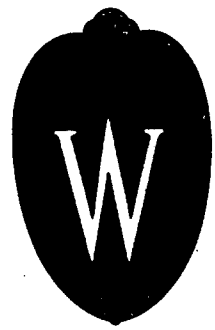

UNIVERSITY OF WISCONSIN
MEDICAL SCHOOL
Department of Preventive Medicine
Center for Health Policy and Program Evaluation

Outcome Evaluation of the Wisconsin Residential Substance Abuse Treatment Program: The Mental Illness-Chemical Abuse (MICA) Program at Oshkosh Correctional Institution 1998-2000

FINAL REPORT Archive

Prepared by

Kit R. Van Stelle, Researcher

D. Paul Moberg, Ph.D., Principal Investigator

Approved By: _____

Date: 1/9/01

August 2000

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EXECUTIVE SUMMARY

The University of Wisconsin - Madison Center for Health Policy and Program Evaluation (CHPPE) was funded by the National Institute of Justice to conduct a two-year outcome evaluation of Wisconsin's Residential Substance Abuse Treatment (RSAT) for State Prisoners project. The methodology included the collection of qualitative and quantitative evaluation research data to assess the effectiveness of the Mental Illness-Chemical Abuse (MICA) Program at Oshkosh Correctional Institution (OSCI) implemented with RSAT funds.

MICA is a residential substance abuse treatment program that utilizes a modified therapeutic community model to provide 8-12 months of residential treatment to male inmates who are determined to be dually diagnosed with both substance abuse and mental health disorders. This outcome study documented important aspects of program implementation and effectiveness, including institutional (intermediate) outcomes and community outcomes of mentally ill offenders involved in the MICA program. The primary study goals were to:

1. Document offender participation in treatment;
2. Document program impact on intermediate outcomes;
3. Document program impact on substance use outcomes;
4. Document program impact on mental health outcomes;
5. Document program impact on outcomes related to stability;
6. Document program impact on criminal justice outcomes; and
7. Investigate program impact on access to community treatment services on parole.

The methodology for the current study included the collection of both qualitative and quantitative evaluation research data to assess participant outcomes and program impact. The

study design included a description of the male inmates who were admitted to MICA, an examination of intermediate outcomes, an examination of outcomes after release to the community, and an investigation of MICA impact upon community service systems through interviews with probation and parole agents in Wisconsin. The design also included a comparison group of offenders who met MICA diagnostic eligibility criteria but did not have enough time remaining on their sentences to participate in the residential program.

Overview of MICA Treatment Program

The 25-bed capacity MICA Treatment Program provides a wide variety of treatment and support services to dually diagnosed men incarcerated within the Wisconsin correctional system. MICA has three primary components including (1) an 8-12 month residential therapeutic community component offering a comprehensive array of mental health and substance abuse treatment and support services, (2) an institutional aftercare component offering supportive services to program graduates while they remain incarcerated after program completion, and (3) a community aftercare component offering supportive services to program graduates after they are released to the community.

MICA has integrated additional therapeutic community elements into the residential treatment component as the program has developed over time, and has proposed to move the treatment program into a more isolated physical space in early 2001. MICA staff have continuously modified the program model and structure in efforts to improve program services and retain participants in treatment. MICA staff have also shown a superior level of commitment to the evaluation of the program, including collecting data on residential treatment service dosage at a level of detail rarely captured in evaluation efforts such as these.

Characteristics of MICA Admissions

MICA admissions are an average of 36 years old, and most are either White or African American. The majority were assessed to be either alcohol or cocaine dependent and 80 percent had participated in some type of substance abuse treatment program prior to admission to MICA. MICA participants also reveal comprehensive problems as reflect by Addiction Severity Index (ASI) scores. However, these men do show higher than average levels of motivation and readiness for substance abuse treatment. Most participants have been diagnosed with either schizophrenia, schizoaffective disorder, or bi-polar disorder. The vast majority had been hospitalized for mental health treatment prior to admission and 90 percent are on psychotropic medication to control mental illness. The assessment results for men who were assessed show them to be quite a low-functioning and chronic group of inmates, with an average IQ of 85. They exhibit memory and attention deficits, higher than average psychiatric symptoms, and deficits in independent living skills.

Their primary criminal offense was most likely to be a property crime such as burglary, theft, or robbery. Fourteen percent were incarcerated for drug possession or delivery, and nine percent were incarcerated for sexual assault crimes. The average sentence length was 6.5 years, and participants had an average of two years to their mandatory release from prison at the time of MICA admission. Approximately one-half had prior adult correctional experience.

Residential TC Component

In the 2 ½ years of operation summarized for the study, a total of 141 offenders were admitted to the program. The average length of stay in the residential treatment component has been approximately 8 ½ months for program completers, with 17% of eligible admissions (20

men) completing the treatment program. Men who completed tend to be younger, have fewer memory/attention deficits, and exhibit severe psychopathy and psychiatric symptoms than men who did not complete. MICA graduates showed significant improvement in Brief Symptom Inventory scores, treatment readiness, and daily living skills from admission to discharge.

Institutional Aftercare Component

The MICA outreach specialist met with graduates about twice per month and had contact with their families and with community agencies on their behalf while they remained incarcerated (an average of 304 days) after program completion. Probation and parole agents indicated that there is little coordination between agents and correctional institution staff while an offender is incarcerated. While this level of institutional aftercare service is not intensive, the study findings indicate that this may have helped these men maintain the gains they made while in residential treatment. Graduates were less likely to receive conduct reports or segregation time than termination or comparison inmates. Graduates were also more likely to be transferred to a minimum security facility prior to release, while terminations and comparison inmates were more likely to be incarcerated in maximum, medium, or secure mental health institutions.

Community Aftercare Component

To date, MICA has focused more on providing community aftercare than institutional aftercare. The MICA outreach specialist met with graduates in the community about two times per month after they were released, and also met with families and agents to facilitate services and relationships. Probation and parole agents interviewed indicated that the outreach specialist performed a significant amount of "legwork" in facilitating services, but that most services would have been delivered even without the outreach specialist. Most agents did not feel that the

involvement of the outreach specialist necessarily increased access to or coordination of services for MICA graduates. Agents did feel that the outreach specialist gave insight into the nuances of individual cases rather than increasing their general knowledge of dual diagnosis issues.

Post-Release Outcome Findings

Logistic regression analyses investigating MICA impact on both proximal and distal outcomes revealed that MICA participants (both completers and terminations) are more likely than the comparison group to be medication compliant, abstinent from substances, and more stable at three months after release. The analyses suggest that participation in MICA increases the likelihood of medication compliance after release. The pattern of results suggests that this medication compliance and resulting mental health stability leads to abstinence from substances, which leads to a decreased likelihood of arrest. In addition, mental health stability predicts return to prison within three months. For these men it appears that medication compliance is the pivotal factor in reducing recidivism within three months of release.

Our analysis of longer-term outcomes must be considered as preliminary due to the small sample available at this time. No differences in arrest or return rates at six months or one year after release were found. Assuming resources are available, we plan to continue to track these outcomes and reassess the mediational model.

Implications for the Wisconsin Department of Corrections System

The DOC is putting increasing focus on evaluation of offender programming, and the success of this research study is due in large part to the exceptional level of support received from the Wisconsin DOC. Collecting data to conduct this research study required a cooperative effort on behalf of MICA treatment program staff, Bureau of Offender Programs staff, records

office staff at the correctional institutions, Bureau of Offender Classification staff, and probation and parole regional chiefs, supervisors and agents.

If, as these results suggest, medication compliance is one of the primary keys to success after release for dually diagnosed offenders, then the DOC should address two barriers to medication compliance after release to the community. First, offenders should be given more than two weeks worth of medication upon their release. Both institutional and community corrections staff suggested that if DOC provided enough medication for one month then DOC would not have to pay for a psychiatrist to write a new prescription and SSI funds could be used to pay for the medication. Second, agents recommended that DOC address the problem of psychiatrists in the community changing the medications of dually diagnosed offenders after release. While offenders may be stabilized on a particular medication at the time of their release, a change in medication type can cause their mental health to decompensate quite quickly or produce unsettling side effects.

The vast majority of MICA participants (both graduates and terminations) remained incarcerated for about a year after their discharge from MICA. The implications of continued incarceration after completing substance abuse treatment are unclear, but without ongoing support and monitoring there is likely to be regression of gains made in treatment. Even though graduates did participate in substance abuse treatment and support groups to some extent while they remained incarcerated, they had to cope with a variety of changes including a different clinician monitoring their medications, possible changes in medication, loss of TC structure, and an environment of criminality on the general population units. Enduring these types of changes can only be a detriment to maintaining mental health and abstinence from substances upon

release to the community for these dually diagnosed offenders.

A large proportion of these MICA participants spent time incarcerated at OSCI after their discharge from MICA. While some of these men were housed in the Transitional Treatment Center, many were housed in general population units. The long-term implications of increasing the concentration of dually diagnosed offenders at OSCI are unclear at this time.

There is a need to increase the level of communication among institution staff and community corrections staff to improve service coordination while dually diagnosed offenders are incarcerated. Agents indicated that they need more frequent progress reports from institution social workers and treatment staff because they often don't know that an offender under their supervision is in a prison treatment program, that he has been terminated from treatment, or what services he needs next. In fact, the MICA outreach specialist had very limited contact with the parole agents of MICA graduates prior to their release. Increased communication would also enhance pre-release planning for dually diagnosed offenders. Agents suggested that institution social workers, institution treatment staff, and agents coordinate to make recommendations for needed services and develop a detailed parole plan. One agent felt that a "liaison agent" was needed to help offenders make the transition from institutional treatment to community treatment. Assuring probation and parole agents in more rural units access to email will also increase their ability to coordinate with institution staff; currently staff in smaller units do not have access to email and may be unaware that they have received email correspondence concerning an offender.

Many agents also felt that each probation and parole unit (or county) should have a specialized agent for dually diagnosed offenders. This specialized agent would supervise only

dually diagnosed offenders and be knowledgeable about substance abuse and mental health issues and services in their area. This specialized agent could be familiar with MICA and the MICA outreach specialist, make ATR referrals to MICA, and supervise any MICA graduates assigned to that county or unit. Many agents may be willing to take on the additional responsibility because promotion requires them to perform duties outside their normal workload.

Numerous probation and parole agents also indicated that they would like to see MICA make some changes so that more offenders would be eligible for the program. Agents interviewed suggested that MICA be available to offenders with a broader range of diagnoses and that the residential component be shortened to make it more attractive as an alternative to revocation. However, broadening the range of eligible diagnoses would change the dynamics of the residential TC, and shortening the program would detract from the model of long-term residential treatment. These changes would make treatment available to a larger number of offenders but would decrease the intensity of the treatment itself – likely decreasing the effectiveness of the program as well.

Implications of Findings for the MICA Treatment Program

These findings suggest that MICA should continue to emphasize the importance of medication compliance for participants. Medication compliance should be stressed not only during the residential TC component, but during the institutional aftercare and community aftercare components as well. MICA has great incentive to work within the DOC system to address the barriers to medication compliance encountered by offenders upon release.

MICA should examine the relatively modest level of aftercare provided while graduates remained incarcerated after completing MICA. MICA should consider increasing the level of

institutional aftercare services provided to help graduates maintain gains made in treatment.

One reason that graduates received limited institutional aftercare services may have been due to the large workload of the outreach specialist. The role of the outreach specialist is currently one that spans the course of treatment for MICA participants -- from admission to aftercare. The outreach specialist interviews each MICA participant at admission, gets to know them during TC treatment groups, provides aftercare for them while they remain incarcerated after graduation, and helps with their transition to the community. The outreach specialist is responsible for the provision of all aftercare services (both in the institution and after release to the community) for all graduates. It is clear that the outreach specialist is a critical treatment staff position – the one common thread throughout the MICA treatment experience. As the position is vacant at the time of this writing, it is a good time for MICA to examine the outreach specialist role and re-evaluate appropriate workload for this position. The role should include more pre-release coordination with agents that would involve a team approach.

Implications of Findings for Continued Evaluation of MICA

The Center for Health Policy and Program Evaluation will continue to assist in the outcome evaluation of MICA after NIJ funding ends. Utilizing Wisconsin DOC funds, the data collection for the current study will be continued an additional year. The basic design of the extended MICA evaluation will remain the same, but several improvements will be made to the data collection plan based on what was learned during the current study. These modifications will include a revision/update of the MICA participant data system, improved documentation of institutional aftercare services provided to graduates, using the CIPIS database to gather more of the essential data rather than gathering that information through file review, and gaining access

to the computerized system which tracks urinalysis testing and results for the entire DOC system.

The researcher was asked to participate in a DOC system-wide effort occurring during 2000 to systematize data collection for all of the substance abuse treatment programs within the correctional institutions. The DOC hopes to identify a set of common data elements and participant outcomes that all programs will enter into a central database. Future evaluation efforts should strive to integrate this required reporting for programs into the evaluation design.

Conclusion

The current findings demonstrate the potential effectiveness of the MICA treatment model for dually diagnosed offenders. MICA has confirmed that a residential substance abuse treatment program for this special population of offenders can be effectively implemented in a correctional setting. MICA has also shown that a therapeutic community model can be utilized to provide substance abuse and mental health treatment to dually diagnosed offenders, but that there is a high treatment termination rate. With its multi-disciplinary approach, therapeutic community setting, comprehensive array of services, and extended aftercare component MICA enjoys a promising short-term success rate after participants are released to the community.

Outcome Evaluation of the Wisconsin RSAT:

The Mental Illness-Chemical Abuse (MICA) Program

RESEARCH PROJECT DESCRIPTION

The University of Wisconsin - Madison Center for Health Policy and Program Evaluation (CHPPE) was funded by the National Institute of Justice to conduct an outcome evaluation of Wisconsin's Residential Substance Abuse Treatment (RSAT) for State Prisoners project.

The methodology for the current study included the collection of both qualitative and quantitative evaluation research data to assess the effectiveness of the Mental Illness-Chemical Abuse (MICA) Program at Oshkosh Correctional Institution. MICA is a substance abuse treatment program that utilizes a modified therapeutic community model to provide treatment to male inmates who are determined to be dually diagnosed with both substance abuse and mental health disorders. This outcome study sought to document important aspects of treatment program implementation and effectiveness, including institutional (intermediate) outcomes and community outcomes of mentally ill offenders involved in the MICA program.

Funding for this two-year external outcome evaluation began on September 1, 1998 and was slated to end August 31, 2000. However, due to a slight delay in receiving the evaluation grant award we began work on the project on October 1, 1998, thus losing a month of time at the start-up. Consistent with this loss of the first month, our original workplan and timelines were extended one month with our final report delivered to NIJ in draft form by August 31, 2000 and final form by September 30, 2000. The actual end date for the evaluation study was extended to December 31, 2000 at no additional cost to the National Institute of Justice to allow time for dissemination of study results and preparation/documentation of data files for NIJ.

Overview of Research

There has been increasing attention paid to treatment of persons with co-occurring substance abuse and mental disorders since the publication of findings from the Epidemiologic Catchment Area (ECA) study by Regier et al. in 1990 (see also Mueser, Bennett, and Kushner, 1995; Drake and Mueser, 1996). The ECA study found very high lifetime rates (29%) of substance abuse disorders among persons with diagnosable mental disorders; concomitantly, 37 percent of those with an alcohol use disorder, and 53 percent of adults with a drug disorder, had symptoms of coexisting mental disorders. It has long been recognized in the literature on substance abuse treatment that persons with co-morbid mental disorders have worse treatment outcomes and are more difficult to treat than those with substance abuse disorders without co-morbidities (Drake et al., 1996; Miller and Hester, 1986; McLellan, 1983; Stoffelmayr et al., 1989). As a result, specific treatment programs for persons with dual diagnoses have been developed and tested (Drake and Mueser, 1996; Minkoff, 1989, 1991; Evans and Sullivan, 1991).

The successful use of intensive case management in the community for dually-diagnosed persons has been demonstrated (Drake and Noordsy, 1994; Minkoff, 1991). However, the case management/service integration approach is limited in its applicability to incarcerated populations, where the criminality adds an additional complication to treatment and where case management is irrelevant, given incarceration and the lack of multiple community based services during incarceration. Case management approaches are thus most relevant to post-release service needs of the dually diagnosed offender, and do have demonstrated success (Drake and Noordsy, 1994). There is also evidence of the effectiveness of therapeutic community programs for substance abusers with relatively high levels of psycho-social problems and psychiatric

comorbidity (Landry, 1997; Sacks, 1998; NIDA, 1999). McCorkel, Harrison and Inciardi (1997) attribute much of the success of TCs (at least program completion versus dropout) to the development of a close relationship with a counselor.

A parallel set of literature has developed regarding the implementation and impact of modified therapeutic community programs for incarcerated substance abusing populations. These studies have demonstrated the effectiveness of the TC approach for offenders with substance use disorders who remain in the program for a significant length of stay (Inciardi, 1998; Lockwood et al., 1997; Westreich, 1997). The studies have also emphasized the need for post-release transitional communities to support gains made in the primary TC within prison and to ease transition back to community life and employment (Inciardi and Hooper, 1996; Inciardi, 1998). However, most of these studies fail to address the dually diagnosed offender.

Overwhelming evidence has documented a substantial connection between substance abuse and crime. Compared to the general population, drug abusers are more likely to be involved in criminal activities (Hubbard, Marsden, Rachal, Harwood, Cavanaugh, and Ginzburg, 1989). In the United States in 1986, approximately 43 percent of state prison inmates used an illegal drug on a daily basis prior to incarceration for their current offense (U.S. Department of Justice, 1989). According to the 1991 Report of the National Task Force on Correctional Substance Abuse Strategies "drug-abusing offenders have demonstrated a marked tendency to resume their criminal careers and to participate in what has become known as 'the revolving door of justice'." Many studies have revealed that return to prison is significantly related to the presence and severity of parolee drug use (Forcier, 1991; Owen, 1991; Weekes, Millson, Porporino, and Robinson, 1994; U.S. Department of Justice, 1995), and that "any relapse into

alcohol and other drug use is likely to cause relapse into criminal behavior" (U.S. Department of Health and Human Services, 1993). In addition, many of these studies indicate that substance abuse treatment can significantly lower the likelihood of return to prison (Van Stelle, Mauser, and Moberg, 1994; Mauser, Van Stelle, and Moberg, 1994; Van Stelle and Moberg, 1995).

Mental health issues among incarcerated offenders have also received increased attention recently. It was estimated that in 1998, over a quarter million mentally ill offenders were incarcerated in jails and prisons in the U.S. (Ditton, 1999). Mentally ill inmates were more likely to be incarcerated for violent offenses than other prisoners, and 38 percent of them reported symptoms of alcohol dependence. Findings such as these have lead to headlines such as "Prisons being used to house mentally ill" (Butterfield, 1999). (Similarly, in the substance abuse treatment community, the informal opinion has been that the easiest way for an uninsured person to get treatment in many communities is to go to jail or prison.)

As the survey reported by Ditton (1999) indicates, there is a high rate of alcohol and drug abuse among mentally ill offenders. The dually diagnosed offender population presents unique challenges because although they represent a small portion of the total incarcerated population, they demand disproportionate attention and fiscal resources due to their medical needs and security risk. Persons with mental disorders usually suffer from social isolation, cognitive impairments, extreme mood swings, hostility, and depression which make them a challenging group to treat in traditional substance abuse treatment programs. Wisconsin Department of Corrections data indicate that 14 percent of its incarcerated offenders have moderate to high mental health treatment needs, and that between three and eleven percent of Wisconsin prison inmates have co-existing substance abuse and psychiatric disorders. Recent research has shown

that providing mentally ill individuals with substance abuse treatment can significantly reduce psychiatric symptoms and substance use and improve living situation and support systems (Marcus, Lake, Quirke, and Moberg, 1996). Hiller, Knight, and Simpson (In Press) have found that participation in residential aftercare after release from Texas in-prison therapeutic communities was associated with lower recidivism rates. Similarly, Simpson (1998-99) reports that transitional care during paroled release, and community-based treatment, are both effective for drug abusing offenders.

Little data are available on outcomes of prison-based programs specifically for dually diagnosed offenders. Messina, Wish, and Nemes (1997) have reported that a prison-based therapeutic community was as effective for substance abusing offenders with anti-social personality disorder as it was for those without. Westreich (1997) has described the Greenhouse Program at Bellevue Hospital but has not, to our knowledge, reported on outcomes. The Greenhouse Program, while a model for substance abuse programs for the dually diagnosed, is not prison based. We have not located other studies specifically addressing outcomes of dual diagnosis programs in prison settings.

Evaluation Study Goals

Table 1 outlines the study goals and research questions for the current outcome evaluation study.

Table 1: Study Goals and Research Questions	
Study Goal	**Research Questions**
1. Document offender participation in treatment	A. What are the characteristics of program participants?
	B. What services do participants receive and what is the dosage of those services?
	C. What proportion are successfully terminated?
	D. What is the average length of program stay?
2. Document program impact on intermediate outcomes	A. Does the program reduce or eliminate substance use while in the institution?
	B. Does the program stabilize symptoms and behavioral problems in the institution?
3. Document program impact on substance use outcomes	A. Are participants less likely to use substances after release to the community than the comparison group?
	B. Are participants more likely to participate in treatment after release than comparison group members?
4. Document program impact on mental health outcomes	A. Are participants less likely to decompensate after release to the community than the comparison group?
	B. Are participants more likely to exhibit medication compliance after release than the comparison group ?
	C. Are participants more likely to receive mental health services after release than the comparison group?
5. Document program impact on outcomes related to stability	A. Are participants more likely to maintain a stable living situation after release than the comparison group?
	B. Are participants more likely to develop a social support system after release than the comparison group?
6. Document program impact on criminal justice outcomes	A. Are participants less likely to be arrested after release to the community than the comparison group?
	B. Are participants less likely to be reincarcerated after release to the community than the comparison group?
7. Investigate program impact on access to community treatment services on parole	A. Are participants more likely to receive coordinated community services due to the involvement of the MICA outreach specialist than parolees not in MICA?
	B. Do parole agents who supervise MICA participants increase their knowledge of dual diagnosis issues?

Human Subjects Review and Approvals for Data Access

CHPPE applied for the approval of the Health Sciences Human Subjects Committee for the outcome evaluation in May 1998. We received approval to enroll subjects in October 1998, and have submitted the project to continuing annual review each year of the project.

The program participation agreement and research consent form was developed jointly by CHPPE and MICA staff during the previous NIJ-funded process evaluation (see Appendix 1). The form received the approval of both the DOC legal office and the UW Health Sciences Committee for the Protection of Human Subjects. The format was modified slightly by MICA staff during the course of the study to include routing instructions and a space for recording the inmate ID number. The program also made a few minor terminology and wording changes to the form during the course of the two-year study.

We developed a plan to gain access to sensitive information in comparison group inmate files such as substance use and mental health diagnoses. We requested the appropriate clearances from DOC in early 1999 that allowed the CHPPE researcher to enter all necessary institutions and facilities to locate and abstract data from the inmate case files for these men. Approval to enter correctional institutions and centers was received in late May 1999 from the administrators of the DOC Division of Adult Institutions and Division of Community Corrections (Appendix 2). Informational letters regarding the study were then sent out to all institution wardens and correctional center superintendents. Securing these approvals resulted in a five-month delay in initiation of data collection, but the data were still collected within the planned timeframe.

