be far less intensive.

Interviews with Access and DSAS personnel, in fact, suggested that the recent high demand for outpatient drug treatment – and the concomitant demands

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[10] The research literature (Jaffe, 1984; Ludford, 1984) indicates that outpatient drug treatment programs are generally less successful in keeping clients in treatment than other modalities (residential or methadone maintenance.) The literature also suggests that criminal justice clients are generally less likely to stay in treatment than other types of client (Hubbard et al., 1988; Jaffe, 1984.)

[11] Despite the general finding that criminal justice clients do worse in treatment, the literature supports this notion that the mandatory nature of some drug treatment for criminal justice clients can build motivation and actually prolong treatment. Studies further indicate that, even if clients stay in treatment because it is compulsory, retention in treatment is associated with decreased drug use and lower rates of recidivism (Cook, Weinman et al., 1988; Hubbard et al., 1988.) In fact, the literature suggests that criminal justice clients who stay in treatment do as well as clients of other types. The central problem appears to be structuring conditions so that they do in fact increase retention in treatment among the criminal justice population.

on overburdened program staff -- has adversely affected attempts at keeping clients in treatment. Because programs can easily replace those that are insufficiently motivated, some may be doing less now than in the past to encourage and support faltering clients.

Relationship with Parole. Although a few programs did claim to have excellent working relationships with parole officers, the majority had some complaint about their interaction with Parole. A number of program operators, although willing to cooperate, felt that parole officers were overly lax about monitoring client participation in treatment, often depending on programs to do this for them. Similarly, resentment was voiced over IPOs "never monitoring urines," in spite of conditions requiring them to do so, instead relying on the results of program urinalyses.[12] One staff member reported: "Parole is not doing the job. I'm not going to do *their* job." In general, given an already close to unmanageable workload, programs were wary of cooperating to the point of doing work more properly performed by the IPO.

Conversely, one program, whose primary clients were criminal justice referrals, described having extensive dealings with parole officers and reported a willingness to help parole officers "keep tabs on parolees." This program, in fact, spoke of making efforts to involve non-cooperative parole officers in treatment issues and to keep parole officers apprised of client absences. Such an attitude was the exception, however.

Some programs claimed they would respond if directly questioned by parole officers about client status, but they would not take the initiative in reporting dirty urines or client attrition. Program operators generally did not want to be in the position of "volunteering" such damaging information to parole officers, but reported taking steps to convince them that a particular client might be in need of more intensive treatment (detoxification or residential placement) if there was any threat of parole violation. Several staff members claimed that Parole placed programs in a false position by making them "responsible for the violation." Finally, there were some program supervisors who questioned the value of close associations with IPOs in the first place. They spoke of not wanting to be seen as "an arm of parole," feeling that such a perception would hinder their ability to build therapeutic relationships with clients.

A final irritant to parole officer/provider relations reported in our interviews springs from concurrent employment and treatment conditions and FPOs' tendency to emphasize the former. Many counselors argued that if substance abuse is a

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[12] On the program side, there was considerable diversity among programs in their approach to urine testing. Some took random, supervised urine tests and required that clients pay for urinalysis. In other instances, urines were taken but not supervised.

parolee's central problem, an emphasis on employment can be counter-productive. It may, in fact, provide money for drugs in some instances or contribute to stress that could trigger relapse.

Although a number of treatment providers reported little contact with the Access program, several considered their interaction with Access staff better than that with parole officers. One supervisor claimed to be "more comfortable with the Access approach [because] they maintain regular contact." Another reported that, although Access staff did not follow-up on clients past the initial intake visit, they still "fostered a good climate between the parole officer and the agency."

Identifying Service Gaps and Improving the System. When asked about "perceived gaps" in the service delivery system for substance abusers, program staff generally agreed that there was "not enough of everything." Perhaps most pervasively, they spoke of the need for increased residential treatment, particularly for crack abusers. They also pointed to the dearth of detoxification beds for drug abusers.

