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# FINAL REPORT OF A PROCESS EVALUATION OF THE OZARK CORRECTIONAL CENTER DRUG TREATMENT PROGRAM

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## I. Introduction

Therapeutic communities (TC) are emerging as the primary approach used in prisons to treat substance abuse (Wexler, 1995). Through a 24-hour per day learning experience, TC programs seek to make global life-style changes in the residents that include refraining from substance use, engaging in pro-social conduct, obtaining employment, and adopting attitudes and values that support these changes (Pan, Scarpitti, Inciardi, & Lockwood, 1993). Researchers have documented the success of prison-based TC programs in reducing substance abuse and recidivism, particularly when combined with follow-up treatment in the community (Field, 1985; Knight, Simpson, & Hiller, 1999; Martin, Butzin, Saum, & Inciardi, 1999; Wexler, Falkin, & Lipton, 1990; Wexler, Melnick, Lowe, & Peters, 1999). Based in part on their early success, a panel of national experts in the fields of corrections, social services, and substance abuse treatment recommended in 1992 that TC programs be implemented in every federal prison and every state prison system (Wexler & Lipton, 1993).

In October 1993, the Missouri Department of Corrections (DOC) received a 3-year Center for Substance Abuse Treatment (CSAT) grant to create a therapeutic community (TC) substance abuse treatment program for inmates in Ozark Correctional Center (OCC), an all male, 650-bed minimum security prison. Program development and implementation proceeded under this grant, and by April 1995, the first program graduates were released into the community. Most candidates are referred to the OCC Drug Treatment Program (OCCDTP) by the Missouri Board of Probation and Parole. A limited number are sentenced directly to the program by Missouri circuit court judges. DOC staff screens all persons referred to the program. During the

study's evaluation period, primary program criteria included a history of substance abuse, the absence of serious health or mental health problems, and eligibility to participate in the prison's work release program.

OCCDTP consists of four phases. During Phase 1, which typically lasts about 30 days, treatment staff completes assessments and develops treatment plans. Phase 2 involves intensive treatment for a minimum of 30 hours weekly for 6 to 9 months. This treatment includes participation in the TC structure and activities, in substance abuse and life skill psychoeducational activities, in individual and group therapy, and in weekly Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings. In Phase 3, inmates participate in supervised community work release projects for 40 hours weekly for 3 to 6 months. While in the work release program, inmates continue to participate in the TC structure and activities, in relapse prevention activities, and in AA/NA groups. Phase 4 usually takes place during inmates' last 30 days at the prison. During this period, the aftercare plan is completed, including finalization of the community-based aftercare activities. The program activities and total length of time in the program, usually 12 to 18 months, are similar to TC programs in other states (Inciardi, 1995; Knight, Simpson, Chatham, & Camacho, 1997).

An initial evaluation of OCCDTP conducted at the end of the 3-year CSAT grant period found that program graduates released into the community experienced fewer rearrests and had lower levels of substance abuse than a matched comparison group of DOC inmates who did not participate in any substance abuse treatment prior to release. In January 1998, the National Institute of Justice (NIJ) awarded a grant (NIJ #97-RT-VXK013) to the Addition Technology Transfer Center, University of Missouri at Kansas City, to conduct a more extensive evaluation

of OCCDTP. The grant called for an expansion of the outcome and process studies funded under the initial CSAT grant.

This report provides final results of a process evaluation of OCCDTP that was funded by the 1998 NIJ grant. Areas included in this report are (a) changes in OCCDTP treatment activities; (b) characteristics of OCCDTP participants; (c) utilization of aftercare; and (d) participant ratings of OCCDTP and aftercare. The report begins with an overview of the methods used to collect and analyze the data. Next, the results for each area are presented. Finally, a concluding section summarizes key findings.

To assist in determining the degree of change in characteristics of OCCDTP clients over time, comparisons are made between two cohorts of clients based upon dates of admission to the program (N=1,268). Cohort 1 clients were admitted to OCCDTP between February 1, 1994 and June 30, 1995 (N=642). Cohort 2 clients were admitted between July 1, 1995 and September 30, 1996 (N=626). Among both cohorts, 693 clients successfully completed the program and 575 clients dropped out of the program.

To assess clients' utilization of aftercare and their perceptions of the program, attempts were made to collect follow-up data from clients who successfully completed the program. Clients were once again divided into two cohorts, this time by date of release from OCC. Cohort 1 clients were released between April 1, 1995 and June 30, 1996; and Cohort 2 clients between July 1, 1996 and September 30, 1997. Among clients who successfully completed the program, follow-up data were collected on 145 of 259 Cohort 1 clients (56.0%) and 144 of 363 Cohort 2 clients (39.7%).