In addition to receiving approval from the Department of Corrections to access confidential offender data, approval from the UW Health Sciences Committee for the Protection

of Human Subjects, and a privacy certificate from the National Institute of Justice, we also found it necessary to seek the approval of the Wisconsin Department of Health and Family Services (see Appendix 1). Wisconsin Sec. 51.30(4)(b)3., Stats., indicate that we may see the clinical records without written consent if the research project is approved by Wisconsin Department of Health and Family Services. We received this approval in July 1999.

In July 1999 CHPPE was asked to provide the following additional confidentiality assurances to the Wisconsin DOC (see Appendix 1): the confidential records would be used only for the purposes of the study, confidential records would not be released to anyone not connected with the study, and the study final report will not reveal information that would serve to identify study participants. The Presentence Investigation (PSI) may be seen by us under sec. 972.15(5), Stats., as long as the inmates' identities are kept confidential. Wisconsin Sec. 146.82(2)(a)6., Stats., provides that we may see the medical files due to our affiliation with the health care provider (DOC) if we provide written assurances. In August 1999 we were also asked by the DOC to sign an additional memorandum of understanding to assure the DOC that we would share the study results with them when completed (see Appendix 1).

SCOPE AND METHODOLOGY

Research/Evaluation Design

The methodology for the current study included the collection of both qualitative and quantitative evaluation research data to assess participant outcomes and program impact. The study design included a description of the male inmates who were admitted to MICA, an examination of intermediate outcomes, an examination of outcomes three months after release to the community, and an investigation of MICA impact upon community service systems. The design also included a comparison group identified as part of the prior process evaluation study.

Table 2 summarizes the data collection intervals for study participants and the comparison group. Major data collection points in the current study included: baseline/program admission, end of residential therapeutic community (TC) component, six months after the end of the TC component while the offenders remained incarcerated, release to community, three months after release to community, and six months after release (for the small sample available). These intervals translated to collection of data for graduates at eight months after graduation (two months for the optional two-month transition phase plus six months follow-up) or at time of release (whichever came sooner). For MICA terminations data were collected at 10 and 16 months after admission to reflect when they would have completed MICA had they remained in treatment.

This report summarizes two and one-half years of MICA treatment program admissions from October 1997 through March 2000. Year 3 (October 1, 1999 - March 31, 2000) is comprised of six months because data collection was concluded in Spring 2000 to prepare the final report prior to the end of NIJ funding for this research effort.

Table 2: Data Collection Intervals				
Interval	When.....	Graduates	Terminations	Comparison
Month 0/ Baseline	MICA Admission	✔	✔	✔
Month 8	End of Institutional TC Component	✔	✔	
Month 10	End of Optional TC Phase Five	✔	✔(10 months after admission)	
Month 16	Six Months After End of TC Services	✔(8 months after graduation)	✔ (16 months after admission)	
Release to Community	Varies By Inmate	✔	✔	✔
Three Months Post-Release	Post-Release Follow-up	✔	✔	✔
Six Months Post-Release (May 2000)	Criminal Recidivism Follow-up	✔	✔	✔

A modification was made to our proposed plan for collecting data on offender outcomes after release to the community. This change involved shortening the post-release follow-up interval from six months after release to three months after release. This change was necessitated both by changes in the composition of the Wisconsin Parole Board/Commission as well as policy changes in Wisconsin including recent "truth-in-sentencing" legislation resulting in very few early parole grants issued. These changes mean that MICA graduates remain incarcerated after completion of the residential treatment program rather than being released/paroled to the community as initially anticipated, and that fewer program participants reached the community during the short time-frame of this research study. Thus, the follow-up interval was shortened in an effort to maximize our sample size.

Assuming a three-month follow-up, participants had to be released to the community by February 2000 to gather a three-month follow-up during May 2000. Estimating an average of

release six months after graduation, participants had to complete MICA by September 1999. To complete the ten-month residential treatment program inmates must have been admitted by December 1998. Thus, anyone admitted after December 1998 is not included in the *follow-up* component of this study. [However, all admissions through March 2000 are included in the tables summarizing program activity for this report.]

There were 20 MICA program graduates and 116 terminations during the study data collection period, with 14 graduates and 19 terminations released to the community (these men remained incarcerated for extended periods after program exit). Shortening the follow-up interval from six months post-release (as originally planned) to three months post-release increased the sample size by more than one-third. There were 31 offenders (12 graduates and 19 terminations) appropriate for three-month follow-up, and only 20 (six graduates and 14 terminations) appropriate for the originally planned six-month follow-up. There were 51 comparison group offenders appropriate for three-month follow-up and 46 who were appropriate for six-month follow-up.

On a practical level, we've also learned that gathering follow-up information on offenders from probation and parole agents is best done in a timely fashion. Follow-up reports on offender progress at three months after release are more reliably obtained because the offenders are still likely to be on their caseloads (i.e., not yet reincarcerated or transferred to another agent).

The six-month criminal recidivism follow-up utilizing the Wisconsin Crime Information Bureau (CIB) database remains in our study design. We maximized the available small sample size (six graduates, 14 terminations, and 46 comparison) by waiting until May/June 2000 to obtain, analyze, and summarize the data prior to submission of this report in Summer 2000.

Composition of Treatment and Comparison Groups: During the development of the proposal for this study, we estimated that the potential sample of treatment participants available for this study would be approximately 100 treatment admissions. In fact, there were 141 dually diagnosed offenders who were admitted to MICA during a two and one-half year period (October 1, 1998 and March 31, 2000). We also estimated that the first cohort of participants would be released to the community in June 1998, with at least 50 MICA participants "at risk" in the community for a minimum of six months by Spring 2000 when data collection ended. Unfortunately several factors combined to decrease the sample size of MICA participants who were released to the community during the timeframe of this study. The MICA therapeutic community component was made longer by an additional two months and changes in the parole commission resulted in fewer offenders allowed early parole to the community. This meant that MICA graduates were likely to spend an extended time incarcerated after program completion. Rather than the 50 participants that we expected to follow, there were 31 participants out for three months or more during the study timeframe.

A comparison group of dually diagnosed inmates who did not receive MICA services was identified during the prior NIJ-funded process evaluation study. These inmates met all program diagnostic and eligibility criteria, but did not receive MICA services because they had less than 18 months to mandatory release (MR) and so would likely be released prior to completion of the treatment program. A group of 79 of these inmates was initially identified by the DOC Bureau of Offender Classification using the CIPIS database. Of these 79 men, 13 were excluded for a variety of reasons (i.e., they had already refused MICA, were currently in the community on intensive supervision, or had been transferred to prisons outside of Wisconsin). Thus, the

comparison group for this outcome study included 66 men. There were 51 comparison group offenders in the community for three months or more during the study timeframe. There were a larger proportion of comparison group men released to the community than MICA participants because the shorter time remaining on their sentences had prevented them from entering MICA.

Table 3 presents baseline demographic, diagnostic, and criminal justice data for offenders admitted to MICA during the study period and for the comparison group. There were few statistically significant differences between the participant and comparison groups with respect to any of the factors examined. The first difference is that comparison group inmates were more likely to receive a diagnosis of "poly-substance dependence" or "alcohol abuse" than the MICA admissions. However, this difference can likely be accounted for by the fact that different clinicians conducted the diagnostic assessments. All of the MICA participants were diagnosed by the MICA psychologist at admission to MICA, while the comparison group men were diagnosed by a variety of DOC clinicians at variety of prisons. The second difference is that the primary criminal offense of comparison group offenders was more likely to be violent or aggressive. However, this difference could be due to the fact that the offense of participants entering MICA as an alternative to revocation (ATR) of their parole is documented to be "ATR" rather than the criminal offense for which they were convicted. Thus, it is unclear whether the 15 percent of participants for whom this primary offense data was essentially unavailable could be skewing the results. The third difference is that the comparison group tended to have slightly more conduct reports than MICA admissions in the six months prior to baseline.

Table 3: Comparability of Treatment and Comparison Groups

	All Admissions (N = 141)	Comparison (N = 66)
Average Age at Baseline	36.2 years	36.0 years
Race/Ethnicity		
White	48%	36%
Black	50	62
Native American Indian	1	0
Hispanic	1	2
Average Reading Level (TABE)	6.8	6.6
Average Highest Grade Completed	11.0	11.2
Primary Mental Health Diagnoses		
No Axis I diagnosis	6%	0%
Schizophrenic	34	38
Schizoaffective	19	27
Bi-polar	19	15
Psychotic disorder	9	3
Depressive disorder	7	4
Anxiety/mood disorder	1	4
Personality disorder	0	4
Dementia NOS	1	2
Other	4	4
Proportion on Psychotropic Medication	90%	89%
Primary Substance Use Diagnoses		
Alcohol dependence	35%	23%
Cocaine dependence	40	9
Marijuana dependence	7	4
Opiate dependence	3	2
Sedative dependence	1	0
Hallucinogen dependence	1	2
Poly-substance dependence	2	24
Alcohol abuse	7	24
Marijuana abuse	2	3
Cocaine abuse	1	3
Other diagnoses	1	6

Table 3: Comparability of Treatment and Comparison Groups (continued)

	All Admissions (N = 141)	Comparison (N = 66)
Primary Offense		
Property	40%	38%
Violent/aggressive	16	41
Sexual Assault	9	12
Drug or Alcohol	14	9
Other	6	0
ATR admission (MICA only)	15	0
Average Overall Parole Risk Rating [1=high, 2=moderate, 3=low]	1.8	1.6
Average Conduct Reports in Six Months Prior		
Minor	1.6 (s.d.=2.9)	2.6 (s.d.=3.5)
Major	0.4 (s.d.=0.9)	2.2 (s.d.=4.2)

Overview of Variables and Issues Examined: The current study examined variables in four primary domains -- personal, substance use, mental health, and criminal justice. Table 4 outlines the types of measures that we used to document baseline participant characteristics, intermediate outcomes in the institution and at discharge, and community outcomes three months after release. A subset of these measures were available for the comparison group.

Table 4: Variables Examined

Domain	Baseline	Intermediate Outcomes	Post-Release Outcomes
Personal	*age, ethnicity, years of education, reading level, ever employed*, daily living skills, IQ, medical problems	daily living skills, hygiene, support services received, treatment staff progress ratings, support system development	*living situation*, independent living skills, *hygiene, employment, support system, service referrals*
Substance use	*diagnosis, primary drug*, needle use, *treatment history*, motivation and readiness for treatment, ASI, CMRS	*AODA treatment dosage*, program performance and progress, *urinalysis results*, treatment staff progress ratings, CMRS	*aftercare participation, referrals for treatment, parole urinalysis results, breathanalysis results*, ASI
Mental health	*diagnosis, treatment history, psychotropic medications, conduct report history*, DIS, BSI, DPRS	*mental health treatment dosage*, symptoms, BSI, DPRS, PCL-SV, *conduct reports*, medication compliance, treatment staff progress ratings,	*behavioral episodes, medication compliance, referrals for/participation in counseling or support groups*, BSI
Criminal justice	*current offense, sentence length, parole eligibility, mandatory release date, prior incarceration*	*DOC risk/needs assessment results*, treatment staff progress ratings	*arrests and convictions, offense severity, parole performance, reincarceration*

Note. Italicized measures were available for both participant and comparison group offenders.

In addition, our examination of the impact of MICA on access and coordination of community services after release collected data investigating such issues as the number and type of treatment services received (both AODA and mental health), support services received (housing, financial assistance, and transportation referrals), support system development (family, friends, and religious), and level of communication/coordination among agents and MICA staff.

Data Sources and Data Collection Strategies

The current study employed a variety of data collection sources and strategies. We collected information from the treatment program database, parole agents, MICA staff, offender case files, and corrections data systems. We combined data from the MICA computerized participant data system and electronic corrections data systems with inmate case file review, parole agent follow-up reports, and outreach specialist follow-up reports. In addition, service system data were gathered from parole agents through mailed surveys and qualitative telephone interviews, and CHPPE staff attended monthly staff meetings at the treatment site to gather contextual information useful for interpretation of outcome evaluation results.

Table 5 outlines each specific data source and the types of information collected from each. Copies of the data collection forms are presented in Appendix 2.

Process/Contextual Data: The primary evaluator (KVS) had extensive contact with the staff of the MICA program. During the two years of outcome evaluation the primary evaluator scheduled and attended 20 meetings to discuss evaluation issues with MICA staff. These meetings were for the purpose of collecting process evaluation data to provide contextual data for the interpretation of outcome evaluation findings, documenting changes to the program model and services, monitoring the implementation of the participant data system and database, and providing formative feedback to the program.

Additional qualitative data were gathered through interviews with the MICA outreach specialist to document the aftercare component of the treatment program and through review of treatment program documents including program reports, policy and procedure documents, treatment materials, etc.

Table 5: Overview of Study Data Sources	
Data Sources	Data Purpose
MICA Participant Data System	describe the treatment participants, to document project services, and to assess intermediate outcomes
Parole Agent Reports	three-month reports on offender progress after release, service system impact mail survey at baseline and telephone interview at follow-up
MICA Outreach Specialist Reports	reports on institutional behavior and services between MICA graduation and release to community for graduates, three-month reports on offender progress after release, process evaluation interviews
Inmate Case File Reviews	baseline descriptive information for comparison group, reports on institutional behavior and services for comparison and MICA terminations
Department of Corrections Integrated Program Information System (CIPIS)	identification of comparison group offenders, baseline descriptive information for comparison group, tracking/locating inmate institutional files, documenting inmate movement to assess reincarceration
Wisconsin Crime Information Bureau (CIB)	printouts to document arrest, conviction, and case disposition data
Offender Active Tracking System (OATS)	data to document incarceration in county jails after release
Meeting notes, program document review	process/contextual data

Descriptive and Service Dosage Data: Multiple data sources were used to gather baseline descriptive data for treatment participants and comparison group offenders including the MICA participant database, the CIPIS database, and inmate case file review.

As part of the 1997/1998 NIJ-funded process evaluation of MICA, participant data collection forms were developed to describe the treatment participants, to document project services, and to assess intermediate outcomes (see Appendix 2). With program staff input, these

forms were designed to summarize/abstract inmate descriptive data from existing DOC forms, as well as collect data regarding assessment results, program services, and inmate performance unique to the project. A database for systematizing the forms was also developed by CHPPE using Microsoft ACCESS. This database was maintained at the MICA program site. A copy of the database file was received from MICA on a semi-annual basis and checked for systematic and data entry errors. A brief summary of participant flow and characteristics was prepared for program staff by CHPPE at that time.

To assist MICA with the transition to collecting and summarizing their own evaluation data at study end, CHPPE also worked collaboratively with MICA staff toward the end of this study to revise the summary forms and database to reflect the changes in MICA emphasis, structure, and services that had occurred since the data system was developed. CHPPE also encouraged MICA administrative staff to facilitate software training of support staff to enable MICA to independently summarize the database files.

To gather similar baseline demographic and descriptive data for the comparison group offenders the CIPIS database was utilized. We abstracted as much relevant information as we could from this system regarding comparison group demographic, needs/risk assessment, treatment need, criminal justice system history, and offense information data. The program participant data system forms were used to summarize these data into a format consistent with that of the MICA participants. These data were supplemented by a baseline review of each offender's institutional case file. Some of the comparison group baseline data necessary for this study was contained only in the social services section of the inmate case file located at the institution where the individual was incarcerated. Data on mental health diagnoses and treatment

received, substance abuse assessment results and treatment received, medical conditions and treatments received, and institutional behavior (conduct reports) were contained only in this case file. These data were collected by the CHPPE researcher who traveled to each institution in Wisconsin that held comparison group members to abstract the particular pieces of information of interest from these paper files.

Intermediate Outcomes: Data pertaining to intermediate outcomes in the institution were gathered for treatment participants both during and after their participation in MICA.

Participant Data System: We received a data file from the MICA program containing the program participant data system on a semi-annual basis. This data file included information on intermediate outcomes for treatment participants while in the treatment program such as institutional behavior (conduct reports, segregation time, etc.) and MICA staff ratings of treatment progress, behavior, and mental health stability.

Inmate Case File Review: Each offender who enters the Wisconsin prison system is assigned an institutional file to organize relevant documents. This file is transferred from institution to institution along with the inmate. The CHPPE researcher reviewed and abstracted offender data from these files housed in records offices at each institution. This manila folder contains separate files for social service, legal, and clinical information which summarize information for each inmate pertaining to institutional movement, sentencing, programming received, conduct reports, parole commission action/correspondence, etc. There is also a separate medical file containing confidential medical information about each offender that we received DOC administrator approval to access. We did not, however, review these medical files because they are typically housed separately from the other files which made access more

difficult, and because some institutional medical staff objected to our review of the files even though we had been granted the authority to do so by their superiors within DOC.

A study log was developed to track when file reviews needed to be completed based on inmate date of admission to MICA, discharge from MICA, and date of release from the institution. At the beginning of each month an assistant in the DOC Bureau of Offender Programs sent a list of the study participants with updated information on their current institutional assignment, mandatory release date, date of release to the community (if released), and assigned parole agent. Each month the researcher matched this list against the evaluation study log to plan trips to the institutions where the study participants and their case files were located for the coming month. A request was then sent to staff in each institution's records office to schedule time to review the group of files. The researcher then traveled to each institution on a monthly basis to review the inmate case files and abstract selected data from them. This file review took approximately 20-30 minutes per offender. To most efficiently collect the data, offender files located in institutions that were more than three hours distant from the research offices were sometimes temporarily transferred to the central records repository for review and then returned. The researcher would frequently travel to the central records repository (one hour from the research offices) to review these files from multiple institutions all over Wisconsin as a group. The local records office staff would typically have the appropriate files ready for review when the researcher arrived at the institution on the scheduled day.

As each comparison group offender was released to the community, data on institutional behavior and services for the comparison group were gathered during an additional case file review. In addition to reviewing the inmate case files of comparison group offenders, the

researcher also personally reviewed the case files of each man terminated from MICA. Data was gathered from case files for each terminated inmate at ten months after admission and again at 16 months after admission to MICA.

The CHPPE researcher made 33 trips to 10 different correctional institutions during the course of this study exclusively for the purposes of collecting these data from offender files. Table 6 presents the number of offender files reviewed by the researcher at various Wisconsin correctional institutions. In addition to these files, the researcher also gathered substance abuse and mental health diagnostic information on twelve MICA participants who were terminated from the treatment program prior to completing these diagnostic assessments.

Table 6: Inmate Case File Reviews Conducted

	Number
Treatment Group -- Terminations/Drop-outs	
Ten-Month Post-Admission Summary	67
Sixteen-Month Post-Admission Summary	51
Diagnostic Summary	12
Comparison Group	
Baseline Characteristics Summary	66
Intermediate Institutional Outcomes Summary	54
Total File Reviews Conducted	250

Post-Release Outcomes: Multiple strategies were employed for collecting the post-release outcomes of study participants -- parole agent reports, MICA outreach specialist reports, and Department of Corrections data systems.

Parole Agent Reports: We worked collaboratively with the statewide administrator of the Division of Community Corrections to obtain the cooperation of the local agents in providing the follow-up information. We enlisted the support of the statewide administrator and regional supervisors to foster the cooperation of busy parole agents.

Parole agents for both the treatment and comparison groups were asked to provide information pertaining to the four primary outcome domains in the proposed study (personal, substance use, mental health, and criminal justice). As each study participant approached the three-month post-release date, a follow-up summary form and brief instruction sheet (see Appendix 2) were sent to the unit supervisor of the agent supervising him. The unit supervisors distributed the follow-up forms to the appropriate agent and returned them to CHPPE in the return envelope provided. In addition, we requested and received follow-up information from parole agents in Illinois and Florida for two MICA graduates being supervised out-of-state. The first requests for information were sent to unit supervisors in late June 1999.

If a completed form was not returned within four weeks a voice mail or email message was sent to the agent reminding them to complete and return the form. If this did not elicit a response, the unit supervisor was asked to remind the agent of the importance of returning the follow-up form. If the form still was not returned, the statewide administrator's office was notified by CHPPE and they contacted the unit supervisor. Utilizing these methods, **we received back 100 percent of the three-month follow-up forms from parole agents.**

Outreach Specialist Reports: The MICA outreach specialist also summarized data on community outcomes for MICA graduates three months post-release. CHPPE worked with MICA staff to develop a format for reporting personal, substance use, mental health, and

criminal justice measures. The MICA outreach specialist also readministered two of the assessments performed at program admission and discharge including the Brief Symptom Inventory (BSI) and the Addiction Severity Index (ASI). The outreach specialist was in regular contact with these parolees and completed the summaries as graduates reached three months in the community.

Corrections Data Systems: We investigated recidivism to the criminal justice system utilizing data obtained from multiple sources. The DOC Bureau of Offender Programs facilitated the collection of these data pertaining to arrest and reincarceration after release.

Data on arrests was obtained from the Wisconsin Crime Information Bureau (CIB) database for offenders in the treatment and comparison groups. DOC staff looked up each study participant in the database and printed out the CIB arrest summaries for CHPPE. These data were obtained for all study participants except one termination. The researcher picked up the printouts from the DOC Bureau of Offender Programs office.

These data were supplemented and verified by incarceration data from Wisconsin's Corrections Integrated Program Information System (CIPIS) database. MICA support staff looked up each study participant in the database and printed out the "Inmate Status/Movement History" for each one. These movement summaries supplied information regarding current incarceration status, and dates and reasons for incarceration in the state prison system.

To document incarceration in county jails we also accessed the Offender Active Tracking System (OATS) database. The OATS data provided information on custody in county jails due to probation/parole holds, probation/parole violations, alternative to revocation violations, revocation holds, and new minor criminal offenses. We received from DOC a data file

containing information regarding date of custody, reason taken into custody, county, and days in custody for each study participant during the study period.

A recidivism abstract form (see Appendix 2) was developed to aid in the summary of data from these data sources. The abstract form documented arrest, case disposition (when available), and incarceration information for each participant and comparison offender. Recidivism data from each source were summarized onto the recidivism abstract form to create a single data set.

Service System Impact: To investigate program impact upon community and parole services for dually diagnosed offenders we collected input from probation and parole agents in two separate efforts: a baseline mailed survey of a random sample of agents in Spring 1999 and telephone interviews with agents who had supervised dually diagnosed offenders in Spring 2000.

Baseline Mail Survey: To investigate program impact upon community and parole services for dually diagnosed offenders we designed a brief baseline survey to be completed by Wisconsin parole agents (see Appendix 2). Although the proposed evaluation plan included telephone or in-person interviews with a very small sample of parole agents, we decided to gather a wider variety of baseline input and opinions from parole agents by drawing a random sample of 400 agents from the pool of over 1,100 parole agents in Wisconsin.