Some program operators spoke of a need to develop an intermediate form of residential treatment specifically designed for this population, such as a short-term (90 day) rehabilitation model. If followed by outpatient treatment, this could be a means of "breaking" addictive patterns and continuing with relapse prevention in a community context. One program operator, in fact, recommended mandatory 90-day residential treatment for parolees who might otherwise be violated because of a return to drug abuse. However, the point was raised at another program that this might not be the answer for the crack-abusing population. One operator argued: "Ninety days won't do anything; crack abusers need even longer treatment than heroin abusers--they're much more resistant."

Program operators held conflicting ideas about how drug and alcohol treatment providers could work more effectively with the criminal justice system in servicing ex-offenders with substance abuse problems. Some believed that the needs of the criminal justice population should "fit into" the existing network of service providers; that is, they do not need separate treatment or their own facilities. Others contended that the criminal justice population would do better in services that are specifically structured for them.

As was alluded to above, many of the treatment providers we spoke with thought parole officers needed to be more actively involved in monitoring and/or serving clients in treatment programs. This included ensuring that parolees had whatever "documentation" was necessary for program involvement, regularly monitoring urines, and enforcing continued program participation. Such steps would counteract the feeling among several program operators that they were being "used" rather than assisted by parole officers.

Although there was some controversy over the potential efficacy of shorter-term residential models, several program operators spoke of the need for some form of mandatory residential treatment that could be used in lieu of parole violation. This sentiment was echoed by DSAS staff as well, who spoke of a "lost ability" to use the criminal justice system to remand drug abusers to residential treatment settings.

Conclusions. Our visits to programs and discussions with experts confirmed the popular perception that drug treatment providers in New York City are severely over-burdened and under-staffed. Because of the currently limited treatment capacity of all drug treatment modalities, the approach to treatment referral outlined by Access and DSAS staff -- an approach which focuses on practical concerns rather than on a clinical matching of client needs to treatment philosophy -- makes considerable sense. When treatment slots are scarce, practical concerns -- availability of space, ease of access, affordability -- become primary determinants of referral.

Were it not for these practical considerations, a more informed matching of recently released offenders to treatment slots would indeed be desirable. Unfortunately, existing research literature says little about the criteria needed for making such matches. Although there is some information about relationships between client characteristics and treatment efficacy in various modalities, there is virtually none on how different types of clients fare within alternate forms of a given modality, i.e., in this case, outpatient drug programs. Steps that might improve this matching process are not easily defined; data on variations in treatment outcome according to program type have not yet been compiled.

Yet, our series of detailed interviews with treatment programs did delineate several program characteristics which seem uniquely suited to the ex-offender population. Because recently released parolees often have a battery of problems and needs (vocational, familial, educational, residential, etc.), which can precipitate a quick return to substance abuse, it is appropriate for programs to employ a holistic approach to treatment.

In fact, most of the programs reported the ability to respond to multiple needs through referral to ancillary services and claimed to offer family counseling, although the actual incidence of these activities was not clear. Nevertheless, the *capacity* for a holistic approach to treatment among the outpatient-drug programs we visited clearly exists.

Our review also suggested, however, that drug treatment programs should not treat the whole client at the cost of their focus on substance abuse itself. Some programs appeared to de-emphasize potential drug problems in this population because many recently released offenders did not present any *active* addiction.

Other programs, however, refused to lose sight of addiction issues; they felt a need to maintain a treatment focus on the "addictive personality" even among offenders who are not active addicts. These programs, stressing a relapse-prevention approach that teaches clients "how not to use," seemed particularly well suited to the ex-offender client.

Yet another important characteristic -- the ability and inclination to focus on the possibility of secondary alcohol problems in the drug-abusing population -- was not, unfortunately, exhibited by many of the programs we visited. Many did report a willingness to treat individuals addicted to both drugs and alcohol, as long as the primary presenting problem correlated with the program's emphasis. Although most drug treatment programs claimed to be capable of dealing with addictions of any type, few professed any concerted effort to identify and respond to secondary alcohol addictions. A more active response in this area is past due, particularly now that the problem -- an individual's resorting to drink when addiction to his drug of choice has been "addressed" -- is becoming increasingly better understood.