## II. Evaluation Methods

To evaluate the four process evaluation areas, a combination of quantitative and qualitative methods and multiple data sources were used, including focus groups, a staff survey, a review of documents, and a quantitative analysis of a client database. Each is described below.

### A. Focus Groups

In focus groups, a moderator leads discussion on a selected topic. The moderator usually has prepared questions, although latitude is given to participants to provide information on related issues. To maximize participation, the size of focus groups is usually limited to 8 to 12 participants. This qualitative method is intended to provide exploratory information regarding participants' perceptions of selected topics.

On April 21, 1998, two members of the evaluation team traveled to OCC to conduct focus groups with key administrative and treatment program staff. To promote openness of discussion, separate focus groups were held with three different groups of staff. In addition, all responses were confidential; thus, when reporting the findings, references are made only to the three focus groups, not to individual respondents. The three focus groups consisted of the following membership.

- Eight OCCDTP counselors who had been employed by both treatment providers. (In the fourth year of operation of OCCDTP, DOC awarded the contract to provide treatment to a new agency, which retained some staff from the previous program. Counselors participating in the focus groups were limited to those who had worked under both treatment providers, with the rationale being they could better assess changes over time.)
- All three OCCDTP counselor supervisors.

- Four administrative staff, including the OCC Superintendent, the OCC Associate Superintendent, the OCC Chief of Custody, and the site director of OCCDTP.

**B. OCCDTP Staff Survey**

In addition to the focus groups, OCCDTP staff was invited to complete the Therapeutic Community Scale of Essential Elements Questionnaire (SEEQ). Twenty of 24 volunteered to do so. SEEQ was developed in 1993 by George De Leon and Gerald Melnick for the Center for Therapeutic Community Research. SEEQ asks respondents to rate the importance of each of the essential elements of TC as practiced in their programs. SEEQ includes 139 questions, which are organized into six dimensions, and further divided into 27 domains. Initial testing of SEEQ found an acceptable level of reliability (Melnick & De Leon, 1999). Cronbach's alpha was .97 for the overall instrument and ranged from .76 to .94 across the dimensions, and 23 of 27 domains had coefficients of .60 or above. Further information about SEEQ is provided in the section that discusses the results. Appendix 1 contains complete SEEQ results, including comparative scores from other TC programs.

**C. Document Reviews**

Three sets of documents were reviewed. These included:

- Oversight Committee meetings minutes. Usually every one to three months, the OCC Superintendent leads a committee referred to as the Oversight Committee. This committee consists of staff from OCC; DOC administrators who work outside of OCC; OCCDTP staff, including the on-site director and regional staff; and the professor from the Center for Social Research at Southwest Missouri State University (SMSU) who was the study's principal investigator. Minutes were reviewed for seven meetings, spanning September 1996 to October 1997.

- A DOC report, "Tobacco Free Procedures for Inmates of Institutional Treatment Centers and Community Release Centers: Pilot Project Evaluation Summary Report."
- Program descriptions, including those found in the original grant proposal and the Request for Proposals delineating the program requirements for the new treatment provider.

**D. Client Database**

Finally, a computerized client database was created including data from the following sources.

- Client demographic information provided by DOC on all persons admitted to OCCDTP between February 1, 1994 and September 30, 1996 (N=1,268).
- Results from a 3-month follow-up survey of clients who successfully completed the program. Conducted by staff from the SMSU Center for Social Research, this survey provided information on clients' perceptions of the program. Results are included for 187 of 259 clients (72%) from release Cohort 1 and 121 of 363 clients (33%) from release Cohort 2. The number of clients surveyed was less for Cohort 2 because funding for the 3-month survey ended at the expiration of the 3-year CSAT grant.
- Results from a 12-month follow-up survey of clients who successfully completed the program. Once again conducted by staff from the SMSU Center for Social Research, this survey included client satisfaction information, suggestions for program improvement, levels of participation in aftercare, and social and clinical data. Data were gathered from 145 of 259 Cohort 1 clients (56%) and 144 of 363 Cohort 2 clients (40%).
- Results from a psychosocial assessment completed on inmates by the contract provider as part of the initial assessment process as clients entered OCCDTP. The psychosocial assessment included a variety of social, criminal, and substance history data. The assessment

was completed on 90% of admission Cohort 1 clients and 62% of admission Cohort 2 clients. The percentage of completion decreased for Cohort 2 clients because funding ended at the close of the initial 3-year CSAT grant.

The above four data sources provided information (a) to identify changes in OCCDTP treatment activities; (b) to determine the extent to which characteristics of program participants have changed; and (c) to assess the degree of utilization of aftercare following the release of OCCDTP graduates into the community. Integrated into the above are clients' evaluation of aspects of OCCDTP and the aftercare they received following their release from OCC into the community. Presented first is an examination of changes in treatment activities within OCCDTP.