We mailed informational letters and an example of the survey to regional chiefs one week prior to the survey mailing, asking them to please notify the numerous parole unit supervisors in their region that the survey would be arriving soon. We mailed surveys to agents on February 15, 1999 asking them to return the completed surveys by March 5, 1999. CHPPE began receiving telephone calls and email messages from agents and supervisors the following day. Many agents called asking if they should complete the survey because they were new or didn't

have any dually diagnosed offenders on their caseloads. Some agents indicated that their supervisors told them not to complete the survey if they had never referred an offender to MICA. One unit supervisor called to inform us that none of their offenders met the dual diagnosis criteria so his agents wouldn't be participating in the survey.

As the surveys were returned to CHPPE it became clear that some regional chiefs and unit supervisors distributed copies of the sample survey (marked "SAMPLE" in large letters) to their agents who supervised dually diagnosed offenders *regardless of whether they had been selected for our random sample*. One unit supervisor indicated that she had received a memo from a Department of Corrections administrator telling her to route the survey only to agents who supervise dually diagnosed offenders.

DOC central office administrators had, indeed, sent an email message in which they told the field that only agents who actually supervised MICA graduates should complete the survey. It should be noted that at the time of the survey no MICA graduates had yet been paroled and agents could not have supervised a MICA graduate in the community. CHPPE alerted DOC central office to the situation and administrators emailed the regional chiefs on March 10, 1999 asking all agents who received the survey to complete it by March 19. We received only about 20 additional surveys after that time.

We received a total of 139 useable surveys, including some surveys from parole agents not chosen for the random sample (Table 7). Fortunately, the resulting survey sample was quite similar to our targeted random sample of agents, with Region 3 (the unit that supervises mentally ill offenders in Milwaukee) adequately represented. A brief qualitative summary of the results was prepared and discussed with treatment staff during the April 1999 monthly staff meeting.

Table 7: Representativeness of Baseline Agent Mail Survey Sample						
	Surveys Received		Random Sample		Agent Population	
	#	%	#	%	#	%
Region 1	21	15%	58	14%	162	14%
Region 2	9	6	50	13	141	12
Region 3	44	32	116	29	346	30
Region 4	17	12	39	10	121	11
Region 5	12	9	28	7	81	7
Region 6	7	5	27	7	75	7
Region 7	16	12	44	11	114	10
Region 8	13	9	38	9	108	9
TOTAL	139	100%	400	100%	1,148	100%

Follow-up Telephone Interviews: A follow-up with parole agents was also conducted in May 2000 to assess any changes in offender access to community treatment and support services over the course of the project. This follow-up effort included telephone interviews with probation and parole agents who had returned three-month follow-up forms for this study and therefore had directly supervised at least one dually diagnosed offender in the past year. A telephone interview was developed (see Appendix 2) to ask about agent experiences and opinions related to using MICA as an alternative to revocation (ATR), MICA impact on offender behavior, MICA services, and suggestions for increasing access and coordination to services for the dually diagnosed offender. Forty-nine probation and parole agents who had returned three-month follow-up forms for MICA participants (N=21) or comparison group offenders (N=28) were identified. Letters were sent to the appropriate unit supervisors informing them that an agent in their unit had been selected to participate in a short telephone interview. Letters were

sent to the selected agents describing the interview and asking them to contact the researcher with a preferred time within a selected week in May 2000 to complete the interview.

The goal was to draw a convenience sample of 20 agents, including 10 agents who had supervised participants and 10 who had supervised comparison group offenders. We also deliberately oversampled the probation/parole unit in Milwaukee dedicated to supervising offenders with mental illness because we had received a larger group of three-month follow-up forms from that unit than any other.

Table 8 summarizes the results of the data collection effort. Twenty-three interviews were scheduled and 22 completed. The completed interviews were evenly divided among agents who had supervised MICA participants and those who had supervised comparison group members. About one-quarter of the respondents were from the special mental health unit.

Table 8: Description of Follow-up Parole Agent Telephone Sample

	Number
Total Agents Invited to Participate in Interview Via Letter	49
Agent had left position	4
Agent did not respond to voice mail follow-up of letter	29
Scheduled interview through telephone conversation	11
Scheduled interview through email	12
Total Interviews Scheduled	23
Unable to reach on day of interview	1
Completed interviews with agents who...	22
Supervised MICA graduates	5
Supervised MICA terminations	6
Supervised comparison offender(s)	7
Used MICA as an ATR and supervised comparison	4

Methods of Data Analysis

In comparing MICA subjects to the comparison subjects, an "intent to treat" analysis was used to avoid confounding factors predicting completion with program effectiveness. Logistic regression was use as the primary analytic technique for dichotomous dependent measures, and OLS for continuous measures. Our basic model for analyzing outcome was:

$$Y = a + B_i X_i + B_i D_{trt} + e, \text{ where}$$

Y = *Outcome at three months (e.g., incarcerated, stable, in treatment)*

a = *intercept,*

B_i = *regression weights,*

X_i = *array of time 1 (baseline) covariates (e.g., age, ethnicity, reading level),*

D_{trt} = *dummy variable indicating treatment group assignment (1 if MICA, 0 if comparison), and*

e = *error.*

In this model, the coefficient B_i for D_{trt}, if significant, indicates the mean treatment effect for MICA participants compared to comparison subjects, controlling for the various covariates in the model.

Substance Use Outcomes. MICA participants were compared to the comparison group with regard to AODA diagnosis, primary drug, level of substance use after release, and treatment involvement after release. We utilized Chi-square, t-tests, analysis of variance, and multiple regression to investigate the factors that impact substance use after release for both groups.

Mental Health Outcomes. MICA participants were compared to the comparison group with regard to treatment involvement, mental health stability, medication compliance, and episodes of deterioration. We utilized Chi-square, t-tests, analysis of variance with

treatment/comparison and exposure/dosage as factors, and OLS and logistic regression to investigate factors that impact mental health outcomes after release for both groups.

Recidivism Outcomes. Arrest records provided information on the types of offenses for which MICA offenders and those in the comparison group were most frequently arrested after release to the community. Analyses describe recidivism to the criminal justice system with specific emphasis on the impact of parolee mental health, the impact of parolee substance use and treatment involvement, and a calculation of the number of days elapsed from release to the community to the new arrest. Statistics include Chi-square, t-tests, analysis of variance, multiple regression, and analysis of covariance as appropriate.

Relationships Among Measures. Recidivism data was linked to intake, discharge, and follow-up data collected by MICA staff and data on institutional behavior collected by the researcher. Analysis of the relationships among these measures was examined utilizing bivariate correlation, analysis of covariance, and ordinary least squares (OLS) and logistic regression. Both proximal and distal outcomes were investigated.

DETAILED FINDINGS

Brief Summary of Treatment Program Design and Model

The Wisconsin Residential Substance Abuse Treatment (RSAT) for Prisoners grant started on January 22, 1997. The federal Department of Justice provided annual funding of $303,643 and an additional $101,214 in matching funds were supplied by the Wisconsin Department of Corrections (DOC).

The Mental Illness - Chemical Abuse (MICA) Treatment Program admitted the first cohort of treatment participants in October 1997. MICA is a 9-12 month modified therapeutic community (TC) offering integrated treatment for substance abuse and mental health issues. The program design provides for a regimented environment that includes strict community norms regulating participant behavior and involvement in community management. The current treatment focus which evolved is on basic habilitation and skills acquisition related to cognitive, behavioral, social, and vocational issues. Psycho-education is provided through didactic groups which address addiction, mental illness, social and emotional skills, anxiety, depression, medications, and physical health. Individual counseling is also provided. Medication compliance and urinalysis protocols have been established to control and manage psychiatric symptoms and to ensure abstinence from non-prescribed drugs.

The 25-bed capacity MICA program is currently situated within the existing Transitional Treatment Center for mentally ill inmates at Oshkosh Correctional Institution (OSCI). All program participants share cells in one 62-bed wing of this unit, but also have contact in common areas with the other 115 inmates who reside in the unit. As of Summer 2000, there is a preliminary proposal to move MICA to a completely isolated unit currently vacant within OSCI

(the old segregation unit). This move would eliminate contact with general population inmates for MICA participants. It is unclear when this much-needed move will be accomplished.

The overall purpose of MICA has been defined in a mission statement:

> *The Mental Illness-Chemical Abuse (MICA) treatment program is designed to provide opportunities and challenges for participants to develop the attitudes and attributes necessary to live positively and become responsible, contributing members of the community.*

As part of this overall mission, MICA strives to help participants (1) increase independent living and self-management skills and (2) demonstrate appropriate skills and responsibility to transition to community living. The primary goals of the MICA treatment program are:

- Stabilize acute symptoms and behavioral problems evidenced in both the institutional and community settings.
- Engage the offender to participate in a long-term, community-based program of maintenance, rehabilitation, and recovery.
- Reduce the impact of disruptive behavior on the institution and the community to which they return.
- Prepare inmates for release utilizing a long-term treatment program and monitoring regime.
- Provide consultation for parole agents on specific treatment and behavior monitoring.

The MICA program has nine primary staff members: a program director (50%),

psychologist, treatment specialist, psychiatrist (20%), outreach specialist, social worker, nurse clinician, corrections officer, and program assistant. There has been very minimal staff turnover, with changes in only the nurse clinician and psychiatrist positions during the course of the data collection period. However, in Summer 2000 the outreach specialist transferred to another institution – the impact of this turnover upon MICA is currently unknown.

Eligibility and Assessment: Eligibility criteria for MICA state that an inmate must:

- Receive an Axis I diagnosis of a severe and persistent mental illness such as schizophrenia, schizoaffective disorder, bipolar disorder, or delusional disorder which prevents participation in a traditional correctional substance abuse treatment program.
- Receive a diagnosis of substance abuse or substance dependence;
- Volunteer to enter treatment program;
- Be medically and clinically stable;
- Have at least 12 or more months to mandatory release (in Wisconsin inmates serve a maximum of two-thirds of their sentence and must be released); and
- Be at a medium or minimum security level.

Eligible offenders throughout the prison system are identified based on proximity to their release date by the institution classification office. If the inmate is interested in entering MICA, the MICA psychologist reviews his clinical appropriateness utilizing the "Review for Mental Health Placement" summary form completed by the referring institution's psychologist. If deemed appropriate the inmate is transferred to OSCI to fill existing MICA vacancies.

MICA also accepts offenders referred by probation and parole as an Alternative to

Revocation (ATR). The referral process begins with a telephone contact from probation/parole agents, public defenders, or attorneys to MICA staff. MICA sends a referral packet explaining the program and its eligibility requirements, as well as the required application documenting the offender's eligibility. MICA staff review the information and arrange for a bed reservation and the offender's transfer to MICA.

Each participant undergoes a multi-disciplinary assessment upon admission to MICA. In addition to a complete medical examination conducted by the MICA nurse clinician, the MICA psychologist has developed a comprehensive set of assessment tools which include:

- Diagnostic Interview Schedule (DIS);
- Circumstances, Motivation, and Readiness for Treatment Scales (CMRS);
- Addiction Severity Index (ASI);
- Mini Mental Status Examination (MMSE);
- Wechsler Abbreviated Scale of Intelligence (WASI);
- Brief Symptom Inventory (BSI);
- Derogatis Psychiatric Rating Scale (DPRS);
- Hare Psychopathy Checklist – screening version (PCL-SV); and
- Daily Living Skills Assessment (modified by the MICA psychologist to be more relevant to the institutional environment).

Overview of Treatment Model Components: The MICA program is based on the New Hampshire Greater Manchester Integrated Treatment Model for dually diagnosed individuals and emphasizes providing pre-treatment services prior to active treatment. MICA has revised the community-based New Hampshire model into a ten-month treatment program to better meet the

needs of dually diagnosed inmates. The MICA model currently includes the following three basic components: the Therapeutic Community (TC) component, the Institutional Aftercare component, and the Community Aftercare component.

Therapeutic Community (TC) Component: The TC component includes five residential treatment program phases:

- Phase 1: Engagement/Persuasion (convincing participants that treatment has something desirable to offer, develop relationship with staff, become acclimated to a therapeutic environment, and motivate them to take corrective action);
- Phase 2: Active treatment - 1(knowledge and understanding of chemical abuse, mental illness, and dual diagnosis);
- Phase 3: Active treatment - 2 (increasing understanding of chemical abuse, mental illness, and dual diagnosis);
- Phase 4: Relapse prevention (learn relapse prevention theory and techniques to address feelings/behaviors that lead to relapse and criminal behavior); and
- Phase 5: Transition (for graduates only, as needed, to provide step-down services as a transition to a less structured environment outside of the treatment program).

MICA participants in all program phases participate in a variety of activities to enhance their treatment experience. Participants attend community meetings, treatment groups, and social activities each weekday throughout the treatment phases. They attend a community meeting at the beginning of the day and a wrap-up meeting late in the afternoon. They participate in individual sessions with their primary staff person, social skills treatment groups, structured social activities, daily living skills groups, and mental illness and substance abuse treatment

groups. During the active treatment phases men also participate in groups addressing criminal thinking, health, anger management, and relapse prevention.

MICA has incorporated numerous elements of a therapeutic community model: community meetings, a system of behavioral consequences and rewards, using program graduates as program aides/tutors, common meals, creation of treatment cohorts, common work assignments, and group recreational activities.

MICA participants are required to submit to urinalysis (UA) testing as a part of treatment. Participants are tested randomly on a weekly basis (six men are selected each week) and at the end of each treatment phase. While the general population inmates are tested for cocaine and marijuana, at the end of each treatment phase MICA participants submit to both a full drug panel and a therapeutic drug panel.

Institutional Aftercare Component: The MICA outreach specialist provides supportive services to MICA graduates who remain incarcerated after completing the TC component. The outreach specialist periodically visits each graduate in the institution (either medium security prisons or minimum security correctional centers), provides pre-release preparation services, conducts relapse prevention groups, contacts community agencies, and contacts family members.

Community Aftercare Component: The role of the outreach specialist is also to identify and develop treatment and supportive services for offenders completing the residential component of the program. In addition to an individual monthly meeting, the outreach specialist facilitates access to ongoing mental health treatment and substance abuse treatment in the community. She also assists graduates open bank accounts, locate housing, find furniture, set up utility services, seek/obtain employment, meets with their families, meets with their agents, and

completes in-person follow-up interview/assessments.

The MICA outreach specialist also developed a network of community-based services for MICA participants upon parole. The outreach specialist disseminated information about MICA to community organizations that provide services to dually diagnosed individuals. She developed a directory of community resources within Wisconsin for the dually diagnosed offender which can be used by corrections staff when developing release plans, and conducted informational visits to the Madison and Milwaukee probation and parole departments.

MICA Residential Therapeutic Community (TC) Component

The following section of this report summarizes data pertaining to Study Goal #1: Document offender participation in treatment. The research questions posed under Goal #1 include those pertaining to describing the characteristics of program admissions, service types and dosage, completion rates, and average length of program stay. Data presented in this section are from the MICA program database maintained by treatment program staff.

Description of Treatment Program Participant Flow: Table 9 illustrates the flow of MICA admissions through the residential treatment program. MICA admitted 141 offenders to treatment during a 2 ½ year period. Fifteen percent of these admissions (21 men) were administratively terminated from MICA because they were found to not meet program eligibility criteria after they were admitted. Seventeen percent (20 men) of the appropriate admissions completed the program.

Table 9: MICA Participant Flow (October 1, 1997 - March 31, 2000)

	Year 1 10/1/97-9/30/98	Year 2 10/1/98-9/30/99	Year 3 * 10/1/99-3/31/2000	Overall
Admissions	**55**	**54**	**32**	**141**
From Inmate Population	51	43	29	123
Alternative to Revocation (ATR)	4	11	3	18
Phase 1 Discharges	**53**	**53**	**22**	**128**
Positive - to next treatment phase	33	28	6	67
Administrative termination	7	9	4	20
Disciplinary termination	11	13	7	31
Drop-out	1	2	2	5
Other	1	1	3	5
Phase 2 Discharges	**34**	**29**	**6**	**69**
Positive - to next treatment phase	25	23	3	46
Administrative termination	0	0	1	1
Disciplinary termination	5	4	0	9
Drop-out	3	2	0	5
Other	1	0	2	3
Phase 3 Discharges	**27**	**21**	**1**	**49**
Positive - to next treatment phase	21	15	1	29
Administrative termination	0	0	0	0
Disciplinary termination	6	5	0	11
Drop-out	0	1	0	1
Phase 4 Discharges	**19**	**11**	**0**	**30**
Positive - to next treatment phase	14	6	0	20
Administrative termination	0	0	0	0
Disciplinary termination	4	5	0	9
Drop-out	1	0	0	1
Completed MICA TC Component	**14**	**6**	**0**	**20**
Graduates	13	4	0	17
Complete/max program length	1	2	0	3

* Year 3 is a partial year (six months).

Characteristics of MICA Admissions: Tables 10 - 13 provide a description of program admissions by year of admission with regard to demographic, substance abuse, mental health/functioning, and criminal justice factors. MICA admissions undergo a comprehensive multi-disciplinary assessment process during the first weeks after admission and the results of the assessment are also presented in the tables. One-way analysis of variance and Chi-Square analyses revealed no significant differences in these factors by year of program operation. Although no significant differences were found by year, Tables 10-13 present the detail as formative feedback to MICA staff for the purposes of program improvement.

MICA admissions are an average of 36 years old, and most are either White or African American (Table 10). They have nearly a seventh grade reading level, have completed 11th grade, and have been employed at some time in their lives. The majority were assessed to be either alcohol or cocaine dependent and 80 percent had participated in some type of substance abuse treatment program prior to admission to MICA (Table 11). MICA participants also reveal comprehensive problems in their Addiction Severity Index (ASI) scores, where "0" is normal and "9" is an extreme problem. However, these men do show higher than average levels of motivation (CMRS neutral score = 15) and readiness for substance abuse treatment (CMRS neutral score = 21) as assessed by the CMRS. Higher CMRS scores indicate greater motivation and readiness for treatment.

Most participants have been diagnosed with either schizophrenia, schizoaffective disorder, or bi-polar disorder (Table 12). The vast majority had been hospitalized for mental health treatment prior to admission and 90 percent are on psychotropic medication to control mental illness. The assessment results for men who were assessed show them to be quite a low-

functioning and chronic group of inmates. The average IQ of participants was 85. The average MMSE score was 30 on a scale for which 36 is the "expected" score and anything lower than 32 indicates memory and attention deficits. The average PCL-SV score of 15 reveals a typical level of psychopathy among criminal populations who ordinarily score around 15. Participants showed higher than average psychiatric symptoms as measured by the Global Severity Index of the Brief Symptom Inventory (score of 1.4) than expected for inpatient psychiatric populations for whom the average is 0.78. The DPRS Global Pathology Index ranges from " 0" (normal) to "6" (extreme psychiatric problems) and MICA admissions score an average of 4.1. They also show deficits in independent living skills. Two percent were reported to have a developmental disability and three percent were reported to have some type of organic brain damage.

Their primary criminal offense was most likely to be a property crime such as burglary, theft, or robbery (Table 13). Fourteen percent were incarcerated for drug possession or delivery, and nine percent were incarcerated for sexual assault crimes. The average sentence length was 6.5 years, and participants had an average of two years to their mandatory release from prison at the time of MICA admission. Approximately one-half of the admissions had prior adult correctional experience. These inmates had incurred few conduct reports in the six months prior to program admission and received a "moderate" overall DOC risk rating.

Table 10: MICA Admissions By Year of Admission - Demographics

	Year 1 10/1/97-9/30/98 (N=55)	Year 2 10/1/98-9/30/99 (N=54)	Year 3* 10/1/99-3/31/2000 (N=32)	Overall (N=141)
Age				
Average age in years	36	37	36	36
18-25 years	13%	13%	12%	13%
26-35 years	36	28	31	32
36-45 years	33	46	41	40
46+ years	18	13	16	15
Race				
White	51%	56%	31%	48%
Black	47	44	63	50
American Indian	2	0	0	1
Hispanic	0	0	6	1
Reading Level (TABE)				
Average	6.7	7.9	5.2	6.8
4th grade or less	34%	24%	59%	35%
5th grade	8	19	0	11
6th - 8th grade	26	14	18	20
9th -11th grade	18	12	9	14
12th grade and up	14	31	14	20
Highest Grade Completed				
Average	10.6	11.3	11.2	11.0
8th grade or less	13%	5%	12%	10%
9th grade	19	5	17	13
10th grade	17	18	8	16
11th grade	4	21	4	11
12th grade or GED	43	42	38	41
More than 12th grade	4	9	21	9
Employment History				
Full-time Job Ever	82%	86%	82%	84%
Part-time Job Ever	82	77	71	78

* Year 3 is a partial year (six months).

Table 11: MICA Admissions By Year of Admission - Substance Use

	Year 1 10/1/97-9/30/98 (N=55)	Year 2 10/1/98-9/30/99 (N=54)	Year 3 * 10/1/99-3/31/2000 (N=32)	Overall (N=141)
Primary Substance Use Diagnoses				
Alcohol dependence	43%	34%	22%	35%
Cocaine dependence	26	40	63	40
Marijuana dependence	11	0	9	7
Opiate dependence	2	4	6	3
Sedative dependence	2	0	0	1
Hallucinogen dependence	2	2	0	1
Amphetamine dependence	0	2	0	0
Poly-substance dependence	2	4	0	2
Alcohol abuse	9	8	0	7
Marijuana abuse	0	4	0	2
Cocaine abuse	0	2	0	1
Other/missing	3	0	0	1
Prior AODA Treatment	76%	72%	100%	80%
Addiction Severity Index				
Medical	2.3	3.6	4.5	3.2
Employment/support	4.3	4.8	5.4	4.6
Alcohol	6.2	4.5	5.4	5.4
Drug	6.0	5.4	6.1	5.8
Legal	3.8	4.8	5.5	4.5
Family/social	4.9	5.1	5.7	5.1
Psychiatric	6.2	5.9	5.7	6.0
Circumstances, Motivation, and Readiness for Treatment Scales (CMRS)				
Treatment motivation	21.3	19.6	20.4	20.5
Treatment readiness	28.3	29.5	29.4	28.9

Table 12: MICA Admissions By Year of Admission - Mental Health/Functioning

	Year 1 10/1/97-9/30/98 (N=55)	Year 2 10/1/98-9/30/99 (N=54)	Year 3 * 10/1/99-3/31/2000 (N=32)	Overall (N=141)
Primary Mental Health Diagnoses				
No Axis I diagnosis	5%	4%	12%	6%
Schizophrenic	36	34	28	34
Schizoaffective	22	23	6	19
Bi-polar	17	24	19	19
Psychotic disorder	8	9	18	9
Depression	9	6	3	7
Dementia NOS	2	0	0	1
Other	1	0	14	4
Prior MH Hospitalization	70%	93%	84%	82%
On Psychotropic Medication(s)	85%	90%	100%	90%
Average Assessment Scores:				
IQ score	82	89	81	85
Mini Mental Status Exam (MMSE)	28	33	31	30
Psychopathy Checklist (PCL-SV)	15	15	17	15
Brief Symptom Inventory (BSI)	1.6	1.2	1.5	1.4
Psychiatric Rating Scale (DPRS)	4.2	4.2	4.1	4.1
Daily Living Skills (number of low areas)	2.8	1.1	2.1	2.0
Developmental Disability	0%	4%	0%	2%
Organic Brain Damage	6	0	0	2

Table 13: Description of MICA Admissions By Year of Admission - Criminal Justice

	Year 1 10/1/97-9/30/98 (N=55)	Year 2 10/1/98-9/30/99 (N=54)	Year 3 10/1/99-3/31/2000 (N=32)	Overall (N=141)
Primary Offense				
Property	45%	43%	28%	40%
Violent/aggressive	25	15	3	16
Sexual assault	9	8	6	9
Drug or alcohol related	11	15	16	14
Other	7	6	9	6
ATR admission	3	13	38	15
Average Sentence Length (years)	8.7	5.7	3.9	6.5
Average Days to Mandatory Release at MICA Admission	807	686	529	719
Prior With Correctional Experience				
Juvenile	28%	19%	9%	21%
Adult	57	40	59	51
Average Conduct Reports Past Six Months				
Minor	2.1	1.1	1.2	1.6
Major	0.3	0.5	0.1	0.4
Average Overall DOC Risk Rating [1=high, 2=moderate, 3=low]	1.9	1.7	1.9	1.8

MICA Services and Service Dosage: Table 14 contains data pertaining to the amount of service provided by the MICA program. At the end of each treatment phase, the number of hours, sessions, or activities received through MICA were summarized for each of 12 treatment service categories for each MICA participant. These categories were: staffings, therapeutic community meetings, other TC activities, individual counseling (contact) sessions, psychiatric consultations, psychological services, group treatment/therapy, structured socialization activities, support group meetings, medical consultations, contacts with community service providers, and contacts with participants' families.