Although the opposite point of view was also voiced, by most accounts there are advantages to programs that deal primarily or exclusively with criminal justice clients. Some research subjects spoke of feeling "more comfortable" in settings with predominately ex-offenders. In addition, as noted above, several programs emphasized attitudinal differences between criminal justice clients and voluntary referrals. These perceived differences -- that criminal justice clients show more resistance, less motivation, and attend treatment only because of a condition -- may lead to disadvantages for ex-offender referrals; it is possible that program staff will favor voluntary clients or at least be perceived as doing so. The likelihood of this happening would be far less in a program geared specifically to clients from the criminal justice system.

A final, broad characteristic essential to a program's successfully treating ex-offenders is a smooth relationship between program personnel and parole officers. As discussed above, a few programs sought to maximize the amount of information shared with parole officers. Others, though, regretted parole's placing them in a "false position" with regard to clients by making them responsible for violating clients who failed to appear or who had dirty urines. Some program operators complained that parole officers unfairly depended on them for urinalysis results, rarely taking them on their own. Other programs claimed this as their own responsibility and randomly conducted supervised urine tests, for which clients were charged. It seems likely that this latter approach, if done consistently, provides more supervision of clients with a high potential for relapse. Nonetheless, if parole officers do not actively seek information about the results of in-program urinalysis, such monitoring can be of little benefit to them.

As a final point on the program/parole officer relationship, the potential conflict between them might well be mitigated in treatment programs that are designed specifically for criminal justice clients. One such program, in fact, tries to make use of parole officers to keep wavering clients in treatment. By actively maintaining contact with parole officers, this approach attempts to maximize both treatment and supervision.

The need for intensive interaction between program staff and parole officers is highlighted by the current high attrition rate of criminal justice referrals in outpatient drug treatment programs. Clearly, programs that make greater efforts to follow-up clients who fail to return to treatment and to fight the recognized resistance of criminal justice clients are better suited to the needs of ex-offenders with substance-abuse histories.

Appendix B

The Research Plan: Design and Implementation

THE RESEARCH DESIGN

The design implemented in the second and third years of the initiative closely followed the preliminary research proposal specified in Vera's first interim report. The population being studied includes a 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 C.P.O.D. – Community Preparation - Open Date population (C.P.O.D. inmates are general population inmates who have been granted parole and been given an "open date" – a tentative release date). 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 additional qualitative process data collected on CPU participants, the same information is collected on both pilot and comparison subjects. These data contain drug and alcohol histories amassed at a screening interview; extensive intake data obtained from DOCS files and during a face-to-face interview; follow-up information from interviews with subjects and their supervising parole officers at two and six months post-release; and arrest record data through twelve months post-release.

The selected design will afford an assessment of the central hypothesis of the Interagency State initiative: offenders participating in the Lincoln pilot program will be less likely to commit crimes, abuse drugs and/or alcohol, and remain estranged from the community after release. At the most fundamental level, these outcomes will be statistically contrasted between men who graduated from the Lincoln CPU, men who attended other in-prison treatment, and men who received no in-prison treatment.[1] Additionally, data collected at intake and at follow-up will be analyzed to yield information on such factors as prevalence of drug and alcohol problems in the DOCS population and their demographic correlates, and participation in prison and community-based treatment programs.

[1] 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 -- Lincoln C.P.O.D. After several months of pilot testing instruments and procedures, Vera researchers began screening for comparison subjects in April, 1987. Screening data were obtained on virtually all Lincoln C.P.O.D. inmates who meet pre-determined criteria.[2] 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 after the first Monday following their arrival at Lincoln.

Once having determined an inmate's eligibility (in terms of residence and release date), his DOCS file is investigated for references to previous drug or alcohol involvement, and drug- or alcohol-related treatment. When available from the file, the score from the DOCS-administered Michigan Alcoholism Screening Test, or MAST (Selzer, 1971), is recorded. Following the review of the DOCS file, Vera staff asks the inmate to partake in a 15-30 minute interview during which a series of research instruments are administered that measure different dimensions of any drug and/or alcohol history. The inmate is also asked about particpation in treatment programs during his current incarceration and given a brief introduction to Vera's role at Lincoln. If an inmate does not wish to participate in all or part of the screening interview, he is thanked for his time and excused.