## III. Treatment Activities

The process evaluation outlined in the NIJ grant included one question regarding treatment activities: "What changes in program treatment activities have occurred from the first cohort to the second?" Information from the following sources addressed this question: (a) the three focus groups of OCC/OCCDTP staff; (b) Oversight Committee meeting minutes; (c) the DOC no-smoking report; (d) the results of the TC scale completed by OCCDTP staff; and (e) client input gathered from the 3-month and 12-month follow-up surveys.

Emerging from this formation were three events that influenced the treatment process. The first two were of major importance and included (a) a change in treatment providers contracted to operate the program, which became effective on May 1, 1997; and (b) the initiation of an inmate no-smoking policy, which began on July 1, 1996 and was rescinded on April 1, 1998. A third event was the integration of work release into the treatment program, although its impact was considerably less than the first two events. Rather than simply listing changes in treatment activities, it is more meaningful to describe these three occurrences and the manner in which they influenced the treatment program.

### A. Change in Treatment Providers

The use of private providers to operate entire prisons or to provide programming within state-run prisons is increasingly common, although the privatization of public services is still controversial (Chalk, 1999; Gormley, 1994; Patterson, 1998; Travis, Latessa, & Vito, 1985; York, 1993). While DOC still operates the state prisons, it contracts with private organizations to provide inmates with medical care and some substance abuse treatment and educational services. OCCDTP is implemented by a private provider under contract with DOC. One treatment provider held the contract throughout the 3-year initial CSAT grant period, which

ended on September 30, 1996. At the end of the grant period, DOC assumed funding for the program in its entirety and initiated a competitive process for the treatment contract. On November 1, 1996, DOC issued a Request for Proposals (RFP) for the service contract. DOC selected a different treatment provider, and on May 1, 1997, the conversion to the new provider was completed. Information from both staff and clients indicated that the change in treatment providers had a negative impact on the program. It affected staffing levels, staff training, and the use of individual treatment of clients.

***Staffing changes***

The initial CSAT grant funded 21 counselors and three counselor supervisors. According to the counselor supervisors, on April 18, 1997, the program had 24 counselors and 4 supervisors. On May 1, 1997, the new provider cut the salaries of all treatment staff and reduced the number of counselor positions and counselor supervisor positions to its previous level of 21 and 3, respectively. A number of counselors chose not to accept the pay cut and resigned. Consequently, the number of counselors fell from 24 to 17 almost immediately. New hirings increased the staffing levels to 20 counselors, although it was not until January 1998 that the new treatment provider reached its full staffing of 21 counselors.

Participants in all three focus groups raised concern over the staffing reductions and turnover of staff. Counselors identified the added stress of trying to cover the workload of the counselors who left and believed they no longer had the time to provide needed treatment to all clients. The counselor supervisors indicated that several of the staff members who left were "key" staff members who had worked in the program since its inception. Supervisors believed their absence reduced the overall quality of the program.

The supervisors also believed that staffing changes, such as those described above, could pose the greatest threat to TC programs. Staffing changes disrupted the sense of trust and community that are integral to such programs. They strongly indicated that staff retention was vitally important to maintaining the integrity of TC programs.

Not only did the staffing changes disrupt relationships between counselors and clients, but participants in the administrator focus group said it also negatively affected the relationships between counselors and correctional officers. In a TC system, open communication between the two groups is important, and it is facilitated by strong working relationships that develop over time. The turnover in counselors made the development of such working relationships difficult, particularly during the initial period when the hiring of new counselors occurred.

***Counselor training***

The issue of counselor training was raised in the counselor and counselor supervisor focus groups. The counselors indicated that while all had prior work experience and education in substance abuse treatment, some had not worked within the TC model, and none had previously worked within a prison setting. They agreed that it takes counselors about one year to become fully trained and to function as an independent counselor in a prison environment. The counselors indicated that one of the benefits of working during the initial program start-up that was funded through the CSAT grant was the extensive training they received about substance abuse treatment, the TC model, and functioning within a prison setting. Some counselors reported that they found the incremental nature of the training to be particularly beneficial, during which they would learn one piece of information, have the opportunity to test that knowledge and skill, and then receive feedback and retraining if necessary prior to beginning the next training topic. Although the counselor training provided by the new treatment provider

appeared to meet contract requirements, both counselors and counselor supervisors believed that the training the employees received from the new provider was substantially less than that received under the initial grant and inadequately prepared counselors to implement the TC model within a prison setting.