To reduce the data collection burden for staff, service data were collected for each MICA participant for each type of treatment and support service without regard to hours or sessions. These treatment service data were then summarized as "units of service". For example, a community meeting (which may take 30 minutes), an individual counseling session (which could take an hour or more), or a support group session (which could last two hours) were each counted as one unit of service.

Table 14 summarizes the total units of service provided to MICA participants as reported by MICA staff during each treatment phase, as well as the average amount of service documented per participant. Participants received an average of 253 hours/sessions during Phase 1, 394 hours/sessions during Phase 2, 438 hours/sessions during Phase 3, and 406 hours/sessions during Phase 4. The nine graduates who also entered Phase 5 for transitional services received an average of an additional 40 hours/sessions of treatment services.

Table 14: Units of Service Received - Therapeutic Community Component (October 1, 1997 - March 31, 2000)

	Engagement Phase 1 (N=127)	Treatment 1 Phase 2 (N=69)	Treatment 2 Phase 3 (N=50)	Relapse Prevention Phase 4 (N=30)	Transition Phase 5 (N=9)
Total Units of Service:					
Staffings	121	102	88	34	8
Community meetings	4,446	3,101	2,770	1,216	na
Other TC activities	18,936	15,092	12,315	7,350	159
Contact sessions	1,845	1,371	1,143	477	139
Psychiatric consultations	380	269	198	90	13
Psychological services	529	98	88	45	10
Group therapy	4,019	5,467	4,025	2,172	na
Socialization activities	1,373	966	815	427	na
Support group	127	352	204	184	17
Medical consultations	228	250	150	97	na
Community contacts	45	19	33	43	10
Family contacts	112	110	64	55	9
TOTAL	32,161	27,186	21,893	12,190	365
Average Per Admission:					
Staffings	1	2	2	1	1
Community meetings	38	45	56	41	na
Other TC activities	162	221	246	245	18
Contact sessions	16	20	23	16	15
Psychiatric consultations	3	4	4	3	1
Psychological services	4	1	2	2	1
Group therapy	34	80	80	72	na
Socialization activities	12	14	16	14	na
Support group	1	5	4	6	2
Medical consultations	2	4	3	4	na
Community contacts	0	0	1	2	1
Family contacts	1	2	1	2	1
OVERALL AVERAGE	253	394	438	406	40

Note. Administrative terminations included.

MICA Length of Stay and Program Completion: Table15 shows the average length of stay in the MICA residential TC component by year. MICA graduates participated for an average of a little more than eight months, while terminations participated for an average of a little more than three months. Length of stay increased slightly from Year 1 to Year 2 as MICA staff tried a variety of strategies to increase participant retention in treatment (particularly; the lower functioning offenders) including repeating treatment phases, designing a less intensive treatment schedule for some, telling others that they would be kept in the program until completion regardless of their progress, and initiating a complete program "shutdown" for two days in October 1999 to address widespread disruptive behaviors within the therapeutic community. It is unclear whether customizing the program to address individual needs decreased the number of men who had to be terminated from the program.

Table 15: Average Days in MICA Residential Therapeutic Community Component By Year of Admission

	Year 1 10/1/97-9/30/98 (N=48)	Year 2 10/1/98-9/30/99 (N=41)	Year 3 10/1/99-3/31/2000 (N=9)	Overall (N=98)
Average Days in Each Phase				
Phase 1	42	58	40	48
Phase 2	65	74	na	69
Phase 3	76	72	na	74
Phase 4	63	71	na	66
Phase 5	54	na	na	54
Average Days in MICA TC				
Graduates/Completers	260	270	na	262
Terminations	104	127	40	108

Note. Days adjusted for days out of unit due to segregation, observation, court, etc.
Note. Analyses exclude administrative terminations and active participants.

Of the 141 program admissions, 21 men were administratively terminated as being ineligible for MICA based on incorrect diagnosis, insufficient clinical stability, or insufficient medical stability. **Of the 120 appropriate admissions, 17 percent (20 men) successfully completed the residential treatment program.**

Changes in measures of psychiatric stability and symptoms, treatment readiness and motivation, and daily living skills were investigated using paired samples t-tests. Table 16 reveals that MICA graduates/completers show a significant decrease in mental health symptoms as measured by the BSI from baseline to graduation. They also show a significant increase in motivation for treatment and maintained their motivation for treatment. There was also a significant improvement in daily living skills, with a decrease in the number of deficit areas.

Table 16: Comparison of Assessment Scores at Admission and Residential TC Discharge for MICA Graduates/Completers (N=20)

	Admit Mean	Discharge Mean	*t* score(df)	Signif.
Psychopathology Checklist (PCL-SV)	12.7	11.2	1.44(19)	.16
Brief Symptom Inventory (global)	1.2	0.7	3.32(19)	.00 *
Derogatis Psychiatric Rating Scale DPRS (global scale)	3.7	3.4	1.16(18)	.26
Circumstances, Motivation, and Readiness Scales (CMRS)				
Treatment motivation	20.5	21.7	-1.47(19)	.16
Treatment readiness	28.5	30.9	-3.85(19)	.00 *
Daily Living Skills (number of low areas)	1.5	0.8	2.36(18)	.03 *

*statistically significant change from admission to residential TC completion

MICA treatment staff also documented the number of conduct reports and segregation time received by MICA participants while they were involved in treatment. Approximately one-third of the participants in each treatment phase received at least one minor conduct report By Phase 3 the participants who would eventually become graduates receive significantly fewer conduct reports than those who would eventually become terminations. By Phase 4, participants who were terminated by staff tended to be dismissed for significant behavioral incidents that lead to major conduct reports.

Table 17: Conduct Reports and Segregation While in MICA

	Graduate (N=18)	Termination (N=69)	Overall (N=87)
Phase 1			
Percent with Minor Conduct Report	28%	36%	34%
Percent with Major Conduct Report	6	17	15
Percent with Days in Segregation	0	15	13
Phase 2			
Percent with Minor Conduct Report	24%	36%	32%
Percent with Major Conduct Report	6	8	7
Percent with Days in Segregation	6	9	8
Phase 3			
Percent with Minor Conduct Report	17%	44%	32%
Percent with Major Conduct Report	0	4	2
Percent with Days in Segregation	0	4	2
Phase 4			
Percent with Minor Conduct Report	22%	18%	21%
Percent with Major Conduct Report	0	27	10
Percent with Days in Segregation	0	17	7

Note. Excludes administrative terminations

MICA residential TC component staff rated each participant along a variety of behavioral dimensions at the end of each treatment phase. Table 18 shows these ratings for MICA completers/graduates at the end of Phase 4. At the time of successful treatment completion, only roughly one-half of these men received ratings of "good" or "excellent" with regard to their program participation. Three-quarters were medication compliant at the time of program completion. Most graduates received ratings of "adequate" on items related to their preparation for release to the community. While two-thirds of the graduates were able to apply their knowledge of mental illness, less than one-half of them received a "good" rating with regard to their ability to apply what they had learned about chemical use and criminal behavior.

MICA staff also provided ratings of the treatment team's confidence in each offender who participated in MICA Phase 4 (the final phase). Little confidence was shown in the post-release prognoses for graduates. Staff felt that about one-quarter of the graduates had a poor chance of maintaining stability of any sort. Only about one-third of the graduates were rated as having a good chance of maintaining their mental health stability, and only two of the graduates were rating as having a good chance of maintaining their stability with regard to chemical use and criminal behavior. These findings are consistent with comments made by the outreach specialist: "These guys are fearful when released – they know that they haven't made all the changes they need to."

Table 18: Staff Ratings of Graduate Treatment Program Behavior in Phase 4 (N=18)

	Poor	Adequate	Good/ Excellent
Program Activities:			
honesty/openness with staff	11%	39%	50%
active group participation	11	39	50
participation in TC activities	17	27	56
accepts responsibility as senior TC member	28	25	47
refrains from criminal attitudes/behaviors	11	33	56
medication compliance	12	12	76
Release Planning:			
active role in release preparation	12%	35%	53%
takes responsibility for job seeking	13	47	40
time management skills	22	44	33
money management skills	17	72	11
community support system	17	61	22
self-esteem	11	67	22
Applies Knowledge and Skills...			
regarding mental illness	11%	22%	67%
regarding chemical use	17	39	45
regarding criminal behavior	22	33	45
Staff Confidence in Maintenance of Stability of.....			
mental illness	24%	41%	35%
chemical use	35	53	12
criminal behavior	23	65	12
personal issues	25	69	6

Multivariate Predictors of Program Completion: Logistic regression was used to investigate the relationship between selected baseline measures and failure to successfully complete the MICA residential TC component (Table 19). Statistically significant predictors of treatment completion included age at admission, MMSE score (where lower scores indicate memory/attention deficits), PCL-SV score, and BSI score. **These results indicate that dually diagnosed offenders who completed MICA were younger, displayed lower levels of memory/attention deficits, and exhibited less severe psychopathy and psychiatric symptom patterns.** Measures of prior adult correctional experience and reading level were marginally significant, with terminations more likely to have correctional experience prior to their current incarceration episode and lower reading levels. Ethnicity, the overall DOC risk rating, and treatment motivation and readiness measures were not significant predictors of treatment completion.

Table 19: Logistic Regression Predicting Residential TC Component Termination

Baseline Predictor Measures	Exp(B)	Significance
Age at admission	1.13	.03 *
Ethnicity (0=white, 1=non-white)	0.83	.85
Overall DOC risk rating	2.01	.69
Prior adult correctional experience	7.18	.06
Reading grade level	0.79	.13
Mini Mental Status Exam (MMSE)	1.49	.04 *
Psychopathy Checklist (PCL-SV)	1.39	.01 *
Brief Symptom Inventory (BSI)	4.09	.03 *
CMRS - treatment motivation	0.82	.29
CMRS - treatment readiness	1.13	.41

Note. Completion Coded as 0 = completer/graduate, 1 = disciplinary termination
Note. Excludes administrative terminations.

Institutional Aftercare Component

After completion of MICA's residential TC component, program completers either enter back into the prison general population or enter MICA's Phase 5 (Transition Phase) to receive assistance in transitioning out of the structure of the therapeutic community. Treatment staff make the determination as to whether a graduate could benefit from participating in Phase 5. The MICA outreach specialist provides aftercare services to graduates while they remain institutionalized after their graduation.

MICA institutional aftercare services included weekly or bi-weekly visits with graduates at the institutions, discussions with institution social workers, contacts with community agencies to arrange halfway house placements, and contacts with offender families. Table 20 summarizes the actual institutional aftercare services reported to have been provided. The outreach specialist met with each man an average of 15 times, made contacts with community agencies and services on their behalf an average of two times, and had contact with the graduate's families an average of two times. In the 2 ½ years encompassed by these data, the outreach specialist conducted 251 individual aftercare meetings, made 40 community agency contacts, and made 36 family contacts.

Table 20: MICA Institutional Aftercare Services Provided to Graduates (N=17)
[Summary of Services Until Release or First 8 Months After Graduation]

	Average	Standard Deviation	Total/Sum
Services From MICA Outreach Specialist			
Individual Aftercare Meetings	15	6	251
Community/Agency Contacts	2	2	40
Family Contacts	2	3	36

MICA graduates spent an average of 304 days (s.d. = 205, range = 4-638) incarcerated after their completion of the MICA TC component. MICA participants are transferred to a variety of settings after discharge from MICA. Graduates have been either retained at OSCI in the general population (50 percent) or have been transferred to a minimum security facility. One MICA graduate deteriorated and was sent to a mental health facility. One-half of the MICA terminations remain at OSCI, 28 percent are transferred to other medium security facilities, seven percent are sent to maximum security facilities, 13 percent are sent to mental health facilities, and only one percent are sent to minimum security facilities.

As of the writing of this report no MICA aftercare services were being offered to graduates in the institutions during June, July, or August 2000 due to vacancy in the outreach specialist position. This lapse in service provision could potentially extend into Fall 2000 if additional delays in filling the position are encountered.

Community Aftercare Component

As part of the aftercare component, the MICA outreach specialist provides supportive services to MICA graduates after release from prison. She has in-person and telephone contact with graduates, their families, substance abuse and mental health treatment providers, and their probation/parole agents throughout Wisconsin. The outreach specialist helps to coordinate a wide variety of treatment and support services for MICA graduates including housing, vocational opportunities, psychological and medical services, and community support programs. The outreach specialist also facilitates access to medications for graduates, and helps graduates open bank accounts, find furniture, set up utility services, and seek/obtain employment. She also completed in-person follow-up interview/assessments with seven graduates three months after their release to the community.

Table 21 details the types and frequency of these in-person and telephone contacts as reported by the MICA outreach specialist. These data summarize the extent of contact during the first three months after release from prison only; the actual extent of service provided to MICA graduates in the community is much larger. We did not ask the outreach specialist to document the actual dosage of treatment and support services received by each graduate as that information was asked of parole agents on the three-month follow-up form that they were asked to complete.

Table 21: MICA Community Aftercare Services Provided to Graduates During the First Three Months After Release (N=10)

Total Number of Outreach Specialist Contacts With...	Average	Standard Deviation	2 ½ Year Total/Sum
MICA Graduate	5	3	47
Graduates' Family	2	2	18
Treatment Providers	2	3	19
Support Services	1	1	6
Agent	4	2	36

As of the writing of this report no MICA aftercare services were being offered to graduates in the community and had not been offered during June, July, or August 2000 due to vacancy in the outreach specialist position. This lapse in service provision could potentially extend into Fall 2000 if additional delays in filling the position are encountered.

Treatment Program Impact on Offender Outcomes

Study Goal #2 was addressed related to documenting program impact on the intermediate outcomes of substance use and behavioral problems while incarcerated. Study Goals #3, #4, #5 and #6 were also addressed related to documenting program impact on post-release outcomes related to substance use, mental health, stability, and criminal justice recidivism.

Intermediate Outcomes: The primary intermediate outcomes investigated for study

participants related to program impact on reduction of substance use and stabilization of mental illness symptoms and behavioral problems in the institution.

Several types of unexpected difficulties were encountered gathering data related to the behavior of study participants while they were incarcerated. The results of urinalysis (UA) testing were not in the institutional files abstracted for the comparison group and MICA terminations. Either none of the study participants were tested or these results are documented in another manner. Unfortunately, accurate UA data were unavailable for MICA graduates receiving aftercare services through the program as well, as the aftercare UA summary data submitted by the outreach specialist was found to also include UA testing during the residential TC component. In any event, with only five percent of the prison population chosen randomly for drug testing it is unlikely that any of the study participants were even tested while not in MICA. In addition, it was hard to gather accurate data on some medical services received as this information is kept in a separate medical records file which was not accessed. We had planned to also calculate the number of days that offenders were released prior to their mandatory release (MR) date to assess any impact of MICA upon early release. We were unable to complete the calculations because the MR date was changed and extended for many of our study participants during the course of the study due to time spent in segregation and this rendered meaningless the baseline MR date we had collected.

There was no significant difference between MICA graduates, terminations, and the comparison offenders with respect to the number of days from their discharge from MICA to release to the community (Table 22). However, there was a significant difference between MICA participants and the comparison group with regard to where they were transferred during

the time after MICA. Graduates/completers were more likely to be transferred to a minimum security facility, while MICA terminations and comparison inmates were more likely to be transferred to a medium security facility other than OSCI. Inmates in the comparison group were much more likely to be transferred to a mental health facility due to deterioration in their mental health. In addition, comparison group members and terminations were somewhat more likely than graduates to be transferred to a maximum security facility.

Table 22: Post-MICA Institutional Movement

	MICA Participants		
	Graduates (N=17)	Terminations (N=55)	Comparison (N=53)
Days from TC Exit to Release*			
Average	304	391	346
Standard deviation	205	226	114
Range	4-638	0-715	167-590
Transferred After TC Exit to...			
Maximum Security	0%	7%	8%
Mental Health Facility	1	14	43
Medium Security (not OSCI)	0	34	36
Minimum Security	47	2	10
Halfway House	12	0	0

*For the comparison group an estimated date of TC exit was created by adding eight months to the time the comparison group would have entered MICA in November 1997.
Note. Excludes administrative terminations.

Table 23 summarizes the behavior of study participants while they remained incarcerated. **MICA graduates/completers were much less likely to receive conduct reports or segregation time than either terminations or members of the comparison group.** MICA graduates were also significantly more likely to maintain their mental health stability than terminations or comparison offenders. Similarly, graduates were less likely to have experienced a major episode of mental health deterioration prior to their release to the community.

Table 23: Institutional Behavior After Discharge From MICA

	Graduates (N=15)	Terminations (N=50)	Comparison (N=53)
Segregation Days			
Percent Put in Segregation	13%	40%	49%
Average Days	4	26	58
Standard deviation	16	47	100
Conduct Reports - Minor			
Percent with Any	60%	68%	75%
Average	1.9	3.3	3.9
Standard deviation	2.4	3.9	6.9
Conduct Reports - Major			
Percent with Any	20%	56%	60%
Average	0.3	1.5	2.5
Standard deviation	0.6	1.8	3.4
Most Serious Conduct Report			
No conduct report	40%	22%	15%
Assaultive	na	22	29
Order/security	na	40	32
Property	na	0	2
Contraband	na	3	10
Movement	na	6	4
Safety/Health	na	6	6
Miscellaneous	na	0	2
Mental Health Rating			
Unstable	12%	34%	33%
Stable on medication	71	62	59
Stable without medication	17	4	8
Had At Least One Major Episode of Mental Health Deterioration	23%	43%	42%

Note. Excludes administrative terminations.

Table 24 shows that MICA graduates were more likely to receive services while they remained institutionalized prior to release than either terminations or comparison group members. In particular, they were more likely to receive substance abuse and treatment services through the MICA aftercare component. Graduates were also more likely to receive employment and educational services.

Table 24: Institutional Services Received After Discharge From MICA Or One Year Prior to Release For Comparison Subjects

	Graduates (N=17)	Terminations (N=55)	Comparison (N=51)
Received.....			
Mental health service	82%	22%	29%
Psychiatric medication monitoring	82	100	94
Substance abuse education	65	0	4
Substance abuse treatment	65	8	6
Employment/vocational	41	4	15
Educational	24	6	29

Post-Release Outcomes: Data on offender outcomes three-months post-release were collected from MICA outreach specialist reports (for graduates only) and probation/parole agent reports. In addition, criminal justice recidivism data (arrest and incarceration) were collected from the CIB and CIPIS databases to provide information pertaining to longer-term outcomes for those study participants who had been at risk in the community for longer than three months.

Agents were not able to provide post-release outcome information for six study participants: three of the comparison group and one MICA termination were not under parole agent supervision after release because they were incarcerated until their maximum discharge date (had served their full sentence), one comparison was deceased, and one comparison had

been confined in a mental health facility since his release from prison. In addition, the majority of agents did not provide requested data pertaining to the *amount* of treatment and support services received by parolees under their supervision. While most agents did provide data related to the service referrals they made for each offender and whether each offender actually received the service, it is likely that the amount (hours, sessions, days, etc.) of service received was either unavailable or not readily accessible to the agents.

Table 25 summarizes the primary three-month outcome indicators for the study as **reported by probation/parole agents** using Chi-Square and one-way analysis of variance (ANOVA) to contrast the outcomes of comparison group members with all MICA admissions as well as separate analyses contrasting comparison group offenders with only MICA completers/graduates. The study participants included in these analyses were all those offenders who had been released for at least three months during the study data collection period.

Three-Month Substance Use Indicators: These analyses (Table 25) revealed no significant differences between participants and comparison with regard to positive urinalysis (UA) results after release. MICA participants were somewhat more likely to be abstinent from substances since release and have an appropriate AODA treatment arrangement. While the contrasts were only marginally significant ($p<.10$ and $p<.15$, respectively), these results are in the predicted direction and suggest a positive impact of the program.

Table 25: Three-Month Post-Release Outcomes Based on Agent Reports: Comparison Group vs. All MICA Participants and Completers Only

	Comparison	MICA Participants		MICA Completers Only	
Number Released to Community	55	41		13	
Substance Use Outcomes:					
Any positive UA result	17%	15%		18%	
Abstinent from substances since release	47	67	**	70	*
Have appropriate AOD treatment arrangement	65	82	*	82	
Mental Health (MH) Outcomes:					
At least one episode of mental health relapse	42%	20%	**	11%	**
Have taken medications consistently	37	71	****	54	**
Have appropriate MH treatment arrangement	76	78		82	
Rated as "stable" with or without medication	41	68	***	82	****
Stability Outcomes:					
Have appropriate housing	81%	89%		82%	
Have appropriate social support system	76	78		91	
Average stability scale (4 items, range 0-4))	2.9	3.2	*	3.6	***
Criminal Justice Outcomes:					
Overall Rating of Parole Compliance					
Poor	42%	23%	*	10%	
Fair	18	31		40	
Good	35	31		40	
Excellent	5	15		10	
Average Score (range = 1-4)	2.0	2.4	*	2.5	*
Arrested within three months	39%	8%	***	9%	
Average number of arrests	0.50	0.01	****	0.01	**
Returned to prison					
No	65%	83%	***	91%	**
Yes, parole revoked	17	3		9	
Yes, ATR to prison treatment	9	14		0	
Yes, new offense	9	0		0	

**** Chi-square or one-way ANOVA significant at p<.01
*** Chi-square or one-way ANOVA significant at p<.05
** Chi-square or one-way ANOVA significant at p<.10
* Chi-square or one-way ANOVA significant at p<.15

In addition, the MICA outreach specialist conducted the ASI with seven graduates at an interview three months after release to the community. Even with this small sample, paired t-tests revealed statistically significant decreases ($p<.05$) in all of the subscales except the ASI medical subscale (not tabled). Thus, for those graduates who provided ASI data there were decreases in the negative impact of their addiction on their lives. However, this result should be interpreted with caution as MICA staff expressed some concern regarding the reliability of the assessment ratings at follow-up (e.g., the outreach specialist may have used the instrument's rating scales differently than other MICA staff).