Those who complete the screening interview are assessed by researchers according to a pre-set criteria to determine if they qualify for inclusion in the comparison group. If their scores indicate a history of significant alcohol/drug abuse, as determined by the scoring of responses, they are further informed about the research objectives and procedures, and asked to participate as a research subject. If the inmate agrees, he and the Vera researcher read and sign a consent form which outlines the research, assures anonymity and confidentiality, and presents the rights of the individual as a Vera research subject.

The Screening Interview -- Lincoln CPU. Vera researchers engage essentially in the same screening 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 scores on instruments. With

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[2] Occasionally, Vera staff was unable to see all C.P.O.D. inmates entering the facility in a given 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.

pilot subjects, this first interview is also used to familiarize the ASAT inmate with Vera staff, our research plans, and our role in the Lincoln initiative. The drug and alcohol measures, queries about prior treatment, and the consent form are identical for both pilot and comparison participants.[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.

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 (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 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 augmented self-report data with information available from the inmate's DOCS file. In introducing the instruments to the inmate, he is asked to recall his

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[3] DOCS agreed to inform men at the feeder sites about Vera's research plans, and to obtain an assurance from the man that he would, by virtue of his status as a Lincoln participant, cooperate with Vera's research. On occasions, DOCS had difficulties implementing this arrangement and, in a few cases (six), 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).

drinking and drug use (and related behavior) in the one-year period prior to the current incarceration.[4] Inmates rarely have problems specifying and remembering this period quite clearly; 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. A participant who denies or misrepresents an apparent history of abuse is reminded that his file has already been checked; any discrepant information is reviewed with him prior to continuation of the questioning. In such cases, the inmate is encouraged 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 carried out 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. Suggested by Hubbard et al.'s (1984) analysis of numerous widely used measures of drug use severity, SAFQ responses for individual drug items are 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 responds with a 2 or 3 on any drug type, the man is 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 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. (The Alc-QF

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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 they will more accurately reflect the incidence 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.

includes separate probes for three types of beverage alcohol, with respect to the number of bottles, cans, shots, etc., drunk in 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 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]

Scoring of Measures at Screening. Responses on the screening instruments are recorded and analyzed in two different ways, initially to determine if a C.P.O.D. 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. The Alc-QF is scored dichotomously (excessive or not excessive alcohol consumption) in the screening interview

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[5] The ADS is similar to the MAST, but was developed with the specific intention of measuring the 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).

(average daily alcohol intake was calculated only for inmates in the research sample and not for all screened inmates). Respondents were assigned a score of 1 (indicative of 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 at screening. The quantities represent a range of ethanol contents (from 2 to 3 ounces), and thus this scoring provides only an approximate, global indicator of excessive consumption.

On the SAFQ, respondents are assigned an overall score of 0, 1 or 2 at screening. (Again, more precise coding for each substance is recorded on research subjects.) High frequency drug users (scoring 2 on the overall scale) include subjects who (a) reported use of one or more drugs daily or almost daily (most commonly cocaine or marijuana, followed by heroin or crack) or (b) use of two or more substances at least 1-2 times weekly. To score a 1 ("moderate users"), the subject had to report weekly use of any drug other than marijuana; less frequent use was scored a 0.

Alc-QF and SAFQ 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* (b) has a score of 10 or more on the MAST (as recorded in his DOCS file), *or* (c) scores 10 or more on the ADS, *or* (d) scores 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]

Scoring of Measures for the Screening Sample. The screening sample results reported in the text for individual alcohol and drug measures correspond with the scoring procedures described above. In addition, simple composite indices of

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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.

alcohol and drug problem severity were created for purposes of analyzing screening data. The drug severity composite used for the screening data combined scores from the ACQ-D and the SAFQ; preliminary analyses indicated these two drug use measures are sufficiently correlated (r=.54) to compute this 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.

Inspection of the correlations of the three alcohol measures (ACQ-A, Alc-QF and ADS) suggested that a composite alcohol severity index would also be useful. (For the quantity/frequency and adverse consequences, r=.57; for the Alc Q/F 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. This alcohol composite yielded scores ranging from 0 to 6.

Scoring of Measures for the Research Sample. The more complete alcohol and drug data recorded on research subjects permitted more detailed analyses of individual items, as well as the creation of more sophisticated composite measures. The simple composite indices described above are specific to the screening sample results; the more complex severity composites used in analyses of comparison and pilot group data differ from these screening composites. The composite measures used for the research sample are described in the text.