***Services provided***

Both counselors and counselor supervisors agreed that the number of group activities offered by counselors remained about the same under both treatment providers. However, the staffing reduction influenced treatment services in two ways. First, both counselors and counselor supervisors indicated that the amount of work with individual clients greatly diminished because of the staff reductions. Second, counselors indicated the number of clients participating in each group therapy session greatly increased, which they believed reduced the effectiveness of the treatment. They stated that the optimal group therapy size was 12 clients with a maximum of 16 clients, but that group size grew in some instances to 24 clients or occasionally more. One counselor indicated that this growth began under the first provider as the program reached full implementation. Others stated that the increased number of clients did not appear to be as great a burden under the first provider because that provider gave staff an opportunity to process the changes and deescalate. They believed that the new provider did not offer this support.

At the same time the new treatment provider reduced the number of staff, the number of inmates participating in OCCDTP increased. Under the initial CSAT grant, at any given time approximately 500 of the 650 OCC inmates were participating in one of the four treatment phases. Those not in treatment usually fell into one of four groups: (a) they were new to the prison; (b) they were barred from treatment because of disruptive behaviors; (c) they voluntarily

chose to withdraw from treatment; or (d) they had graduated from the program and were awaiting release, with this last group constituting, on average, about 100 of the 150 inmates not in treatment. DOC later decided to make the entire prison a TC, rather than having separate rules for a segment of the prison population. When DOC decided to bid the OCCDTP contract, they wrote into the contract that all OCC inmates were to participate in the TC program. During the first week of its operation, the new treatment provider assessed or reassessed the remaining 150 clients and began offering services to them. The speed of the transition was due in part to the method of reimbursement contained in the new treatment contract. DOC changed the method of payment from a flat rate paid on a monthly basis, as was done in the initial 3-year CSAT grant, to payment based upon the number of clients served in each phase of the program. Thus, the new treatment provider had a financial incentive to include all clients in treatment as quickly as possible, which they did with approval from the Oversight Committee.

The infusion of the remaining 150 inmates into OCCDTP had several negative consequences. First, according to the participants in the counselor focus group, the inclusion of all of the remaining 150 inmates into OCCDTP during the new treatment provider's first week was a major disruption to ongoing treatment activities. Counselors said they were pulled from much of their treatment activities to complete the intake of the new clients. This was exacerbated by already being short-staffed because of the counselor resignations when the new treatment provider began. Also, the counselors indicated that the intake process was not as thorough as they normally provided because of the volume of clients entering OCCDTP in a short period of time.

The incorporation of all inmates in treatment included, according to Oversight Committee minutes, those who were awaiting transfer out of the prison for disruptive behaviors or refusal to

actively participate in the program. Counselor supervisors believed the inclusion of these clients lessened the power of other clients, who, within the TC model, should be able to recommend moving inmates out of treatment who are not appropriately participating in the program. Also, Oversight Committee minutes reported that some of these inmates were continuing to be disruptive in treatment groups, which lessened the benefit to other clients. The policy of inclusion of all clients in treatment was modified approximately six months later to include reviews of such behaviors on an individual basis, with discharge from the program while the inmate was at OCC being one option. While OCC makes every effort to quickly transfer inmates out of OCC who are disruptive to treatment, overcrowding in other DOC prisons often prevents a timely transfer from OCC to another DOC prison. However, at least some of the focus group respondents believed that the benefit of all clients continuing treatment during their entire stay at OCC outweighed the logistical problems of transferring disruptive clients to other prisons.

In retrospect, according to a DOC administrator, the Oversight Committee could have phased-in the additional clients into the TC community at a slower pace and could have been more sensitive to the workload of the counselors and to its potential negative consequences on the program.

***Clients' evaluation of the change in treatment providers***

Clients' reactions to the change in treatment providers were measured through two questions added to the 12-month follow-up survey of clients who had successfully completed the program and who had received treatment from both treatment providers. The first question examined the impact of the change in treatment providers on clients' morale and the second on their treatment. Table 1 includes clients' responses to both questions.

Clients' evaluation of the change in treatment providers is consistent with the findings from the focus groups that the change had a negative effect on the treatment program. Morale was largely unaffected for the majority of clients, although about one-fourth indicated it slightly hurt morale and an additional 13.3% indicated it significantly hurt their morale. The impact on treatment was much greater. Almost two-thirds of the clients indicated that the change in treatment providers hurt the program, including 36% who indicated that it significantly hurt treatment. None of the respondents indicated the changed in providers significantly improved the program, and only 9% of the clients indicated the change slightly improved the program.