Three-Month Mental Health Indicators: MICA participants were significantly more likely to have taken their psychotropic medications consistently since release and to be rated as "stable" by their supervising agent than the comparison group (Table 25). Participants were somewhat less likely to have suffered at least one episode of mental health relapse since release ($p<.10$). There was no significant difference between the groups with regard to having an appropriate mental health treatment arrangement, with roughly three-quarters of each group receiving mental health services of some type after release.

The MICA outreach specialist also conducted the BSI with seven graduates at an interview three months after release. A paired t-test revealed a statistically significant decrease ($t=2.46$, $df=6$, $p<.05$) in the BSI indicating a decline in stress and symptoms of mental illness from admission to follow-up (not tabled). These data are much more reliable and valid (in contrast to the ASI data), as the BSI is less affected by the interpretation of the assessor.

Three-Month Stability Indicators: Two primary research questions related to stability of living situation and development of a social support system were also addressed. There were no

significant differences between the groups with regard to these two items (Table 25). We also developed a simple summative Stability Scale which included the following four items yes/no items: has an appropriate place to live, schedule of daily activities, source of financial support, and support system of family/friends. The one-way ANOVA conducted revealed no statistically significant difference between the two groups ($p<.15$), but the means were in the predicted direction with the MICA participants scoring slightly higher than the comparison group.

We also investigated the possibility that MICA participants (especially graduates) received abstinence and mental health stability ratings from agents at higher levels than the comparison group due to a structured halfway house placement. While participants were about twice as likely to receive a halfway house placement as parolees in the comparison group, there were no significant differences in abstinence or mental health stability ratings between those in a halfway house and those who were not. Thus, halfway house placement does not appear to mediate the effects of MICA.

Three-Month Criminal Recidivism Indicators: Table 25 also begins to address our research questions pertaining to criminal recidivism after release. While only marginally significant with this small sample and short timeframe, both MICA participants and graduates only tended to receive higher ratings of parole compliance from agents. However, if the ratings are collapsed to compare "poor" ratings to "fair", "good", and "excellent" combined graduates receive better ratings of parole compliance than the comparison group. In addition, MICA participants were significantly less likely to be arrested or returned to prison within three months of release than comparison group offenders.

Preliminary Longer-Term Recidivism Indicators: Although continued follow-up of study participants is necessary to access MICA's longer-term impacts on recidivism, preliminary analyses of outcome data were conducted for the small sample of offenders who had been at risk in the community longer than three months. These results should be interpreted with caution due to small sample sizes.

The current study design also included follow-up of recidivism outcomes six months after release to the community utilizing the CIB database to document arrest and offense information, and the CIPIS database to document reincarceration. However, the CIB data regarding arrest was found to be flawed. The CIB data did not capture a large proportion of arrests reported to us by probation and parole agents on the three-month follow-up forms. We attribute this discrepancy to a long lag time between arrest and entry into the CIB database. Thus, we were unable to utilize the CIB data to investigate arrest rates and document type of offense beyond three months after release as we had planned.

While examination of longer-term outcomes for arrest could not be conducted utilizing the CIB data, we were able to investigate longer-term outcomes for incarceration after release using the CIPIS data available. Using the dates of the last incarceration episode obtained from CIPIS we were able to determine when study participants were incarcerated after their release.

Thirty-one of the 97 offenders released had been reincarcerated during the study period. There was no significant difference between the comparison offenders and MICA participants with regard to days to reincarceration. For the 31 offenders who had been reincarcerated, the average number of days to incarceration was 190 days for the comparison group (s.d. = 104.58), 153 days for MICA graduates (s.d. = 120), and 163 days for MICA terminations (s.d. = 114).

There were 49 comparison and 25 MICA participants who were released six months or more before the end of the study. There was no significant difference between the two groups in the proportion who were incarcerated within six months of release, with 26 percent of the comparison and 20 percent of the participant groups incarcerated.

There were 29 comparison and 10 MICA participants who were released twelve months or more before the end of the study. Again, there was no significant difference between the two groups with regard to incarceration rates one year after release, with 24 percent of the comparison and 30 percent of the participant groups incarcerated.

Thus, these findings suggest a short-term impact of MICA on arrest after release. These data will continue to be collected, and as the sample size increases it may be possible to determine whether MICA has a significant impact on arrest.

Relationships Among Measures: Logistic regression was used to investigate the relationship between selected baseline measures, MICA program participation, and the proximal and distal outcome measures. The primary proximal outcome measures at three months post-release were mental health treatment involvement, substance abuse treatment involvement, and medication compliance. The primary distal outcome measures at three months post-release were arrest, return to prison, abstinence from alcohol and drugs, and mental health stability.

Proximal outcomes. Logistic regression was used to investigate the relationship between selected baseline measures, MICA program participation, and the proximal outcomes of mental health treatment involvement, substance abuse treatment involvement, and medication compliance (Table 26). None of the baseline measures were statistically significant predictors of involvement in substance abuse treatment three months after release. However, the total number

Table 26: Logistic Regressions Predicting Proximal Outcomes Three Months After Release Based on Parole Agent Reports

Baseline Model Predictor Measures	Exp(B)	Significance
Predicting Presence of Appropriate Substance Abuse Service Arrangement:		
Age at admission	0.99	.88
Ethnicity (0=white, 1=non-white)	0.94	.91
Reading grade level (TABE score)	1.12	.16
Total number of lifetime adult arrests	0.99	.75
Study group (0=comparison, 1=treatment)	1.68	.40
Predicting Presence of Appropriate Mental Health Service Arrangement:		
Age at admission	1.07	.14
Ethnicity (0=white, 1=non-white)	1.93	.32
Reading grade level (TABE score)	0.98	.88
Total number of lifetime adult arrests	0.91	.02 *
Study group (0=comparison, 1=treatment)	0.54	.37
Predicting Medication Compliance:		
Age at admission	1.04	.24
Ethnicity (0=white, 1=non-white)	0.54	.30
Reading grade level (TABE score)	0.96	.68
Total number of lifetime adult arrests	0.95	.19
Study group (0=comparison, 1=treatment)	3.42	.04 *

Note. Medication compliance coded as 0=not at all/inconsistently, 1=consistently.
Note. Excludes administrative terminations.

of adult arrests was a significant negative predictor of involvement in mental health treatment. **Study group was a significant predictor in the model predicting medication compliance after release, with MICA treatment participants more likely to be taking their medications consistently than members of the comparison group.**

Distal outcomes. Table 27 presents the bivariate correlations among the measures. There were significant correlations between the primary recidivism measures and study group, ethnicity, abstinence from substances, mental health stability, and medication compliance.

Logistic regressions were conducted to investigate the impact of MICA upon distal outcomes. The basic model utilized age at admission, ethnicity, reading level, total number of lifetime arrests, and study group (comparison or MICA participant) to predict the proximal and distal outcomes. The expanded (mediational) models added abstinence from alcohol and drugs and mental health stability ratings to the models predicting recidivism, added medication compliance to the model predicting abstinence from alcohol and drugs, and added abstinence from alcohol and drugs to the model predicting mental health stability.

Study group was the strongest predictor of mental health stability at three months after release utilizing the basic model (Table 28). In the expanded model abstinence from substances and medication compliance were marginally significant predictors of mental stability.

The basic model predicting abstinence from substances since release reveals marginally significant impacts of study group, age, and lifetime arrests (Table 29). **In the expanded model, medication compliance was the strongest predictor of abstinence from substances.** Age at admission was also marginally significant in a negative direction.

Table 27: Correlations Among Outcome Predictor Measures Based on Three-Month Post-Release Parole Agent Reports

	Not Arrested/ Arrested	Not Incar./ Incarcerated	Study Group	#Adult Arrests	Race	Reading Level	Age	Substance Abstinence	MH Stable	Medication Compliance
Study Group (comparison/participant)	-.31 **	-.16	--							
Lifetime Adult Arrests	.21	.21	-.25 *	--						
Race/Ethnicity (0=white, 1=non-white)	.19	.24 *	-.26 *	.16	–					
Reading level	.05	.00	.11	-.30 **	-.40 **	--				
Age at Baseline	-.21	-.07	.10	.18	-.06	-.10	--			
Maintained Abstinence From Substances	-.50 **	-.36 **	.21	-.24 *	-.16	.03	-.07	--		
Mental Health Stability	-.50 **	-.58 **	.24 *	-.16	-.09	-.05	-.03	.36 **	--	
Medication Compliance	-.41 **	-.34 **	.28 *	-.17	-.14	.06	.20	.37 **	.31 **	--

** p<.01
* p<.05

Table 28: Logistic Regression Predicting Mental Health Stability Within Three Months After Release Based on Parole Agent Reports

Baseline Model Predictor Measures	Exp(B)	Significance
Basic Model:		
Age at admission	0.96	.27
Ethnicity (0=white, 1=non-white)	0.72	.58
Reading grade level (TABE score)	0.92	.33
Total number of lifetime adult arrests	0.97	.43
Treatment group (0=comparison, 1=treatment)	3.56	.03 *
Expanded Model:		
Age at admission	0.96	.38
Ethnicity (0=white, 1=non-white)	0.69	.57
Reading grade level (TABE score)	0.93	.42
Total number of lifetime adult arrests	0.99	.99
Treatment group (0=comparison, 1=treatment)	2.16	.23
Abstinence from alcohol and drugs	2.53	.11
Taken medications consistently since release	1.99	.12

Note. Mental health stability coded as 0 = unstable, 1 = stable (with or without medication)
Note. Excludes administrative terminations.

Table 29: Logistic Regression Predicting Abstinence from Alcohol and Drugs Within Three Months After Release Based on Parole Agent Reports

Baseline Model Predictor Measures	Exp(B)	Significance
Basic Model:		
Age at admission	0.94	.14
Ethnicity (0=white, 1=non-white)	0.60	.39
Reading grade level (TABE score)	0.95	.58
Total number of lifetime adult arrests	0.95	.17
Study group (0=comparison, 1=treatment)	2.50	.13
Expanded Model:		
Age at admission	0.93	.08
Ethnicity (0=white, 1=non-white)	0.56	.35
Reading grade level (TABE score)	0.95	.57
Total number of lifetime adult arrests	0.96	.31
Study group (0=comparison, 1=treatment)	1.67	.41
Taken medications consistently since release	2.71	.02 *

Note. Abstinence coded as 0 = not abstinent, 1 = abstinent
Note. Excludes administrative terminations.

Utilizing the basic model, lifetime arrests was a significant predictor of arrest within three months after release (Table 30). Study group (comparison/participant) was also a marginally significant predictor. The expanded model revealed that age and mental health stability were significant predictors of arrest. Offenders who were younger and were rated as unstable by parole agents were more likely to be arrested within three months after release. **These results suggest that MICA participation leads to increased mental health stability which decreases the likelihood of arrest after release.**

Table 31 shows results predicting return to prison within three months after release. Again the basic model reveals marginally significant impacts of study group and ethnicity, suggesting that comparison offenders and non-white offenders are more likely to be returned to prison. **Similar to that predicting arrest, the expanded model reveals that mental health instability is the strongest predictor of return to prison within three months after release.**

Additional analyses were conducted to investigate the relationship between treatment program dosage (units of residential service received) and the predictor measures. None of the predictors were significantly correlated with units of service, and logistic regression yielded no significant results.

Table 30: Logistic Regression Predicting Arrest Within Three Months After Release Based on Parole Agent Reports

Baseline Model Predictor Measures	Exp(B)	Significance
Basic Model:		
Age at admission	0.92	.13
Ethnicity (0=white, 1=non-white)	2.33	.23
Reading grade level (TABE score)	1.14	.16
Total number of lifetime adult arrests	1.07	.05 *
Study group (0=comparison, 1=treatment)	0.22	.07
Expanded Model:		
Age at admission	0.85	.03 *
Ethnicity (0=white, 1=non-white)	2.34	.35
Reading grade level (TABE score)	1.15	.22
Total number of lifetime adult arrests	1.05	.27
Study group (0=comparison, 1=treatment)	0.30	.28
Abstinence from alcohol and drugs	0.46	.20
Mental health stability (0=unstable, 1=stable)	0.05	.00 *

Note. Arrest coded as 0 = no arrest, 1 = one or more arrests
Note. Excludes administrative terminations.

Table 31: Logistic Regression Predicting Return to Prison Within Three Months After Release Based on Parole Agent Reports

Baseline Model Predictor Measures	Exp(B)	Significance
Basic Model:		
Age at admission	0.98	.76
Ethnicity (0=white, 1=non-white)	2.73	.12
Reading grade level (TABE score)	1.07	.42
Total number of lifetime adult arrests	1.02	.44
Study group (0=comparison, 1=treatment)	0.31	.11
Expanded Model:		
Age at admission	0.95	.33
Ethnicity (0=white, 1=non-white)	2.66	.22
Reading grade level (TABE score)	1.06	.50
Total number of lifetime adult arrests	0.98	.79
Study group (0=comparison, 1=treatment)	0.60	.55
Abstinence from alcohol and drugs	0.44	.11
Mental health stability (0=unstable, 1=stable)	0.21	.02 *

Note. Incarceration coded as 0 = not incarcerated, 1 = incarcerated
Note. Excludes administrative terminations.

Treatment Program Impact on Service System

Study Goal #7 "Investigate program impact on access to community treatment services on parole" was addressed through soliciting the input of probation and parole agents throughout Wisconsin. A baseline mail survey and one-year follow-up telephone interview helped to assess whether MICA services increased coordination of community services for program graduates and whether MICA increased probation/parole agent knowledge of dual diagnosis issues. Appendix 2 contains copies of the baseline mail survey and follow-up telephone interview instruments.

As described in more detail in the methodology section of this report, the baseline survey was sent to a random sample of 400 agents throughout Wisconsin. We received 139 surveys back in spite of the fact that many agents were mistakenly told by their unit supervisors not to complete the survey. The follow-up interview was conducted with 22 agents selected because they had supervised MICA graduates and other dually diagnosed offenders in the past year.

After each of the two data collection efforts (baseline and follow-up) a brief qualitative summary of the results was prepared. This summary was presented to MICA treatment staff during a monthly staff meeting so that they could use the formative data for program improvement purposes in a timely manner.

Baseline Survey: According to the agents surveyed, the treatment and support services typically received by dually diagnosed parolees include public or private mental health outpatient services, public or private AODA treatment services, vocational rehabilitation services, financial assistance through SSI, protective payee, medication monitoring, and housing assistance. While smaller, more rural counties tended to have no waiting lists for local services, Milwaukee and other larger counties reported waiting lists of several months for services.

Agents were also asked to detail needed support services for dually diagnosed parolees that were not currently available in their area. Several mentioned the need for a "reintegration worker" or specialized agent to coordinate services specifically for dually diagnosed offenders. Many agents also mentioned the need for supervised or group housing for this population. Other services needed included AODA treatment specifically for dually diagnosed individuals, mental health treatment other than outpatient, daily living assistance, transportation, medication monitoring, and medical care. Some agents summarized the most critical needs as follows:

- "A specialized agent that sees the client in a group process and individually – an agent that has time to follow up on the referrals and contacts and knows who to call and why"
- "Someone to work with them 2-4 times per week to assist in survival and reintegration process"
- "More cohesive programs set up with social worker help in the institution to be initiated day of release"
- "Housing is hard to find. Halfway house for AODA may screen out the dually diagnosed for mental reasons"
- "Need group homes, not temporary halfway houses"
- "Specialized group home – not available for people dealing with criminality, and criminals seem not to do well in regular mental health group homes"

The baseline mail survey also asked agents to describe the types of problems encountered by typical dually diagnosed parolees in the community. The biggest challenges mentioned by agents included the lack of treatment services specifically for the dually diagnosed and the lack of coordination between substance abuse and mental health treatment providers. Agents

described a system in which substance abuse treatment programs are unable to address the mental health issues of the dually diagnosed, and mental health service providers won't treat the dually diagnosed because they are chemically dependent. Agents described the biggest challenges as:

- "Lack of affordable treatment that addresses both issues, and to have it in one program"
- "Finding an agency that will deal with both issues at the same time"
- "Need one agency geared toward cooperation and appropriate service; not to deny [services] if possible"
- "Getting the proper treatment – not just generic AODA; mental health issues are greatly ignored and focus for treatment is on AODA and employment problems"
- "Tendency by providers to demand AODA issues be totally brought under control before mental health issues are examined"
- "No appropriate treatment – want to treat one before the other, or won't treat"
- "Mental health won't fund them because they are chemically dependent and 'belong' to corrections"
- "They think 'the other guy' should be doing more [when offenders fail to follow through with treatment]; conflict between mental health and AODA people"
- "Lack of 'combined' treatment – poor psychiatrists who would rather just medicate than provide holistic treatment"

Other difficulties encountered by dually diagnosed parolees include access to medications in a timely manner after release, poor acceptance of the dually diagnosed within the Alcoholics Anonymous community, lack of suitable housing options, and a lack of resources for treatment.

According to the agents survey responses, dually diagnosed parolees are usually required to report to the agent two times per month, some as often as four times per month. The primary indicator of substance abuse relapse or mental health relapse for agents is that the offender stops reporting as scheduled. Other behavioral signs mentioned included positive urinalysis tests (offenders submit to testing once per month), poor personal hygiene and anxiety/mood swings.

Agents indicated that between one-half and two-thirds of parolees follow the referrals to mental health, substance abuse, and support services made by agents. About one-half of the agents contact the service provider to follow-up on the referral, and the service provider will alert the agent in less than one-half of the cases if a parolee has stopped attending treatment or had a relapse. In spite of this low level of coordination, only one-third of the agents felt that there should be increased communication between agents and service providers regarding parolee treatment performance and compliance with required treatment.

Agents also described a corrections system with little communication among community corrections staff (probation/parole agents) and institutional corrections staff (prison substance abuse treatment, mental health treatment, or social work personnel). More than one-third of the agents indicated that they had never been contacted by institutional corrections staff regarding a dually diagnosed parolee under their supervision. One agent felt that prison staff in general often underutilize agents as a source of information about the offender; "I wish we had more input into what kind of programs they get in the institution. We could recommend some things that we think are best for the guy." In addition, nearly three-quarters of the agents who supervised dually diagnosed parolees have no contact with the offender prior to their release from prison; only one-quarter have written or telephone contact with the offender prior to release.

Although MICA had been in operation for nearly 1 ½ years at the time of the baseline survey, only one-third of the agents responding to the survey had ever heard of the treatment program. The agents who had heard of MICA had learned about the program through either a program brochure distributed to agents or from an informational session conducted by MICA staff at the Milwaukee probation and parole office that serves as a specialized mental health unit.

Follow-up Telephone Interviews: According to probation and parole agents, the MICA outreach specialist provided the following services for MICA graduates after they were released to the community: met with offender weekly or monthly, provided progress updates to agents, provided employment assistance, provided emotional support, facilitated family involvement, assisted with housing, helped move, opened bank accounts, obtained medications, and made mental health appointments. When asked about duplication of services, agents indicated that these services would have been provided by the agent or someone else anyway, but that the outreach specialist did more legwork. One agent commented -- "Most would have gotten covered, but not as effectively."

One agent felt that the outreach specialist helped graduates maintain mental health stability or abstinence from substances. She felt that MICA helped him by obtaining resources, meeting with him, reminding him that his medications were low, and reminding him of upcoming medical appointments. While most agents did not feel that the services provided by MICA in the community necessarily helped graduates maintain mental health stability or abstinence from substances, they did appreciate having an additional support person and advocate for the MICA graduates. One commented that it would be beneficial if the outreach specialist met with offenders in the community weekly during the first month after release.

In general, **agents did not feel that MICA increased access to services** to any great extent. However, they did feel that access to medications and employment services were somewhat increased – "It helped." Some felt that MICA graduates experienced a smoother transition to the community than other parolees and attributed this to the involvement of the outreach specialist. **Agents disagreed regarding whether MICA increased coordination of services for program graduates.** Some felt that the outreach specialist did not know the resources in their particular counties well enough to increase coordination, likely a function of the fact that the outreach specialist provided aftercare services to MICA graduates spread over five counties. However, other agents felt that MICA was able to focus on different things than agents need to – "As an agent I don't have the resources to give that level of individual service. She filled in gaps we're not able to provide." The outreach specialist could set up support services that weren't a priority for agents and agents felt that her involvement benefitted case planning. One agent commented "It showed him (the offender) that he wasn't out there on his own. She had good expectations for (offender name) and impossible expectations for the agent. We're limited in what we can do for them."

While **agents did not feel that MICA staff had increased their general knowledge of dual diagnosis issues**, many agents indicated that the MICA outreach specialist had given them insight into each specific offender's patterns and behaviors. For example, the outreach specialist could tell if a MICA graduate had stopped taking his medications because she had spent time with him in the institution during the MICA TC component. One agent was quick to express her gratitude for the additional information provided by the outreach specialist – "She knew because she had spent time with him at OSCI so she knew his specific triggers. That assisted me a lot."

Probation and parole agents were asked to discuss their perceptions of the impact of MICA on the post-release behavior of MICA participants. Agents indicated that MICA improved graduates' ability to identify relapse triggers, level of cooperation and focus, self-confidence, and ability to acknowledge his need for medication to manage his mental health issues. One agent summarized her feelings by saying "He had more skills coming out". Agents felt that even some offenders who did not successfully complete MICA "benefitted somewhat" and "learned a lot in treatment." One agent who had supervised a MICA termination discussed the benefits of participating in the treatment program. She indicated that agents frequently see the beginnings of mental illness in younger adults – "the tip of the iceberg." She used the case of a man who had been offered MICA as an alternative to revocation (ATR) of his probation as an example: "For 23 years we fought with him on probation. We ATR'd him to MICA, and MICA diagnosed him with schizophrenia and put him on medication. Now he's doing fine in the community. He didn't get diagnosed until he went to prison. How many others on probation are in this situation?"

Probation/Parole Agent Suggestions for Program Improvement: Although not specifically in the study design, probation and parole agents were also asked for their opinions on ease of referring eligible offenders to MICA and their suggestions for improving the treatment program and services. During the telephone interview agents were asked if they had ever used MICA as an alternative to revocation (ATR) for an offender prior to revoking them for poor probation/parole performance. Many agents did not know that MICA was available as an ATR and asked for information regarding how to refer an offender and whom to contact at MICA. Several agents indicated that they were unable to use MICA as an ATR because the nine-month

program length was too long for most offenders – they would not agree to it. Other agents indicated that it is difficult to get psychologists and doctors to examine and assess offenders under their supervision in the community. However, the agents who had used MICA as an ATR liked the fact that they got regular progress reports and email updates from MICA staff while the offender was in treatment. Many agents had very positive things to say about MICA:

- "The program was set up well from beginning to end"
- "MICA is my number one choice for ATR"
- "I like the program very much. I'm very impressed with MICA."
- "Really impressed by MICA"

Agents were also asked for their opinions on how to improve the ATR referral process for MICA. Numerous agents who had supervised MICA terminations had never heard of the program and indicated that they had never supervised anyone who had participated. Many felt that MICA should advertise the program with brochures to increase agent awareness and provide written materials for agents of MICA graduates so they will know what to expect with regard to type and period of MICA staff involvement.