The Research Sample: Intake Data Collection. Comparison group candidates who meet the screening 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 history; familial information with some history; educational data; voca-

tional 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 compiled for further analysis, and items about the relationship between an inmate's drug/alcohol use and criminal activity are recorded. 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, and the second occurring approximately six months after release.[7] In addition to parolee interviews, interviews are done with the subject's field parole officer (FPO) on approximately the same dates. The FPO interview, which typically takes from 10 to 15 minutes, is most often conducted over the telephone, but in some instances the interview takes place at the parole office. If a subject does not participate in one or both of the follow-up interviews his FPO is still interviewed.

Prior to a participant's release from Lincoln several techniques are employed in an attempt to guarantee a subject's participation in the two-month follow-up interview, preferably at Vera's offices. Subjects are given a "contact card" with Vera's address, phone number, and a suggested interview date. They are also asked, with an assurance of confidentiality, to give researchers an address and

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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.

telephone number where they may be reached should they lose the card or neglect to contact us. And finally, they are promised a sixteen dollar stipend immediately upon completion of the follow-up interview.

In addition to these efforts at Lincoln, shortly before the two month interview is scheduled to take place a contact card is sent to the man's field PO, who is asked to pass the information on to the subject. A letter is also mailed about three or four days in advance of the two-month point to the parolee's previously obtained address; if no response occurs within three weeks a second letter is sent. Follow-up phone calls to the FPO and to the man's home are made when necessary. In some cases, we discover that a participant has absconded (and cannot be interviewed), or that he is being detained due to rearrest or a parole violation. In the latter situation, a Vera researcher goes to the facility to conduct the interview. A small proportion of the research subjects contact Vera after release and state that they wish to withdraw from the study, but 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 FPO 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") are collected for criminal history comparisons, and also for twelve month post-release follow-up data. Arrests and dispositions occurring during the year after release from Lincoln are recorded and analyzed.

GENERAL ANALYSIS PLAN

Initial analyses have focused on descriptive information;. further descriptive tests will focus on bivariate analyses, using crosstabs and correlational methods where appropriate. Results of these analyses on data currently available are

presented in this report. For the final report, 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.

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; 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 numerous 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 we cannot assume the study's results can be generalized to the larger population as a whole.

STUDY TIMETABLE

State Fiscal Year 1989. Research objectives for SFY 89 focused on continued implementation of the research design through data collection and monitoring activities, and preliminary analyses of results. 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 on different schedules for the comparison and pilot groups. This difference arises from the delay in participants reaching the Lincoln program. Comparison intake ended in the later half of second quarter of SFY 89, while pilot intake continued into February of the new calendar year.

Our previously stated goal of screening at least 600 (N=678) men, and from this group, completing intake on approximately 450 research subjects, including at least 150 (N=163) in the pilot group and 300 (N=308) in the comparison group was realized during this past fiscal year. Post-release two month follow-up for comparison men ended in December of 1988, and six month follow- up interviews will end in the spring of 1989. Two month follow-up interviews for pilot men will end in early summer and the six month follow-up will conclude in the fall. The allotted timeframe for follow-up data collection will expire by mid-November, 1989 for comparison subjects (13.5 months after the final participants release from Lincoln), but the last pilot subjects will not pass beyond the 13.5 month point until April, 1990.

Project goals for post-release response rates were 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. While all attrition rates have yet to be calculated, preliminary analysis of parolee two month follow-up data (Chapter Six) reveals a 32% rate of attrition, consistent with our original goal of a 33% rate.

State Fiscal Year 1990. During the upcoming fiscal year, data analyses, interpretation of results, and report-writing activities will be of primary importance. Data collection which peaked in the fall and winter of 1988 and early 1989 will continue at a somewhat slower pace throughout SFY 1990; the resulting database, after coding and key-punching, will consist of complete two-month and six-month follow-up information on comparison and pilot subjects, and a vast majority of the twelve month follow-up information. We plan to assess several major research hypotheses, and include these findings in Vera's final report, anticipated for the summer of 1990.

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