TABLE 1
Client Evaluation of the Change in Treatment Providers

| | |
|---|---|
| *How did the change to the new treatment provider affect your morale? Would you say it:* | |
| Significantly improved your morale? | 0.0% |
| Slightly improved your morale? | 2.7% |
| Had no effect on your morale? | 58.7% |
| Slightly hurt your morale? | 25.3% |
| Significantly hurt your morale? | 13.3% |
| *Total* | *100.0%* |
| | *(N=75)* |
| *How did the change to the new treatment provider affect your treatment? Would you say it:* | |
| Significantly improved the treatment program? | 0.0% |
| Slightly improved the treatment program? | 8.6% |
| Had no effect on the treatment program? | 27.1% |
| Slightly hurt the treatment program? | 28.6% |
| Significantly hurt the treatment program? | 35.7% |
| *Total* | *100.0%* |
| | *(N=70)* |

## B. Initiation of No-Smoking Policy

The second major issue identified in the focus group that impacted OCCDTP was the initiation of the no-smoking policy for all OCC inmates. State prisons and jails are increasingly

banning smoking on prison grounds or limiting it to outdoor areas within prison grounds (Falkin, Strauss, & Lankenau, 1998; Lillis, 1994). Consistent with this trend, a group of Missouri legislators approached DOC about banning smoking in Missouri prisons. The two parties agreed to initiate a smoking ban as a pilot project and to evaluate its impact after one year. On July 1, 1996, DOC instituted a tobacco free pilot project that prohibited use of tobacco by inmates at all DOC Institutional Treatment Centers and Community Release Centers, including OCC. Under this policy, inmates could not smoke anywhere on the facility grounds, although staff were still allowed to smoke outdoors. On April 1, 1998, DOC reversed the policy and inmates were allowed to smoke outdoors.

Participants from all three focus groups believed that the no-smoking policy had a substantial detrimental effect on implementation of the TC program at OCC. These conclusions are consistent with statements included in the Oversight Committee meeting minutes, with the findings of a one-year evaluation of the pilot project that included all affected DOC institutions, with a review of inmate incidents at OCC, and with clients' perceptions.

Both staff and clients indicated that within a short time after enactment of the no-smoking policy, cigarettes became the drug of choice, replacing illegal drugs. Smoking created a subculture of criminal activity, and inmates who previously were not involved in policy violations obtained and used cigarettes illegally, became involved in cigarette trafficking, or committed other violations related to smoking.

These behaviors affected treatment at OCC in at least two ways. First, numerous instances were cited by staff in which inmates blatantly smoked in order to obtain violations so they could be discharged from the treatment program and be transferred to a non-treatment prison that permitted smoking. These inmates included some who had previously been actively

participating in treatment and had no previous violations. Hence, the no-smoking policy resulted in an increase in the program dropout rate. Across all DOC Institutional Treatment Centers, the number of negative terminations from treatment increased by 13%, and the number of positive program completions dropped by 15% during the first year of implementation of the no-smoking policy. Consistent with this, 25% of all inmate conduct violations were tobacco-related.

The no-smoking policy also negatively impacted treatment. A DOC report that evaluated the impact of the non-smoking policy on all DOC treatment institutions one year after initiation of the policy concluded that the treatment environment had been significantly impaired as a result of the no-smoking policy. Counselors found it increasingly difficult to provide treatment to the large number of inmates who were involved in behaviors associated with violation of the no-smoking policy. Implementation was widely reported to have caused inmates to lose focus on their treatment goals. The effects of the no-smoking policy interrupted the support that had developed as part of the TC model, particularly since the policy still allowed staff to smoke outdoors. Correctional officers had to assume more of a role of "cop," which negatively affected their ability to support the pro-social behavior of inmates.

***Clients' evaluation of the impact of the no-smoking policy***

The views of OCCDTP clients are consistent with those reported in the focus groups that the no-smoking policy had a detrimental effect on the treatment program. Two questions were added to the 12-month follow-up survey that sought information from clients who were in the treatment program at OCC when the no-smoking policy went into effect. Table 2 summarizes their responses to the two questions. In addition, a sample of open-ended comments made by program participants further expresses their viewpoints.

The vast majority of clients indicated that the initiation of the no-smoking policy hurt their morale. Even more strongly, almost 80% of the clients indicated that the policy change significantly hurt the treatment program. Only 6.2% of the clients responded that the no-smoking policy had no effect or improved the treatment program.

TABLE 2
Client Evaluation of the Impact of the No-Smoking Policy

| | |
|---|---|
| *How did the no-smoking policy affect your morale? Would you say it:* | |
| Significantly improved your morale? | 3.4% |
| Slightly improved your morale? | 2.3% |
| Had no effect on your morale? | 34.1% |
| Slightly hurt your morale? | 19.9% |
| Significantly hurt your morale? | 40.3% |
| *Total* | *100.0%* |
| | *(N=176)* |
| *How did the no-smoking policy affect the treatment program? Would you say it:* | |
| Significantly improved the treatment program? | 1.7% |
| Slightly improved the treatment program? | 1.1% |
| Had no effect on the treatment program? | 3.4% |
| Slightly hurt the treatment program? | 14.3% |
| Significantly hurt the treatment program? | 79.4% |
| *Total* | *99.9%* |
| | *(N=175)* |

A non-random sample of opened-ended comments made by clients on the 12-month follow-up survey illustrates the impact of the no-smoking policy on the treatment program from the clients' perspectives.