Several agents who had referred parolees to MICA but were refused based on an ineligible mental health diagnosis felt that MICA need less stringent admission criteria. They indicated that "MICA could help those with more minor mental health problems too" and "MICA should open up the program to those who could actually make it through the program." One agent expressed frustration with MICA because MICA staff had changed the mental health diagnosis of an ATR that she had referred and terminated him from the program. She indicated that she then could not revoke his parole because "I can't revoke him for failing the program

because it wasn't the right program for him to begin with." She felt that MICA should be more aware of the implications of their actions. Another said that "MICA should take responsibility for him once an offender is admitted."

Agents also had suggestions related to improving the level and quality of the contact that the MICA outreach specialist has with agents. Several agents weren't clear about the outreach specialist's role in the transition from prison to the community and exactly what MICA could do for/with the offenders after release --"They should make it clear that MICA is an ongoing thing." There seemed to be some confusion among agents about MICA aftercare services for graduates in the community, with some agents not realizing that the outreach specialist would be involved in their case after release. A few didn't feel that the outreach specialist and agent were working as a team and thought that the offender, agent, and MICA staff should meet in the agent's office on a periodic basis. Agents also expressed a need for more coordination and treatment planning before release, suggesting that the outreach specialist should be sharing information with the agent at least two months prior to release to "coordinate the release plan and let the agent know his treatment needs."

ANALYSIS AND DISCUSSION

The MICA Treatment Program provides a wide variety of treatment and support services to dually diagnosed men incarcerated within the Wisconsin correctional system. MICA has integrated additional therapeutic community elements into the residential treatment component as the program has developed over time, and has proposed to move the treatment program into a more isolated physical space in early 2001. MICA staff have continuously modified the program model and structure in efforts to improve program services and retain participants in treatment. MICA staff have also shown a superior level of commitment to the evaluation of the program, including collecting data on residential treatment service dosage at a level of detail rarely captured in evaluation efforts such as these.

In the 2 ½ years of operation summarized in this report, a total of 141 offenders have been admitted to the program. The average length of stay in the residential treatment component has been approximately 8 ½ months for program completers, with 17% of eligible admissions (20 men) completing the treatment program in the first 2 ½ years of program operation. Logistic regression revealed that men who completed tended to be younger, have fewer memory/attention deficits, show less severe psychopathy, and exhibit less severe psychiatric symptoms (BSI) than men who did not complete. MICA graduates showed significant improvement in BSI scores, treatment readiness, and daily living skills from admission to discharge. In spite of these gains, treatment staff ratings at the time of MICA completion show surprisingly low confidence in the ability of program graduates to maintain their stability after treatment.

MICA has employed multiple strategies to increase treatment retention by customizing the treatment schedule and requirements for lower functioning inmates. Even program

terminations stayed an average of over three months in treatment (longer than many residential programs require in the community), with ten men terminated while in Phase 4 after completing more than six months of treatment. In addition, the fact that even some of the eventual graduates received minor conduct reports near the end of treatment (in Phase 4) shows that MICA tried to retain them in treatment – they had realistic behavioral expectations rather than expecting these dually diagnosed men to perform flawlessly.

The MICA outreach specialist met with graduates about twice per month and had contact with their families and with community agencies on their behalf while they remained incarcerated (an average of 304 days) after program completion. Probation and parole agents indicated that there is little coordination between agents and correctional institution staff while an offender is incarcerated. Agents who supervised MICA graduates in the community indicated that there is a critical need to increase the level of contact between agents and the outreach specialist *prior to* the offender's release to improve pre-release planning.

While this level of institutional aftercare service is not intensive, the study findings indicate that this may have helped these men maintain the gains they made while in residential treatment. MICA graduates were less likely to receive conduct reports or segregation time than termination or comparison inmates. MICA graduates were also more likely to be transferred to a minimum security facility prior to release, while terminations and comparison inmates were more likely to be incarcerated in maximum, medium, or secure mental health institutions.

To date, MICA has focused more on providing community aftercare than institutional aftercare. The MICA outreach specialist met with graduates in the community about two times per month after they were released, and also met with families and agents to facilitate services

and relationships. Probation and parole agents interviewed indicated that the outreach specialist performed a significant amount of "legwork" in facilitating services, but that most services would have been delivered even without the outreach specialist. Most agents did not feel that the involvement of the outreach specialist necessarily increased access to or coordination of services for MICA graduates. Agents did feel that the outreach specialist gave insight into the nuances of individual cases rather than increasing their general knowledge of dual diagnosis issues. Many agents identified a need for a specialized agent in each unit to supervise dually diagnosed offenders. This specialized agent should be knowledgeable about dual diagnosis issues and the resources available in their community specifically for these offenders.

Logistic regression analyses investigating MICA impact on both proximal and distal outcomes revealed that MICA participants (both completers and terminations) are more likely than the comparison group to be medication compliant, abstinent from substances, and more stable at three months after release. The analyses suggest that participation in MICA increases the likelihood of medication compliance after release. The pattern of results suggests that this medication compliance and resulting mental health stability leads to abstinence from substances, which leads to a decreased likelihood of arrest. In addition, mental health stability predicts return to prison within three months. For these men it appears that medication compliance is the pivotal factor in reducing recidivism within three months of release.

Our analysis of longer-term outcomes must be considered as preliminary due to the small sample available at this time. No differences in arrest or return rates at six months or one year after release were found. Assuming resources are available, we plan to continue to track these outcomes and reassess the mediational model.

CONCLUSIONS AND IMPLICATIONS

Implications for the Wisconsin Department of Corrections System

The DOC is putting increasing focus on evaluation of offender programming, and the success of this research study is due in large part to the exceptional level of support received from the Wisconsin DOC. Collecting data to conduct this research study required a cooperative effort on behalf of MICA treatment program staff, Bureau of Offender Programs staff, records office staff at the correctional institutions, Bureau of Offender Classification staff, and probation and parole regional chiefs, supervisors and agents.

If, as these results suggest, medication compliance is one of the primary keys to success after release for dually diagnosed offenders, then the DOC should address two barriers to medication compliance after release to the community. First, offenders should be given more than two weeks worth of medication upon their release. Both institutional and community corrections staff suggested that if DOC provided enough medication for one month then DOC would not have to pay for a psychiatrist to write a new prescription and SSI funds could be used to pay for the medication. Second, agents recommended that DOC address the problem of psychiatrists in the community changing the medications of dually diagnosed offenders after release. Medication types may be changed because one medication is less expensive than another, or because a doctor prefers one brand name over another. While offenders may be stabilized on a particular medication at the time of their release, a change in medication type can cause their mental health to decompensate quite quickly or produce unsettling side effects.

The vast majority of MICA participants (both graduates and terminations) remained incarcerated for about a year after their discharge from MICA. The implications of continued incarceration after completing substance abuse treatment are unclear, but without ongoing support and monitoring there is likely to be regression of gains made in treatment. Even though graduates did participate in substance abuse treatment (65 percent) and support groups (76 percent) to some extent while they remained incarcerated, they had to cope with a variety of changes including a different clinician monitoring their medications, possible changes in medication, loss of TC structure, and an environment of criminality on the general population units. Enduring these types of changes can only be a detriment to maintaining mental health and abstinence from substances upon release to the community for these dually diagnosed offenders.

A large proportion of these MICA participants remained incarcerated at OSCI after their discharge from MICA. While some of these men were housed in the Transitional Treatment Center, many were housed in general population units. The long-term implications of increasing the concentration of dually diagnosed offenders at OSCI are unclear at this time.

There is a need to increase the level of communication among institution staff and community corrections staff to improve service coordination while dually diagnosed offenders are incarcerated. Agents indicated that they need more frequent progress reports from institution social workers and treatment staff because they often don't know that an offender under their supervision is in a prison treatment program, that he has been terminated from treatment, or what services he needs next. In fact, the MICA outreach specialist had very limited contact with the parole agents of MICA graduates prior to their release. Increased communication would also enhance pre-release planning for dually diagnosed offenders. Agents suggested that institution

social workers, institution treatment staff, and agents coordinate to make recommendations for needed services and develop a detailed parole plan: "The more individuals involved the more chance of success for the offender." One agent felt that a "liaison agent" was needed to help offenders make the transition from institutional treatment to community treatment: "We drop the ball when they get out; no structure, lacking follow-up and aftercare." Assuring probation and parole agents in more rural units access to email will also increase their ability to coordinate with institution staff. Currently staff in smaller units do not have access to email and are unaware that they have received email correspondence concerning an offender.

Many agents also felt that each probation and parole unit (or county) should have a specialized agent for dually diagnosed offenders. This specialized agent would supervise only dually diagnosed offenders and be knowledgeable about substance abuse and mental health issues and services in their area. This specialized agent could be familiar with MICA and the MICA outreach specialist, make ATR referrals to MICA, and supervise any MICA graduates assigned to that county or unit. Many agents may be willing to take on the additional responsibility because promotion requires them to perform duties outside their normal workload.

Numerous probation and parole agents also indicated that they would like to see MICA make some changes so that more offenders would be eligible for the program. Agents interviewed suggested that MICA be available to offenders with a broader range of diagnoses and that the residential component be shortened to make it more attractive as an alternative to revocation. However, broadening the range of eligible diagnoses would change the dynamics of the TC model and shortening the program would detract from the model of long-term residential treatment. If MICA were to follow these suggestions the program would no longer "be MICA."

These changes would make treatment available to a larger number of offenders but would decrease the intensity of the treatment itself – likely decreasing the effectiveness of the program as well.

Implications of Findings for the MICA Treatment Program

These findings suggest that MICA should continue to emphasize the importance of medication compliance for participants. Medication compliance should be stressed not only during the residential TC component, but during the institutional aftercare and community aftercare components as well. MICA has great incentive to work within the DOC system to address the barriers to medication compliance encountered by offenders upon release.

MICA staff have been extremely responsive to utilizing formative feedback to improve the program model and services. For example, the researcher provided feedback on the results of the follow-up telephone survey with agents related to lack of agent awareness of MICA. MICA immediately prepared an informational packet for agents and sent out an informational memo to regional probation and parole chiefs and unit supervisors throughout Wisconsin. There is also an apparent need to increase general community awareness of dual diagnosis issues and to educate existing treatment service providers that there is a need for services for this population. A resource directory could be developed for agents summarizing programs, contacts, and numbers to assist them in identifying and accessing services for dually diagnosed offenders.

MICA should examine the relatively modest level of aftercare provided while graduates remained incarcerated after completing MICA. MICA should consider increasing the level of institutional aftercare services provided to help graduates maintain gains made in treatment.

One reason that graduates received limited institutional aftercare services may have been

due to the large workload of the outreach specialist. The role of the outreach specialist is currently one that spans the course of treatment for MICA participants -- from admission to aftercare. The outreach specialist interviews each MICA participant at admission, gets to know them during TC treatment groups, provides aftercare for them while they remain incarcerated after graduation, and helps with their transition to the community. The outreach specialist is responsible for the provision of all aftercare services (both in the institution and after release to the community) for all graduates. These graduates are geographically dispersed and the outreach specialist drove about 16,000 miles during Project Year 2 to provide aftercare and support services. It is clear that the outreach specialist is a critical treatment staff position – the one common thread throughout the MICA treatment experience. As the position is vacant at the time of this writing, it is a good time for MICA to examine the outreach specialist role and duties and re-evaluate appropriate workload for this position. The role should include more pre-release coordination with agents that would involve a team approach (agent, MICA, and offender). After the outreach specialist role is clearly defined probation and parole agents requested that MICA make the parameters of that role clear to them.

Implications of Findings for Continued Evaluation of MICA

The Center for Health Policy and Program Evaluation will continue to assist in the outcome evaluation of MICA after NIJ funding ends. Utilizing Wisconsin DOC funds, the data collection for the current study will be continued an additional year.

The basic design of the extended MICA evaluation will remain the same, but several improvements will be made to the data collection plan based on what was learned during the current study:

- A comprehensive modification of the MICA participant data system is planned for Fall 2000 to accommodate changes in the treatment program model and to eliminate unnecessary items;
- Document MICA institutional aftercare services provided to graduates more accurately (i.e., contacts with social workers, urinalysis results, etc.);
- Eliminate the Crime Information Bureau (CIB) database as a source of arrest data because of its imprecision due long lags between offense and entry into the database;
- Utilize the CIPIS database to gather more of the essential data such as segregation days and conduct reports rather than gathering that information through file review;
- In addition to segregation days, gather outcome data on other sanctions such as loss of day room, program segregation, observation, etc.; and
- Access the computerized system which tracks urinalysis testing and results for the entire DOC system to obtain urinalysis data.

The researcher was asked to participate in a DOC system-wide effort occurring during 2000 to systematize data collection for all of the substance abuse treatment programs within the correctional institutions. The DOC hopes to identify a set of common data elements and participant outcomes that all programs will enter into a central database. Future evaluation efforts should strive to integrate this required reporting for programs into the evaluation design.

Implications of Findings for Other Treatment Programs

The current findings demonstrate the potential effectiveness of the MICA treatment model for dually diagnosed offenders. MICA has confirmed that a residential substance abuse treatment program for this special population of offenders can be effectively implemented in a

correctional setting. MICA has also shown that a therapeutic community model can be utilized to provide substance abuse and mental health treatment to dually diagnosed offenders, but that there is a high treatment termination rate. With its multi-disciplinary approach, therapeutic community setting, comprehensive array of services, and extended aftercare component MICA enjoys a promising short-term success rate after participants are released to the community.

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Appendix 1: Consent Form and Research Approvals

MENTAL ILLNESS/CHEMICAL ABUSE (MICA) AGREEMENT

Name _____ DOC # _____

PROGRAM PARTICIPATION AGREEMENT

I have been invited to participate in the MICA treatment program. This program will help me learn the attitudes and skills I need when I leave prison. Participating in MICA means that I:

1. Agree to take part in all treatment groups.
2. Agree to take part in all required program activities.
3. Agree to follow all institution and program rules.
4. Agree to take my medication while in the program and after release into the community.
5. Agree to use services after release that will help me in my recovery and increase my chances of staying out of trouble.
6. Agree to cooperate with my agent to make the transition to the community.
7. Agree to submit urinalysis samples as required by the program.

SIGNATURE _____ DATE _____

PROJECT EVALUATION AGREEMENT

MICA will be involved in a project with the University of Wisconsin to look at the services the program offers and who gets them. This will also let us learn if MICA helps men lead crime-free lives, stop using drugs, and manage their mental health after release to the community.

MICA and the University will study how the program has helped me by measuring my behavior in prison and on parole. This information can be gathered from my records. The program will protect the confidentiality of all information and it will be coded (other than my inmate number) to ensure confidentiality.

I know I may be asked to volunteer to talk with University staff about the program.

The results of the study may help the DOC decide how to spend money for inmate programs. I understand I will not get money for this.

My signature means that I agree to participate. I have discussed this with the MICA staff during my program orientation and my questions have been answered.

SIGNATURE _____ DATE _____

Original: MICA file
CC: Inmate
Records
Center for Health Policy

REV 5/24/00

Tommy G. Thompson
Governor

Jon E. Litscher
Secretary

State of Wisconsin
Department of Corrections

Mailing Address

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May 11, 1999

Kit R. Van Stelle, Researcher
D. Paul Moberg, Director
University of WI - Madison
Center for Health Policy and Program Evaluation
502 N. Walnut
Madison, WI 53705

Dear Ms. Van Stelle and Dr. Moberg:

The department would like to confirm its commitment to facilitate access to the necessary institution and community records required to complete your National Institute of Justice (NIJ) funded evaluation research study of the department's Mental Illness-Chemical Abuse (MICA) Treatment Program. This program is designed to treat offenders who have both mental illness and substance abuse disorders. The research study involves gathering data on program graduates and comparison groups both in the institutions and after release. In the community, some offender data will be obtained by asking the parole agents of the study subjects to complete a single summary of parolee progress and status three months after release. The three-month follow up forms will be sent to field office supervisors for distribution to the appropriate agents.

The Department of Corrections (DOC) recognizes the value and necessity of independent program evaluations and believes that such efforts can assist in making improvements to services. This effort will require that you have access to all adult institutions, centers, field offices, and offender files to collect data from offender files on an ongoing basis through September 30, 2000, when the study is completed. Further, we understand that your project has been approved by the University of Wisconsin Committee for the Protection of Human Subjects and that appropriate safeguards of offender confidentiality are in place. We understand that you also have a Privacy Certificate from NIJ as an added protection of the data.

You are approved for access to offender social service, clinical, medical, education, and legal files for the purposes of the research study. We hereby authorize all institution, center, and field office personnel to assist you to gain access to these records. Questions regarding the department's provision of access to offender files may be directed to Barb Johnson, Program Specialist, at the DOC central office, phone (608) 266-5443.

Sincerely,

Dick Verhagen, Administrator
Division of Adult Institutions

William Grosshans, Administrator
Division of Community Corrections

Phil Kingston, Assistant Administrator
Division of Community Corrections

Cc: Institution Wardens
Regional Chiefs
Center Superintendents
Field Office Supervisors
Cindy O'Donnell
John Husz
Mickey Thompson
Pam Brandon
Tony Streveler
Ana Boatwright

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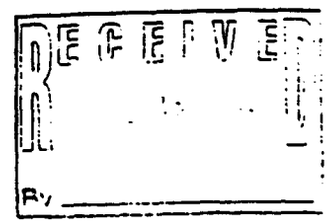
PHONE: (608) 266-8428

July 20, 1999



Director D. Paul Moberg, and Researcher Kit R. Van Stelle
Center for Health Policy and Program Evaluation
Department of Preventive Medicine
University of Wisconsin Medical School
502 North Walnut Street
Madison, WI 53705-2335

RE: Approval for Access to Confidential Mental Health Treatment Records

Dear Dr. Moberg and Ms. Van Stelle:

The Department received your letter of July 13th describing your project's evaluation of the Mental Illness-Chemical Abuse (MICA) Treatment Program at Oshkosh Correctional Institution. As documented by the records attached to your letter, I understand that your project has been approved by the Wisconsin Department of Corrections, by the US Department of Justice, by the National Institute of Justice, and by UW Health Sciences Committee for the Protection of Human Subjects.

This Department approves your evaluation project for access to confidential mental health treatment records possessed by the Wisconsin Department of Corrections. This approval is conditioned upon the assurances provided in your letter that establish that:

- The confidential treatment record information will be used only for the purposes of the research/evaluation study and report.
- The confidential information will not be released to anyone who is not connected with the research/evaluation.
- The final product of the research/evaluation will not reveal information that may serve to identify the individuals whose treatment records are being accessed, without the informed written consent of the individuals.

These conditions are required under subsection 51.30(4)(b)3 of the Wisconsin Statutes.

If you have any questions, please contact me at 266-8457.

Sincerely,

Paul Harris
Attorney

Tommy G. Thompson
Governor

Jon E. Litscher
Secretary

State of Wisconsin
Department of Corrections

Mailing Address

149 East Wilson Street
Post Office Box 7925
Madison, WI 53707-7925
Telephone (608) 266-247
Fax (608) 267-366

Memorandum of Understanding

The Department of Corrections (DOC) enters into an affiliation with the U W Medical School, Center for Health Policy and Program Evaluation, to conduct an outcome research study on the Mental Illness/Chemical Abuse program at Oshkosh Correctional Institution. In exchange, DOC wishes to have the study results when the study is completed because this will assist DOC with correctional programming.