- "The no-smoking policy creates too much stress and tension. It changes the atmosphere to a street mentality."
- "A lot of guys who were addicted to nicotine lost their focus on the treatment program after the no-smoking policy."

- "Give tobacco back to the men. The no-smoking policy created chaos and criminal thinking in the camp."
- "The no-smoking policy turned the whole camp into a drug set. Where there used to be a few trying to sell drugs in the camp, the no-smoking policy took the focus off drug treatment and just put an emphasis on cigarettes."
- "Bring smoking back so it will allow people to stop the unnecessary criminal behavior and let them have time to think about their lives and self-help, instead of where they can buy cigarettes."
- "The men were becoming treatment-oriented, but the no-smoking policy brought back a drug mind set and behaviors."
- "Give them back their smoking. You can't quit everything at once."

As indicated above, DOC rescinded the tobacco free policy on April 1, 1998. Although the focus group interviews were held only 21 days after this policy change was made to allow inmates to smoke outdoors, respondents already observed a substantial improvement in the atmosphere of the prison, with a corresponding positive impact on the treatment environment.

**C. Work Release**

A third issue raised in the focus groups was the inclusion of OCCDTP clients in work release, although its impact was far less than the two previous issues. OCC has an extensive work release program that allows inmates to leave prison grounds to work in the community. This program was already established when DOC designated OCC as an Institutional Treatment Center. Since initiation of the TC program, inmates are not eligible to participate in work release until they have completed Phases 1 and 2 of the treatment program. At any given time, about 150 inmates, or almost 25% of the total prison population, participate in work release.

The inclusion of treatment program participants in the established work release program raised two issues. First, minutes from the Oversight Committee indicated that a logistical problem existed related to the timing of inmates entering work release. Early in the program's development, not enough inmates were eligible for work release to fill the 150 community work slots, which jeopardized the integrity of the program. However, the work release program now usually has enough inmates to supply the program.

A second process issue emerged from focus group discussions. Two groups, the counselor supervisors and the administrators, identified the positive role work release plays within a TC prison program. They noted that work release (a) offers extra incentives to inmates to participate in treatment and progress to Phase 3; (b) provides inmates with money for use after their release; (c) gives program participants the opportunity to test what they have learned in the program prior to full release into the community; and (d) allows them to re-enter the intensive TC treatment program should they need that additional support.

However, counselors reported that treatment was not well integrated with work release. While work release has the potential for serving as a testing ground, they did not believe that clients' experiences while working were adequately explored or addressed in treatment. In essence, missed opportunities for meaningful treatment were occurring. The inclusion of all OCC inmates into OCCDTP occurred in part to better integrate clients participating in work release into treatment. Further evaluation is needed to determine if this is occurring.

## D. Client Evaluations of OCCDTP

In addition to clients' evaluation of the change in treatment providers and the no-smoking policy previously presented, general input from clients was gathered through two means. First, staff from the SMSU Center for Social Research conducted a follow-up survey with clients who

successfully completed the program and who had been released for three months. This survey included (a) five questions that asked clients to rate OCCDTP features, and (b) ten questions that asked clients to rate their OCCDTP counselors' attitudes and behaviors. A second means of surveying clients' perceptions about OCCDTP was included in the revised 12-month follow-up survey as an open-ended question asking clients to make suggestions for improving the treatment program. Given the timing of the revision to the 12-month follow-up survey, the open-ended responses were given by clients from Cohort 2 who successfully completed the program.

Table 3 includes clients' ratings of OCCDTP categorized as Terrible (1), Adequate (2), or Great (3). Responses are divided between clients from Cohort 1 and Cohort 2 who successfully completed the program. Responses are calculated as percentages in each response category and as mean scores. Chi-squares measured statistical differences between the two cohorts for the categorical responses and t-tests measured statistical differences in mean scores.

TABLE 3
Client Rating of OCCDTP Treatment Features for Cohort 1 (N=178) and Cohort 2 (N=118) Clients