Signed: _____ Date: 8/10/99
Tony Streveler

Signed: D. Paul Moberg Date: 8/10/99
D. Paul Moberg

Appendix 2: Data Collection Forms/Instruments

Participant Data System Forms

REFERRAL/ADMISSION DOC ID Number:_____ seq:____ 1

MICA Referral/Admission Summary

Participant Name:_____ **Staff Name:**_____

Referral Information (DOC-1479)

Referral Date: ___/___/___

Birth Date: ___/___/___

Referral Source:

1 = DCI	9 = FLCI
2 = OSCI	10 = KMCI
3 = OSCI-TTC	11 = RCI
4 = WRC	12 = DCC
5 = CCI	13 = DACC
6 = JCI	14 = OCI
7 = GBCI	15 = ATR
8 = WCI	16 = Other: _____

Axis I Diagnosis: _____

_____

Axis II Diagnosis: _____

_____

Inmate Response to Referral:
1 = Motivated
2 = Low motivation, compliant
3 = Unmotivated, resistant
4 = No response

Ethnicity (DOC-3):

0 = Hispanic	4 = Asian
1 = White	5 = Other
2 = Black	_____
3 = American Indian	

Correctional Experience (DOC-3)

No	Yes	
0	1	Previous juvenile
0	1	Previous adult

Result of Referral:
1 = Transfer to MICA
2 = Waiting for bed space
3 = Inmate refused
4 = Major conduct violation
5 = Medically unstable
6 = Clinically unstable
7 = Parole/other release
8 = Other:_____

Transfer/Intake Date: ___/___/___

Clinical Assessment Information

DSM IV Mental Health Diagnosis Codes:

Primary_____

Secondary_____

Psychotropic Medications?
0 = No
1 = Yes → _____

Previous Psychiatric Treatment (DOC-3018):

_____ # of hospitalizations ever

_____ year of most recent

DSM IV Substance Use Diagnosis Codes:

Primary_____

Secondary_____

Needle Use Ever?
0 = No
1 = Yes

Previous AODA treatment:

_____ # of episodes ever

_____ year of most recent

Medical Assessment (DOC-3002)

No	Yes	
0	1	developmental disability
0	1	organic brain damage
0	1	high blood pressure
0	1	heart disease
0	1	diabetes
0	1	seizures
0	1	cancer
0	1	communicable disease
0	1	other:_____

ENGAGEMENT/PERSUASION DOC ID Number:_____ seq:_____3

MICA Summary of Phase I Services
[Completed at Discharge from Engagement/Persuasion Phase)

Participant Name:_____ **Staff Name:**_____

Phase I Discharge Date: ____/____/____

Reason for Phase I Exit:

1 = Entering Phase II Active Treatment Phase
Date: ____/____/____
2 = Terminated - treatment non-compliance
3 = Terminated - medication non-compliance
4 = Terminated for behavior - chronic/ongoing
5 = Terminated for behavior - major episode
6 = Left against staff advice (dropped out)
7 = Inappropriate referral
8 = Transferred to other institution
9 = Released to community
10= Other_____

Institutional Unit Behavior in Phase I

Conduct Reports:

_____ # of warnings

_____ # of minor conduct reports

_____ # of major conduct reports

Type of most serious report: (Circle one)
1 = Assaultive
2 = Order/security
3 = Property
4 = Contraband
5 = Movement
6 = Safety/health
7 = Miscellaneous

Days Out of Unit Since Admission to Phase:

# Days	
_____	observation
_____	segregation
_____	medical
_____	court appearances
_____	Productive Learning Unit

School/WorkAssignment During this Phase:

No	Yes	
0	1	Work
0	1	School
0	1	Volunteer

Treatment Services Received in Phase I

_____ # of staffings

_____ # of community meetings attended

_____ # of other TC activities

_____ # of contact sessions

_____ # of psychiatric consultations

_____ Hours of psychological services

_____ Hours of group therapy

_____ Hours of socialization activities

_____ # of support group sessions (AA, NA)

_____ # of medical education/consultations

_____ # of community/agency contacts

_____ # of family contacts

Other Support Services Received

No	Yes	
0	1	educational
0	1	medical
0	1	dental
0	1	religious
0	1	recreation
0	1	other: _____

Urinalysis Testing:

_____ # of UA tests conducted

_____ # of positive UA tests

Change in Mental Health Status Since Admission

Rating of Mental Health Stability: (Circle one)
1 = Worse
2 = Same
3 = Improved

_____ # of episodes of deterioration

ACTIVE TREATMENT - 1 DOC ID Number:_____ seq:____ 5

MICA Summary of Phase II Services
[Completed at Discharge from First Active Treatment Component]

Participant Name:_____ **Staff Name:**_____

Phase II Discharge Date: ___/___/___

Reason for Phase II Exit:

1 = Continuing to Phase III Active Treatment
Date: ___/___/___
2 = Terminated - treatment non-compliance
3 = Terminated - medication non-compliance
4 = Terminated for behavior - chronic/ongoing
5 = Terminated for behavior - major episode
6 = Left against staff advice (dropped out)
7 = Inappropriate referral
8 = Transferred to other institution
9 = Released to community
10= Other_____

Institutional Unit Behavior in Phase II

Conduct Reports:

_____ # of warnings

_____ # of minor conduct reports

_____ # of major conduct reports

Type of most serious report: (Circle one)
1 = Assaultive
2 = Order/security
3 = Property
4 = Contraband
5 = Movement
6 = Safety/health
7 = Miscellaneous

Days Out of Unit Since Admission to Phase:

# Days	
_____	observation
_____	segregation
_____	medical
_____	court appearances
_____	Productive Learning Unit

School/Work Assignment During this Phase:

No	Yes	
0	1	Work
0	1	School
0	1	Volunteer

Treatment Services Received in Phase II

_____ # of staffings

_____ # of community meetings attended

_____ # of other TC activities

_____ # of contact sessions

_____ # of psychiatric consultations

_____ Hours of psychological services

_____ Hours of group therapy

_____ Hours of socialization activities

_____ # of support group sessions (AA, NA)

_____ # of medical education/consultations

_____ # of community/agency contacts

_____ # of family contacts

Other Support Services Received

No	Yes	
0	1	educational
0	1	medical
0	1	dental
0	1	religious
0	1	recreation
0	1	other:_____

Urinalysis Testing:

_____ # of UA tests conducted

_____ # of positive UA tests

Mental Health Status

Rating of Mental Health Stability: (Circle one)
1 = Worse
2 = Same
3 = Improved

_____ # of episodes of deterioration

ACTIVE TREATMENT - 2 DOC ID Number:_____ seq:____ 7

MICA Summary of Phase III Services
[Completed at Discharge from Second Active Treatment Component]

Participant Name:_____ **Staff Name:**_____

Phase III Discharge Date: ____/____/____

Reason for Phase III Exit:

1 = Continuing to Phase IV Relapse Prevention
Date: ____/____/____
2 = Terminated - treatment non-compliance
3 = Terminated - medication non-compliance
4 = Terminated for behavior - chronic/ongoing
5 = Terminated for behavior - major episode
6 = Left against staff advice (dropped out)
7 = Inappropriate referral
8 = Transferred to other institution
9 = Released to community
10= Other_____

Institutional Unit Behavior in Phase III

Conduct Reports:

_____ # of warnings

_____ # of minor conduct reports

_____ # of major conduct reports

Type of most serious report: (Circle one)
1 = Assaultive
2 = Order/security
3 = Property
4 = Contraband
5 = Movement
6 = Safety/health
7 = Miscellaneous

Days Out of Unit Since Admission to Phase:

# Days	
_____	observation
_____	segregation
_____	medical
_____	court appearances
_____	Productive Learning Unit

School/Work Assignment During this Phase:

No	Yes	
0	1	Work
0	1	School
0	1	Volunteer

Treatment Services Received in Phase III

_____ # of staffings

_____ # of community meetings attended

_____ # of other TC activities

_____ # of contact sessions

_____ # of psychiatric consultations

_____ Hours of psychological services

_____ Hours of group therapy

_____ Hours of socialization activities

_____ # of support group sessions (AA, NA)

_____ # of medical education/consultations

_____ # of community/agency contacts

_____ # of family contacts

Other Support Services Received

No	Yes	
0	1	educational
0	1	medical
0	1	dental
0	1	religious
0	1	recreation
0	1	other:_____

Urinalysis Testing:

_____ # of UA tests conducted

_____ # of positive UA tests

Mental Health Status

Rating of Mental Health Stability: (Circle one)
1 = Worse
2 = Same
3 = Improved

_____ # of episodes of deterioration

MICA Summary of Phase IV Services
[Completed at Discharge from OSCI Component of MICA]

Participant Name:_____ **Staff Name:**_____

Phase IV Discharge Date: ___/___/___

Reason for Phase IV Exit:

0 = Non-completer, repeat phase
1 = Completed OSCI Component
  1 = Successful completion
  2 = Participated to level of ability
  3 = Participated - questionable motivation
  4 = Maximum program benefit received
2 = Terminated - treatment non-compliance
3 = Terminated - medication non-compliance
4 = Terminated for behavior - chronic/ongoing
5 = Terminated for behavior - major episode
6 = Left against staff advice (dropped out)
7 = Inappropriate referral
8 = Transferred to other institution
9 = Released to community
10= Other_____

Release Placement:
1 = Parole to community
2 = Halfway house/group home
3 = Minimum security facility
4 = Other_____

Date of Parole or Transfer: ___/___/___

Institutional Unit Behavior in Phase IV

Conduct Reports:

_____ # of warnings

_____ # of minor conduct reports

_____ # of major conduct reports

Type of most serious report: (Circle one)
1 = Assaultive
2 = Order/security
3 = Property
4 = Contraband
5 = Movement
6 = Safety/health
7 = Miscellaneous

 # Days Out of Unit Since Admission to Phase:

_____ observation
_____ segregation
_____ medical
_____ court appearances
_____ Productive Learning Unit

Treatment Services Received in Phase IV

_____ # of staffings

_____ # of community meetings attended

_____ # of other TC activities

_____ # of contact sessions

_____ # of psychiatric consultations

_____ Hours of psychological services

_____ Hours of group therapy

_____ Hours of socialization activities

_____ # of support group sessions (AA, NA)

_____ # of medical education/consultations

_____ # of community/agency contacts

_____ # of family contacts

Other Support Services Received

No	Yes	
0	1	educational
0	1	medical
0	1	dental
0	1	religious
0	1	recreation
0	1	other:_____

Urinalysis Testing:

_____ # of UA tests conducted

_____ # of positive UA tests

Mental Health Status

Rating of Mental Health Stability: (Circle one)
1 = Worse
2 = Same
3 = Improved

_____ **# of episodes of deterioration**

MICA Summary of Transition Phase V Services
[Completed at End of Transition or End of MICA-OSCI Institutional Services]

Participant Name:_____ **Staff Name:**_____

Date of MICA Graduation: ___/___/___

Days in Phase V: _____
(If did not enter Transition Phase enter "0" here, indicate reason below, and stop here)

Reason for No Transition Phase:
0 = Transition phase not yet available
1 = Paroled or MR
2 = Over 12-month program length limit
3 = Referred for other treatment needs
4 = Alternative to revocation (ATR)
5 = Other_____

Reason for Phase V Exit:
0 = Return to MICA treatment
1 = AODA relapse
2 = Mental health relapse
3 = Poor behavior - major episode
4 = Transferred to other institution or unit
5 = Parole/release to community
6 = Maximum program benefit
7 = 12-month program length limit
8= Other_____

Placement After Phase V Exit:
1 = OSCI - in V Building
2 = OSCI - NOT in V Building
3 = Oakhill Correctional Center
4 = St. John's Correctional Center
5 = Other minimum security facility
6 = Halfway house
7 = Other medium security (not OSCI)
8 = Maximum security facility
9 = WRC
10 = Other_____

Conduct Reports

_____ # of minor _____ # of major

Treatment Services Received in Phase V

_____ # of staffings
_____ # of TC activities
_____ # of one-to-one contact sessions
_____ # of psychiatric consultations
_____ Hours of psychological services
_____ # of support group sessions (AA, NA)
_____ # of community/agency contacts
_____ # of family contacts

Other Support Services Received:

No	Yes	
0	1	educational
0	1	medical
0	1	dental
0	1	religious
0	1	recreation
0	1	other:_____

Urinalysis Testing:

_____ # of UAs _____ # positive

Rating of Mental Health Stability: (Circle one)
1 = Worse
2 = Same
3 = Improved

Ratings of Treatment Program Behavior Improvement Since Admission to Transition Phase V:

	Ratings of Behavior				Change During This Phase		
	None/ Poor	Ade-quate	Good	Excellent	Worse	Same	Improved
refrains from criminal attitudes/behaviors	0	1	2	3	1	2	3
medication compliance	0	1	2	3	1	2	3
maintains personal and room hygiene	0	1	2	3	1	2	3
occupies time productively	0	1	2	3	1	2	3
active role in release preparation	0	1	2	3	1	2	3
community support system	0	1	2	3	1	2	3
Treatment team confidence in maintenance of stability after release...							
regarding mental illness	0	1	2	3	1	2	3
regarding chemical use	0	1	2	3	1	2	3
regarding criminal behavior	0	1	2	3	1	2	3
regarding personal issues	0	1	2	3	1	2	3

Parole Agent Baseline Mail Survey

UNIVERSITY OF
WISCONSIN-MADISON
MEDICAL SCHOOL

Department of Preventive Medicine
Center for Health Policy and Program Evaluation

TO: FIELD(Title) FIELD(First) FIELD(Last)

FROM: Kit R. Van Stelle
Associate Researcher

DATE: February 1999

RE: Parole Agent Survey of AODA Dual Diagnosis Issues

The Mental Illness-Chemical Abuse (MICA) Treatment Program at Oshkosh Correctional Institution provides treatment services to offenders who are "dually diagnosed" with both a mental health disorder and a chemical abuse disorder (designated "AODA Level 5D"). The MICA program provides services to dually diagnosed offenders both in the institution and after parole to the community.

We are conducting a brief survey of parole agents as part of an evaluation of the MICA program being conducted by the University of Wisconsin Center for Health Policy and Program Evaluation for the National Institute of Justice. We have randomly selected 400 Wisconsin parole agents to participate in the survey, some of which are in your region. This survey will help us to assess the impact of MICA services on parolee access to community services and the system of care available to dually diagnosed offenders. The information collected through this survey is critical to our measurement of program effectiveness. We are asking that agents return the completed surveys to us via either Interdepartmental mail (if available) or U.S. mail by March 5, 1999.

This effort has received the approval of William Grosshans, and **we would greatly appreciate it if you would notify the supervisors in your region of this effort and emphasize its importance to improving services for dually diagnosed offenders.**

Feel free to contact me at (608) 262-5948 or "krvanste@facstaff.wisc.edu" with any questions about this survey. We very much appreciate your support and cooperation.

502 North Walnut Street Madison, WI 53705-2335 608 / 263-6850 FAX 608 / 265-3255

February 1999

Dear Agent:

The Mental Illness-Chemical Abuse (MICA) Treatment Program at Oshkosh Correctional Institution provides treatment services to offenders who are "dually diagnosed" with both a mental health disorder and a chemical abuse disorder (designated "AODA Level 5D"). The MICA program provides services to dually diagnosed offenders both in the institution and after parole to the community.

The following survey is part of an evaluation of the MICA program being conducted by the University of Wisconsin Center for Health Policy and Program Evaluation for the National Institute of Justice. This survey will help us to assess the impact of MICA services on parolee access to community services and the system of care available to dually diagnosed offenders. The information collected through this survey is critical to our measurement of program effectiveness. This effort has received the approval of William Grosshans, and your regional chief and supervisor have been made aware of the importance of your participation in this survey.

Please return your completed survey via Interdepartmental mail using the attached mailing label. Affix the mailing label to the Interdepartmental mail envelope and return the survey to me by March 5, 1999. Return the survey via U.S. mail to me at the address below if Interdepartmental mail is not available in your area.

Feel free to contact me at (608) 262-5948 or "krvanste@facstaff.wisc.edu" with any questions about this survey. Thank you so much for taking the time to complete and return this survey. We very much appreciate your support and cooperation.

Thank you,

Kit R. Van Stelle
Associate Researcher

Baseline Parole Agent Dual Diagnosis Survey

Agent Name:_____ Agent Number:_____

Region:_____ Number of parolees on current caseload:_____

Are you a mental health agent? (Circle one) 0 = No 1 = Yes 2 = Don't know

As part of an examination of alcohol and drug abuse treatment services within the Department of Corrections we are interested in learning about the services available to parolees who are "dually diagnosed" with both a mental health disorder and a chemical abuse disorder (designated "AODA 5D").

1. **How many dually diagnosed parolees have been on your caseload in the past year?_____#**
   (estimate if necessary)

2. **How many dually diagnosed ("5D") parolees are <u>currently</u> on your caseload? _____#**
   (estimate if necessary)

3. **What types of problems are typically encountered by dually diagnosed parolees in the community?**

The next questions ask about the usual supervision requirements for dually diagnosed parolees.

4. **How frequently are dually diagnosed parolees usually required to report to you?**
   1 = Weekly
   2 = Every other week
   3 = Monthly
   4 = Every other month
   5 = Other:_____

5. **How many urinalysis (UA) tests do you usually conduct per month for a dually diagnosed parolee?**

   _____#

6. **What types of treatment requirements are typically part of their parole requirements?**

7. **What are the main behavioral signs of mental illness relapse or mental deterioration that you look for (i.e., they have stopped taking their medication)?**

8. **What are the main behavioral signs of substance use relapse that you look for?**

The next series of questions are about the level of communication that exists among parole agents and community service providers.

9. About what percent of the time do parolees follow the referrals that are made to:

Mental health treatment?	_____ %	Check here if you never make this referral ___
Substance abuse treatment?	_____ %	Check here if you never make this referral ___
Medical treatment?	_____ %	Check here if you never make this referral ___
Housing services?	_____ %	Check here if you never make this referral ___
Transportation services?	_____ %	Check here if you never make this referral ___
Financial assistance services?	_____ %	Check here if you never make this referral ___

10. Do you usually find out whether they have followed the referral? How do you find out?

11. Do you usually find out if a parolee has stopped attending treatment, taking mental health medication, or had a relapse? How?

12. Are you satisfied with the level of communication that you have with service providers in your area regarding parolee performance and compliance with requirements?

0 = No, there should be less communication
1 = Yes, there is the right amount of communication
2 = No, there should be more communication

The next series of questions asks about the level of access that dually diagnosed parolees have to needed support and treatment services in your area.

13. What treatment and support services do dually diagnosed parolees typically receive?

14. Are there waiting lists for these services? How long are these waiting lists?

15. In your opinion, what support services do dually diagnosed parolees need in order to function successfully in the community? Which of these are not currently available in your area?

The last series of questions are about your level of contact with institutional (prison) staff and dually diagnosed inmates.

16. How often do substance abuse, mental health treatment, or social staff inside the institutions (prisons) communicate with you about the dually diagnosed men released to your supervision?

0 = I have never been contacted by institutional treatment staff regarding a parolee
1 = I have been contacted once or twice by institutional treatment staff regarding a parolee
2 = I occasionally have contact with institutional treatment staff regarding a parolee
3 = I frequently have contact with institution treatment staff regarding a parolee
4 = I usually have contact with institution treatment staff regarding a parolee

17. Do you have any contact with dually diagnosed inmates assigned to you prior to their release to the community (while they are still incarcerated)?

0 = No (go to Question #18)
1 = Yes → What percent of these inmates assigned to you do you have such contact with?
_____ % (estimate if necessary)

What type of contact usually occurs?
1 = In-person
2 = Telephone
3 = Email
4 = Written correspondence
5 = Other:_____

18. Had you ever heard of the Mental Illness Chemical Abuse (MICA) Treatment Program for men at Oshkosh prison prior to receiving this survey?

0 = No (Thank you for completing this survey)
1 = Yes → **How did you hear about MICA?** (Circle all that apply)
1 = From MICA program staff
2 = Read program brochure
3 = Read newsletter article
4 = From prison/institutional staff
5 = From community corrections staff
6 = From parolee(s)
7 = Other:_____

Have you had any direct contact with MICA program staff?
0 = No
1 = Yes → **What type of contact was it?** (Circle all that apply)
1 = In-person
2 = Telephone
3 = Email
4 = Written correspondence
5 = Other _____

How often was/is the contact with staff? (Circle one)
1 = One time
2 = Sporadic
3 = Frequent
4 = Regular/ongoing

Thank you so much for your time and input -- it is greatly appreciated!

Please return your completed survey via Interdepartmental mail or U.S. mail (if Interdepartmental mail not available) using the attached mailing label

Parole Agent Follow-up Telephone Interview

April 28, 2000

name
address
city/state/zip

Dear Supervisor Lastname:

As our evaluation of the Mental Illness-Chemical Abuse (MICA) Treatment Program at Oshkosh Correctional Institution draws to a close this summer, I would like to express my sincere thanks to you and the agents in your unit for providing follow-up information on the parolees in our study. By completing and returning the follow-up forms your unit helped us document the outcomes of nearly 100% of the parolees in our study.

One of the final components of our study is to evaluate any impact of the MICA program on community services for parolees. **One or more of the agents in your unit have been specifically selected from among agents who have supervised MICA treatment program participants (both program graduates and terminations) to participate in a 15-20 minute telephone interview.** The interview will ask about agent perceptions of the type and quality of community services provided to dually diagnosed offenders.

I will be contacting agents by mail in the coming week asking them to schedule a time for the telephone interview during the week of May 15-19, 2000. Please encourage your agents to participate in this process and emphasize the importance of their participation in this interview.

Feel free to contact me with any questions at "krvanste@facstaff.wisc.edu" or 608-262-5948. Thank you for taking the time to support this effort -- we very much appreciate your cooperation.

Thank you,

Kit R. Van Stelle
Researcher

May 1, 2000

name
address
city/state/zip

Dear Name:

As our evaluation of the Mental Illness-Chemical Abuse (MICA) Treatment Program at Oshkosh Correctional Institution draws to a close this summer, I would like to express my sincere thanks to you for providing follow-up information on the parolees in our study. By completing and returning the follow-up forms you helped us document the outcomes of nearly 100% of the parolees in our study.

One of the final components of our study is to evaluate any impact of the MICA program on community services for parolees. **Your name was specifically selected from among agents who have supervised MICA treatment program participants (both program graduates and terminations) to participate in a 15-20 minute telephone interview.** The interview will ask about your perceptions of the type and quality of community services provided to MICA participants. Your supervisor has been made aware of the importance of your participation in this interview.

I will be conducting the interviews in the mornings of May 15-19, 2000. **Please email me at "krvanste@facstaff.wisc.edu" or voice mail me at 608-262-5948 with your preference of day by May 8th.** I will make every effort to accommodate your preferred morning and will email or call you with the exact day and time of your interview in advance so that you can plan your schedule accordingly.

Feel free to contact me with any questions. Thank you so much for taking the time to give us your input -- we very much appreciate your support and cooperation.

Thank you,

Kit R. Van Stelle
Researcher

Parole Agent Dual Diagnosis Follow-up Interview - Spring 2000

Agent Number:_____ Agent Name:_____

Date/Time of Interview:_____ Agent for: 1 = MICA graduate(s)
2 = MICA termination(s)
3 = Comparison group
4 = Referred ATR only

Length of Interview: _____ minutes

This interview will ask for your perceptions related to the supervision of dually diagnosed offenders in general, and specifically about your experiences (if any) with the MICA program at OSCI.

1. About how many dually diagnosed offenders have you supervised in the past year?

_____ # parolees _____ # probationers

2. How many dually diagnosed offenders do you <u>currently</u> supervise?

_____ # parolees _____ # probationers

3. Is your caseload a specialized one? Do you supervise a particular type of offender?
0 = No
1 = Yes ☛ What type?_____

4. Have you ever heard of the MICA treatment program at OSCI?
0 = No [Go to Question 9]
1 = Yes ☛ **4a. How did you hear about MICA?** [first response:_____]
(circle all that apply)
1 = From MICA program staff
2 = Read program brochure
3 = Read newsletter article
4 = From prison/institutional staff
5 = From community corrections staff
6 = From offenders
7 = From researcher requests for follow-up information on offender(s)
8 = From a research study survey you received in the mail last year
9 = From this request for an interview
10 = Other:_____

4b. What is your overall impression of the MICA treatment program?
0 = Unable to rate
1 = Poor
2 = Adequate
3 = Good
4 = Excellent

5. Have you ever used MICA as an ATR (alternative to revocation) for an offender?

0 = No (go to Question 7)
1 = Yes

QUESTIONS FOR THOSE WHO HAVE USED MICA AS AN ATR:

6. Overall, how would you rate your experiences using MICA as an ATR for offenders?

1 = Poor
2 = Adequate
3 = Good
4 = Excellent

6a. Why did you rate your experience that way?

6b. How could the process of using MICA as an ATR be improved?

Type of Contact With MICA	No	Yes	
7. Have you ever supervised an offender who participated in the MICA program at OSCI?	0	1	If no, continue to Question 9
8. Have you ever supervised an offender who completed the MICA program at OSCI?	0	1	If yes, go to Graduates Section, Question 12, Page 4

QUESTIONS FOR THOSE WHO SUPERVISED MICA TERMINATIONS OR COMPARISON:

Because you indicated that you have not supervised anyone who has completed the MICA program, the questions I have for you today ask for your opinion on how we can improve services for dually diagnosed offenders.

9. What services do dually diagnosed offenders need while in the institution and after release that they are not currently receiving?

10. How do you think that we can increase <u>access</u> to community services for dually diagnosed probationers and parolees?

11. How do you think that we can increase <u>coordination</u> of community services for dually diagnosed probationers and parolees ?

Thank you so much for your time and input -- it is greatly appreciated!

QUESTIONS FOR THOSE WHO SUPERVISED MICA GRADUATES:

This next series of questions asks specifically about your opinions of MICA treatment and support services provided to the MICA graduates you have supervised.

12. In your opinion, do MICA treatment services offered at OSCI appear to have an impact on offender behavior after release? In what ways? [probes: Substance use, mental health, criminality, daily living skills]

13. What did the MICA staff do for the offender after he was released to your supervision? Would you or someone else have ordinarily performed this function?