| | | *Terrible (1)* | *Adequate (2)* | *Great (3)* | *Mean* | *SD* |
|---|---|---|---|---|---|---|
| 1. Caring of the treatment staff | Cohort 1 | 6.7% | 61.2% | 32.0% | 2.25 | .57 |
| | Cohort 2 | 7.6% | 71.2% | 21.2% | 2.14 | .52 |
| | *Combined* | *7.1%* | *65.2%* | *27.7%* | *2.21* | *.55* |
| 2. Helpfulness of treatment staff | Cohort 1 | 7.3% | 53.9% | 38.8% | 2.31 | .60 |
| | Cohort 2 | 7.6% | 62.7% | 29.7% | 2.22 | .57 |
| | *Combined* | *7.4%* | *57.4%* | *35.1%* | *2.28* | *.59* |
| 3. Caring of custody staff | Cohort 1 | 20.2% | 61.2% | 18.5% | 1.98 | .62 |
| | Cohort 2 | 27.4% | 58.1% | 14.5% | 1.87 | .64 |
| | *Combined* | *23.1%* | *60.0%* | *16.9%* | *1.94* | *.63* |
| 4. Helpfulness of custody staff | Cohort 1 | 16.3% | 62.9% | 20.8% | 2.04 | .61 |
| | Cohort 2 | 24.8% | 59.8% | 15.4% | 1.91 | .63 |
| | *Combined* | *19.7%* | *61.7%* | *18.6%* | *1.99* | *.62* |
| 5. General sense of family or community | Cohort 1 | 13.6% | 55.4% | 31.1%* | 2.18** | .65 |
| | Cohort 2 | 26.3% | 50.8% | 22.9%* | 1.97** | .70 |
| | *Combined* | *18.6%* | *53.6%* | *27.8%* | *2.09* | *.68* |

* $p < .05$ ** $p < .01$

The component with the highest overall "great" rating was "the helpfulness of treatment staff" (35%). The component with highest overall "terrible rate" was "caring of the custody staff" (23%), although 60% rated the caring of the custody as adequate and 17% rated it as great. Over half of the clients rated the five program components as "adequate." The percentage of responses rated as "great" and the mean scores were lower for Cohort 2 than for Cohort 1 for every item, although differences were generally small and were not statistically significant for four of the five areas.

One would expect to find the opposite results in a maturing TC program, with client satisfaction increasing as program development and staff training are completed. One possible mitigating factor may be the initiation of the no-smoking policy, which took place on July 1, 1996. This date unintentionally coincided with the beginning of Cohort 2 release dates. Thus, the lower responses from Cohort 2 may reflect clients' disapproval of that policy.

The 3-month follow-up survey also asked clients to rate their OCCDTP counselors' attitudes and behaviors. Ten positive statements about counselors were included, with responses categorized as Disagree (1), Uncertain (2), and Agree (3). Once again, responses are divided between clients from Cohort 1 and Cohort 2 who successfully completed the program. They are calculated both as percentages in each response category and as mean scores and are measured for statistical significance using chi-squares or t-tests. Table 4 presents the results.

Overall, the vast majority of clients indicated agreement with all ten positive statements about OCCDTP counselors. The two areas with the highest overall level of agreement reflect the learning process and the degree of learning. Overall, 88% of respondents agreed with the statements "your counselors spoke in a way that you understood," and 84% agreed with the statement "your counselors taught you useful ways to solve your problems."

TABLE 4
Client Rating of OCCDTP Counselors' Attitudes and Behavior for
Cohort 1 (N=189) and Cohort 2 (N=120) Clients

| *Your counselor...* | | *Disagree* | *Uncertain* | *Agree* | *Mean* | *SD* |
|---|---|---|---|---|---|---|
| 1. Spoke in a way that you understood. | Cohort 1 | 3.8% | 5.9% | 90.3% | 2.87 | .44 |
| | Cohort 2 | 8.3% | 6.6% | 85.1% | 2.77 | .59 |
| | *Combined* | *5.5%* | *6.2%* | *88.3%* | *2.83* | *.50* |
| 2. Respected you and your opinion. | Cohort 1 | 21.0% | 17.2% | 61.8% | 2.41 | .82 |
| | Cohort 2 | 24.0% | 18.2% | 57.9% | 2.34 | .84 |
| | *Combined* | *22.1%* | *17.6%* | *60.3%* | *2.38* | *.83* |
| 3. Understood your situation and problems. | Cohort 1 | 16.0% | 17.6% | 66.3% | 2.50 | .76 |
| | Cohort 2 | 19.0% | 19.8% | 61.2% | 2.42 | .79 |
| | *Combined* | *17.2%* | *18.5%* | *64.3%* | *2.47* | *.77* |
| 4. Were trusted by you. | Cohort 1 | 21.4% | 20.3% | 58.3% | 2.37 | .81 |
| | Cohort 2 | 23.1% | 18.2% | 58.7% | 2.36 | .84 |
| | *Combined* | *22.1%* | *19.5%* | *58.4%* | *2.36* | *.82* |
| 5. Helped you view problems/situations more realistically than before. | Cohort 1 | 9.1% | 10.7% | 80.2% | 2.71 | .62 |
| | Cohort 2 | 14.9% | 8.3% | 76.9% | 2.62 | .73 |
| | *Combined* | *11.4%* | *9.7%* | *78.9%* | *2.68* | *.67* |
| 6. Focused your thinking and planning. | Cohort 1 | 11.3% | 9.7% | 79.0% | 2.68 | .67 |
| | Cohort 2 | 10.7% | 10.7% | 78.5% | 2.68 | .66 |
| | *Combined* | *11.1%* | *10.1%* | *78.8%* | *2.68* | *.66* |
| 7. Taught you useful ways to solve your problems. | Cohort 1 | 7.6% | 8.6% | 83.8% | 2.76 | .58 |
| | Cohort 2 | 7.4% | 8.3% | 84.3% | 2.77 | .57 |
| | *Combined* | *7.5%* | *8.5%* | *84.0%* | *2.76* | *.58* |
| 8. Motivated and encouraged you. | Cohort 1 | 11.8% | 12.9% | 75.3% | 2.63 | .69 |
| | Cohort 2 | 12.4% | 15.7% | 71.9% | 2.60 | .70 |
| | *Combined* | *12.1%* | *14.0%* | *73.9%* | *2.62* | *.69* |
| 9. Helped you develop confidence in yourself. | Cohort 1 | 16.1% | 10.8% | 73.1% | 2.57 | .76 |
| | Cohort 2 | 15.0% | 8.3% | 76.7% | 2.62 | .74 |
| | *Combined* | *15.7%* | *9.8%* | *74.5%* | *2.59* | *.75* |
| 10. Developed a treatment plan with reasonable objectives for you. | Cohort 1 | 14.6% | 7.6% | 77.8% | 2.63 | .73 |
| | Cohort 2 | 13.2% | 11.6% | 75.2% | 2.62 | .71 |
| | *Combined* | *14.1%* | *9.2%* | *76.8%* | *2.63* | *.72* |