14. In your opinion, did MICA staff provide assistance in the community that helped him remain stable, substance-free, or crime-free? What?

15. Do MICA graduates receive any assistance in the community that other dually diagnosed probationers and parolees do NOT receive?

16. Did MICA staff involvement increase <u>access</u> to services for the offender? How?
[probes: AOD treatment, MH treatment, criminality counseling, sex offender counseling, medical services, housing assistance, employment, educational assistance, vocational rehabilitation]

17. Did MICA staff involvement increase <u>coordination</u> of services for the offender? How?

18. Did MICA staff increase your knowledge of dual diagnosis issues in any way? How?

These last few questions ask for your opinion of MICA staff.

19. Would you say that the level of contact that the MICA staff had with YOU was...
1 = Too little
2 = About right
3 = Too much

19a. In what way could the level and quality of contact with you be improved?

20. Would you say that the level of contact that MICA staff had with THE OFFENDER in the community was...
1 = Too little
2 = About right
3 = Too much

20a. In what way could the level and quality of contact with the offender be improved?

21. Do you have any other comments about the MICA program?

Thank you so much for your time and input -- it is greatly appreciated!

****

Interviewer Comments:

Parole Agent Offender Three-Month Follow-up Form

UNIVERSITY OF
WISCONSIN-MADISON
MEDICAL SCHOOL

Department of Preventive Medicine
Center for Health Policy and Program Evaluation

DATE

FIELD(Sup First) FIELD(Sup Last)
Unit FIELD(Unit) Supervisor
Division of Community Corrections
FIELD(Street)
FIELD(City), WI FIELD(Zip)

Dear FIELD(Sup First):

The Mental Illness-Chemical Abuse (MICA) Treatment Program at OSCI provides treatment services to offenders who are "dually diagnosed" with both a mental health disorder and a chemical abuse disorder (designated "AODA Level 5D"). The MICA program provides services to dually diagnosed offenders both in the institution and after release to the community.

As one component of the evaluation of MICA being conducted by the University of Wisconsin Center for Health Policy and Program Evaluation (CHPPE), the progress and behavior of dually diagnosed offenders involved in the study will be documented after their release to the community. **With the approval and support of William Grosshans, this offender data will be obtained by asking parole agents to provide a summary of parolee progress three months after they are released to the community.** The offender follow-up form asks agents to summarize parolee progress and status regarding substance use, mental health, legal involvement, etc.

Please distribute the enclosed offender follow-up forms to the correct parole agent(s) in your unit and ask them to provide a summary of parolee progress for the specific time period indicated on each form. If this case has been transferred to another unit or agent, please forward this request. You will receive this letter and the associated follow-up forms each time a dually diagnosed offender involved in the study is assigned to your unit. The attached letter emphasizes the department's commitment to providing the parolee data necessary to complete the federally-funded (NIJ) study. The project has been reviewed for protection of offenders confidentiality by the UW Human Subjects Committee, and all data are protected under NIJ's privacy certification.

Please have the agent(s) complete and return the forms to you within one week, and you can return the follow-up forms as a group to me using the attached return envelope. Please contact me at "krvanste@facstaff.wisc.edu" or 608-262-5948 with questions regarding the study or this data collection effort.

Sincerely,

Kit R. Van Stelle, Researcher

502 North Walnut Street Madison, WI 53705-2335 608 / 263-6850 FAX 608 / 265-3255

Tommy G. Thompson
Governor

Jon E. Litscher
Secretary

State of Wisconsin
Department of Corrections

Mailing Address

149 East Wilson Street
Post Office Box 7925
Madison, WI 53707-7925
Telephone (608) 266-2471
Fax (608) 267-3661

May 11, 1999

Kit R. Van Stelle, Researcher
D. Paul Moberg, Director
University of WI - Madison
Center for Health Policy and Program Evaluation
502 N. Walnut
Madison, WI 53705

Dear Ms. Van Stelle and Dr. Moberg:

The department would like to confirm its commitment to facilitate access to the necessary institution and community records required to complete your National Institute of Justice (NIJ) funded evaluation research study of the department's Mental Illness-Chemical Abuse (MICA) Treatment Program. This program is designed to treat offenders who have both mental illness and substance abuse disorders. The research study involves gathering data on program graduates and comparison groups both in the institutions and after release. In the community, some offender data will be obtained by asking the parole agents of the study subjects to complete a single summary of parolee progress and status three months after release. The three-month follow up forms will be sent to field office supervisors for distribution to the appropriate agents.

The Department of Corrections (DOC) recognizes the value and necessity of independent program evaluations and believes that such efforts can assist in making improvements to services. This effort will require that you have access to all adult institutions, centers, field offices, and offender files to collect data from offender files on an ongoing basis through September 30, 2000, when the study is completed. Further, we understand that your project has been approved by the University of Wisconsin Committee for the Protection of Human Subjects and that appropriate safeguards of offender confidentiality are in place. We understand that you also have a Privacy Certificate from NIJ as an added protection of the data.

You are approved for access to offender social service, clinical, medical, education, and legal files for the purposes of the research study. We hereby authorize all institution, center, and field office personnel to assist you to gain access to these records. Questions regarding the department's provision of access to offender files may be directed to Barb Johnson, Program Specialist, at the DOC central office, phone (608) 266-5443.

Sincerely,

Dick Verhagen, Administrator
Division of Adult Institutions

William Grosshans, Administrator
Division of Community Corrections

Phil Kingston, Assistant Administrator
Division of Community Corrections

Cc: Institution Wardens
Regional Chiefs
Center Superintendents
Field Office Supervisors
Cindy O'Donnell
John Husz
Mickey Thompson
Pam Brandon
Tony Streveler
Ana Boatwright

General Instructions for Completing the Three-Month Follow-Up Form

Outcome Evaluation of the MICA Treatment Program

- ➜ Complete both the front and back of the form.
- ➜ The summary information should only be for the three-month period specifically listed at the top of the page. Summarize information on the identified inmate **as of the date he has completed THREE months on parole OR to the point of reincarceration if that occurred during those three months.**
- ➜ Complete the section on treatment and support services to the best of your ability. Please estimate the amount of service received – number of contacts, sessions, hours, or days.

Please return the completed follow-up forms **within one week** to:

Kit R. Van Stelle, Researcher
University of Wisconsin - Madison
Center for Health Policy and Program Evaluation
502 N. Walnut Street
Madison, WI 53705

Call 608-262-5948 with any questions

THREE-MONTH POST-RELEASE SUMMARY

DOC ID: _____ seq: _____

TREATMENT AND SUPPORT SERVICES RECEIVED BY THIS OFFENDER DURING THIS PERIOD:

	Referral Made? No	Referral Made? Yes	Service Received? No	Service Received? Yes	Dosage (specify if hours, sessions, or days) (estimate if necessary)
AODA outpatient	0	1	0	1	_____
AODA residential/inpatient	0	1	0	1	_____
AODA day treatment	0	1	0	1	_____
AODA halfway house	0	1	0	1	_____
AODA support group	0	1	0	1	_____
mental health inpatient	0	1	0	1	
mental health outpatient	0	1	0	1	_____
criminality counseling	0	1	0	1	_____
sex offender counseling	0	1	0	1	_____
medical services	0	1	0	1	_____
					_____
housing assistance	0	1	0	1	
employment assistance	0	1	0	1	_____
educational assistance	0	1	0	1	_____
vocational rehabilitation	0	1	0	1	_____
financial support services	0	1	0	1	_____
transportation assistance	0	1	0	1	_____
clothing assistance	0	1	0	1	_____
other_____	0	1	0	1	_____

ACCESS TO COMMUNITY TREATMENT AND SUPPORT SERVICES DURING THIS PERIOD:

Was this parolee able to obtain the MENTAL HEALTH TREATMENT services he needed?
0 = This parolee was able to obtain ALL of the mental health treatment services he needed
1 = This parolee was able to obtain MOST of the mental health treatment services he needed
2 = This parolee was able to obtain SOME of the mental health treatment services he needed
3 = This parolee was able to obtain VERY FEW of the mental health treatment services he needed
4 = This parolee was able to obtain NONE of the mental health treatment services he needed

Was this parolee able to obtain the SUBSTANCE ABUSE TREATMENT services he needed?
0 = This parolee was able to obtain ALL of the substance abuse treatment services he needed
1 = This parolee was able to obtain MOST of the substance abuse treatment services he needed
2 = This parolee was able to obtain SOME of the substance abuse treatment services he needed
3 = This parolee was able to obtain VERY FEW of the substance abuse treatment services he needed
4 = This parolee was able to obtain NONE of the substance abuse treatment services he needed

Was this parolee able to obtain the COMMUNITY SUPPORT services he needed?
0 = This parolee was able to obtain ALL of the community support services he needed
1 = This parolee was able to obtain MOST of the community support treatment services he needed
2 = This parolee was able to obtain SOME of the community support treatment services he needed
3 = This parolee was able to obtain VERY FEW of the community support treatment services he needed
4 = This parolee was able to obtain NONE of the community support treatment services he needed

PLEASE RETURN THIS FORM TO US USING THE ATTACHED ENVELOPE

Thank you so much for your time and cooperation!!

Center for Health Policy and Program Evaluation 502 N. Walnut Street Madison, WI 53705

THREE-MONTH POST-RELEASE SUMMARY

DOC ID: _____ seq: _____

Community Parole Performance Summary

Information for the Period: ____/____/____ to ____/____/____

Parolee Name:_____ **Agent Last Name:**_____

PAROLE COMPLIANCE

Current Parole Status:
1 = In compliance
2 = Absconded
3 = Incarcerated
4 = ATR

Overall Rating of Parole Compliance:
1 = Poor
2 = Fair
3 = Good
4 = Excellent

Number of Missed Appointments: _____

Number of Technical Violations: _____

Urinalysis Results:

 # performed_____ **# positive**_____

JUSTICE SYSTEM INVOLVEMENT

Number of Arrests Since Release: _____

# of Days from Release to First Arrest: _____

Number of Convictions Since Release: _____

Returned to Prison?
0 = No
1 = Yes, revocation ☞Reason:_____
2 = Yes, ATR back to prison treatment program
3 = Yes, new offense

HEALTH STATUS SINCE RELEASE

Has he maintained abstinence from alcohol and drugs since release?
0 = No
1 = Yes

Rate the stability of his mental health since release:
1 = Unstable
2 = Periods of stability
3 = Stable on medication
4 = Stable without medication

Has he taken his mental health medication as recommended since release?
0 = Has not taken medication since release
1 = Inconsistently
2 = Consistently

# of Episodes of Mental Health Relapse: _____

PAROLEE STABILITY

Does he have an appropriate:

No	Yes	
0	1	Place to live?
0	1	Schedule of daily activities (things to do)?
0	1	Source of financial support?
0	1	Support system of family/friends?
0	1	Mental health service arrangement?
0	1	Substance abuse service arrangement?

INSTITUTIONAL AND COMMUNITY SERVICES

Did this offender participate in the MICA Treatment Program for dually diagnosed men at Oshkosh prison?

0 = No [Continue to Back of Page]
1 = Yes
2 = Don't know

Has this offender received aftercare services from MICA Treatment Program staff since release to the community?
0 = No
1 = Yes
2 = Don't know

Have you been contacted by MICA Treatment staff about this particular offender since his release to the community? [Enter zeros if you have not been contacted]

_____ # of in-person contacts with MICA staff

_____ # of telephone and written contacts

In your opinion, did the involvement of the MICA staff person increase coordination of community services received by this offender after release?
0 = This offender was not involved in the MICA program
1 = There was no involvement by MICA staff after release
2 = MICA staff involvement had a POSITIVE impact on coordination of services for this man
3 = MICA staff involvement made NO difference in coordination of services for this man
4 = MICA staff involvement had a NEGATIVE impact on coordination of services for this man

Rating of MICA Staff Cooperativeness with You (Agent):
1 = Very uncooperative/unreceptive
2 = Somewhat uncooperative/unreceptive
3 = Somewhat cooperative/receptive
4 = Very cooperative/receptive

[Please continue to back of page]

Institutional Behavior Summary Forms

INSTITUTIONAL – COMPARISON

DOC ID # _____ seq: ____

Summary of Institutional Services Received 12 Months Prior to Release

Participant Name:_____ **Staff Name:**_____

Date of Release:____/____/____

Date of Sentence Start: ____/____/____

Date of Mandatory Release: ____/____/____

Institutional Placement Past 12 Months

[Enter facility codes from below]

	Facility	# Days There
Current	_____	_____
Prior	_____	_____
Prior	_____	_____
Prior	_____	_____

0 = Released/paroled/MR
1 = OSCI - in V Building
2 = OSCI - NOT in V Building
3 = Oakhill Correctional Center
4 = St. John's Correctional Center
5 = Other minimum security facility
6 = Halfway house
7 = Other medium security (not OSCI)
8 = Maximum security facility
9 = WRC
10 = Other_____

Services Received in Institution Prior 12 Months:

No	Yes	DK	
0	1	8	mental health services
0	1	8	psychiatric consultations
0	1	8	substance abuse education
0	1	8	substance abuse treatment
0	1	8	employment/vocational
0	1	8	educational
0	1	8	medical
0	1	8	dental
0	1	8	religious
0	1	8	recreational
0	1	8	other:_____

Institutional Behavior

Rating of Mental Health Prior 12 Months:
1 = Unstable
2 = Periods of stability
3 = Stable on medication
4 = Stable without medication

Medication Type:_____

_____ **# of episodes of deterioration**

Conduct Reports

_____ **# of warnings**

_____ **# of minor conduct reports**

_____ **# of major conduct reports**

Type of most serious report: (Circle one)
1 = Assaultive
2 = Order/security
3 = Property
4 = Contraband
5 = Movement
6 = Safety/health
7 = Miscellaneous

Urinalysis Testing:

_____ **# of UA tests conducted**

_____ **# of positive UA tests**

Upon release, did he have an appropriate:

No	Yes	DK	
0	1	8	Place to live?
0	1	8	Source of financial support?
0	1	8	Support system of family/friends?
0	1	8	Mental health service arrangement?
0	1	8	Substance abuse service arrangement?

[redacted]

_____ # Days Segregation

Comments:

INSTITUTIONAL -- DROPS/TERMINATIONS DOC ID Number:_____seq:_____ 1

Summary of Institutional Services Received After OSCI-MICA
[Completed at 10 Months and 16 Months After Program Admission]

Participant Name:_____ **Staff Name:**_____

Follow-up Interval:
1= 10 Month Follow-up
2= 16 Month Follow-up

Participant Type:
1 = Disciplinary termination
2 = Administrative termination

Date of Admission to MICA: ___/___/___

Date of MICA Services Exit: ___/___/___

End Date of Follow-up Period: ___/___/___

Institutional Placement AFTER OSCI-MICA

[Enter facility codes from below]

	Facility	# Days There
Current	_____	_____
Prior	_____	_____
Prior	_____	_____
Prior	_____	_____

0 = Released/paroled/MR
1 = OSCI - in V Building
2 = OSCI - NOT in V Building
3 = Oakhill Correctional Center
4 = St. John's Correctional Center
5 = Other minimum security facility
6 = Halfway house
7 = Other medium security (not OSCI)
8 = Maximum security facility
9 = WRC
10 = Other_____

Date of Parole/Release/MR: ___/___/___
[Enter "00" if not release/paroled]

Services Received in Institution After Termination:

No	Yes	DK	
0	1	8	mental health services
0	1	8	psychiatric consultations
0	1	8	substance abuse education 018
			substance abuse treatment
0	1	8	employment/vocational
0	1	8	educational
0	1	8	medical
0	1	8	dental
0	1	8	religious
0	1	8	recreational
0	1	8	other:_____

Institutional Behavior

Rating of Mental Health: (Circle one)
1 = Unstable
2 = Periods of stability
3 = Stable on medication
4 = Stable without medication

_____ **# of episodes of deterioration**

Conduct Reports

_____ # of warnings

_____ # of minor conduct reports

_____ # of major conduct reports

Type of most serious report: (Circle one)
1 = Assaultive
2 = Order/security
3 = Property
4 = Contraband
5 = Movement
6 = Safety/health
7 = Miscellaneous

Urinalysis Testing:

_____ # of UA tests conducted

_____ # of positive UA tests

Upon release, does/did he have an appropriate:

No	Yes	DK	
0	1	8	Place to live?
0	1	8	Source of financial support?
0	1	8	Support system of family/friends?
0	1	8	Mental health service arrangement?
0	1	8	Substance abuse service arrangement?

Comments:

[redacted]

_____ # Days Segregation

MICA Summary of Institutional Services Received After OSCI-MICA
[Completed at Time of Release, End of MICA Institutional Services, or Eight Months After Graduation]

Participant Name:_____ **Staff Name:**_____

Today's Date: ___/___/___

Reason for Completing This Form:
1 = Release to community
2 = End of MICA Institutional Services
3 = Eight Months After Graduation

Reason for MICA Services Exit:
0 = No Exit: Eight-month follow-up only (Still receiving MICA institutional services)
1 = Paroled ->Date:_____
2 = Mandatory release (MR) -> Date:_____
3 = Maximum program length
4 = AODA relapse
5 = Medication non-compliance
6 = Poor behavior - chronic/ongoing
7 = Poor behavior - major episode
8 = Transfer to other institution/halfway house
9= Other_____

Institutional Placement After OSCI-MICA

Received at: (Enter facility codes from below)

	Facility	# Days There
Current/last	_____	_____
Prior	_____	_____
Prior	_____	_____

0 = Did not receive further MICA services
1 = OSCI - in V Building
2 = OSCI - NOT in V Building
3 = Oakhill Correctional Center
4 = St. John's Correctional Center
5 = Other minimum security facility
6 = Halfway house
7 = Other medium security (not OSCI)
8 = Maximum security facility
9 = WRC
10 = Other_____

Mental Health Status

Rating of Mental Health Stability: (Circle one)
1 = Worse
2 = Same
3 = Improved

_____ **# of episodes of deterioration**

Services Received Through MICA

_____ # of meetings with outreach specialist

_____ # of relapse prevention group sessions

_____ # of community/agency contacts

_____ # of family contacts

No	Yes	
0	1	mental health services
0	1	psychiatric consultations
0	1	psychological services
0	1	substance abuse services
0	1	support group sessions(AA/NA)
0	1	employment/vocational
0	1	educational
0	1	medical
0	1	dental
0	1	religious
0	1	recreational
0	1	other:_____

Urinalysis Testing:

_____ # performed _____ # positive

Release Plans

Upon release, does he have an appropriate:

No	Yes	
0	1	Place to live?
0	1	Source of financial support?
0	1	Support system of family/friends?
0	1	Mental health service arrangement?
0	1	Substance abuse service arrangement?

Ratings of Treatment Program Behavior Improvement:

	Ratings of Behavior				Change During This Time		
	None/ Poor	Ade- quate	Good	Excellent	Worse	Same	Improved
refrains from criminal attitudes/behaviors	0	1	2	3	1	2	3
medication compliance	0	1	2	3	1	2	3
maintains personal and room hygiene	0	1	2	3	1	2	3
develops schedule of activities	0	1	2	3	1	2	3
occupies time productively	0	1	2	3	1	2	3
active role in release preparation	0	1	2	3	1	2	3
money management skills	0	1	2	3	1	2	3
community support system	0	1	2	3	1	2	3
Treatment team confidence in maintenance of stability after release...							
regarding mental illness	0	1	2	3	1	2	3
regarding chemical use	0	1	2	3	1	2	3
regarding criminal behavior	0	1	2	3	1	2	3
regarding personal issues	0	1	2	3	1	2	3

MICA Staff Graduate Three-Month Follow-up Form

THREE-MONTH POST-RELEASE SUMMARY

DOC ID: _____ seq: _____

MICA Community Aftercare Services and Participant Assessment Summary

Information for the THREE-MONTH Period: ____/____/____ to ____/____/____

Parolee Name:_____ **Staff Last Name:**_____

MICA COMPLETION STATUS:

1 = Graduate
2 = Non-graduate (drop-out, termination, etc.)

JUSTICE SYSTEM INVOLVEMENT

Current Parole Status:
1 = In compliance
2 = Absconded
3 = Incarcerated
4 = ATR

Number of Arrests Since Release: _____

Number of Convictions Since Release: _____

Returned to Prison?
0 = No
1 = Yes, revocation ☞Reason:_____
2 = Yes, ATR back to prison treatment program
3 = Yes, new offense

MENTAL HEALTH STATUS SINCE RELEASE

Rating of Mental Health: (Circle one)
1 = Unstable
2 = Periods of stability
3 = Stable on medication
4 = Stable without medication

# of Episodes of Deterioration/Relapse: _____

CHEMICAL USE STATUS

Has he maintained abstinence from alcohol and drugs since release?
0 = No
1 = Yes

# of Episodes of Relapse:_____

PAROLEE STABILITY

Does he have an appropriate:

No	Yes	
0	1	Place to live?
0	1	Source of financial support?
0	1	Support system of family/friends?
0	1	Mental health service arrangement?
0	1	Substance abuse service arrangement?

MICA AFTERCARE SERVICES PROVIDED:

Number of Contacts in Past THREE MONTHS:

	In-person	Other (phone, written, etc.)
Parolee	_____	_____
Parolee family	_____	_____
Treatment providers	_____	_____
Support services	_____	_____
Parole agent	_____	_____

Rating of OFFENDER cooperativeness with MICA staff:
1 = Very uncooperative/unreceptive
2 = Somewhat uncooperative/unreceptive
3 = Somewhat cooperative/receptive
4 = Very cooperative/receptive

Rating of PAROLE AGENT cooperativeness with MICA staff:
1 = Very uncooperative/unreceptive
2 = Somewhat uncooperative/unreceptive
3 = Somewhat cooperative/receptive
4 = Very cooperative/receptive

ASSESSMENT RESULTS

Date Assessments Performed: ____/____/____

BSI: GSI _____

Scales over 65_____

ASI: Medical _____

Emp/support _____

Alcohol _____

Drug _____

Legal _____

Family/social _____

Psychiatric _____

Recidivism Data Abstract Form

Name:_____ _____ _____ Birthdate:____/____/____ May/June 2000
(Last) (First) (MI)

MICA: Summary of Recidivism Data from Crime Information Bureau (CIB) and CIPIS

DOC ID Number:_____ Date of Release:____/____/____ Comparison/Graduate/Termination:_____
(0/1/2)

RECIDIVISM SUMMARY:

Arrests: [1]

Last adult arrest date _____

Arrests _____

Convictions _____

Days Sentenced _____

[1] from CIB printout

Incarceration:

Currently Incarcerated? [2] 0=No 1=Yes

Days Reincarcerated Since Release:

Days in Prison _____

Days in Jail [3] _____

[2] from CIPIS data and screen #73

[3] from OATS database county jail holds

Prison Incarceration History: [4]
[most recent to oldest]

	Dates To/From	# Days
#1		
#2		
#3		

[4] from CIPIS screen #73

Most Recent First....

Date	Arrested for:	Statute Number	Mis=1 Fel=2	Convicted	Mis=1 Fel=2	# Days Sentenced	Prison Days Served