There were no statistical differences between Cohorts 1 and 2 at $p < .10$ in either the % or mean scores.

The two areas with the lowest percent of agreement reflect the relationship between counselors and clients. Overall, 58% of the clients agreed with the statement "counselors were trusted by you," and 60% agreed with the statement "counselors respected you and your opinion." Finally, differences between the responses of Cohorts 1 and 2 were small and not statistically significant for all ten items.

As a final means of obtaining input from clients, an open-ended question in the 12-month follow-up survey asked clients to provide suggestions for improving the program. Table 5, found on the following page, includes a summary of clients' suggestions for improvement.

The suggestion to allow clients to resume smoking was most often cited by clients, which is not unexpected given previously reported input from both staff and clients about the no-smoking policy. Comments pertaining to the change in treatment providers would largely not be represented in these comments because it overlapped Cohort 2 clients by only five months. Several comments reflect previously cited concerns about treatment staff and correctional officers, while others offer practical suggests for improving the program.

TABLE 5
Summary of Areas for Improvement in OCCDTP Identified by Clients

| *Number of Respondents* | *Suggestions for Improvement* |
|---|---|
| 37 | Change the smoking policy to allow inmates to smoke. |
| 6 | Permit inmates to have more non-treatment time. The program is too time intensive. |
| 5 | Don't allow the DOC guards and OCCDTP staff to smoke in front of inmates. |
| 3 | Decrease the strictness of prison and program rules, particularly cardinal rules. |
| 3 | Improve the "bad" attitudes that some of the counselors hold toward clients. |
| 3 | Do not force inmates to participate in the program. |
| 3 | Better prepare inmates for release including consequences of relapse. |
| 2 | Counselors should be allowed to provide individual counseling to inmates. |
| 2 | Provide more books on drug treatment to clients. |
| 3 | Change the policy that allows peers to write-up other inmates for possible violations. |
| 2 | Better integrate correctional officers into treatment. |
| 2 | Allow clients who relapse a second chance at inpatient treatment at OCCDTP. |
| 2 | Extend visiting hours to enhance family involvement in the program. |
| 1 | Resume having an OCCDTP graduation ceremony. |
| 1 | Treatment staff should allow clients to speak more freely without putting them down. |
| 1 | Hire a more racially diverse staff. |
| 1 | Provide more group sessions and less classes per day. |
| 1 | Hire more counselors to reduce group size. |
| 1 | Screen inmates better; some only enter the program because they want the shorter outdate. |
| 1 | Increase the number of AA meetings from 2 to 4 times per week. |
| 1 | Encourage inmates to form a support group amongst themselves once released. |
| 1 | Allow inmates to participate in OCCDTP as volunteers. |
| 1 | Reevaluate discipline techniques that are degrading and childish. |
| 1 | Provide more regimented activities. |
| 1 | Keep strict rules. |
| 1 | Test inmates for how much they are learning weekly or bi-weekly. |
| 1 | Make treatment activities more adult-like. Some were too "juvenile." |

## E. Staff Evaluation of TC Elements

As an additional means to assess the treatment program at OCC, 20 of 24 OCCDTP staff voluntarily completed the Therapeutic Community Scale of Essential Elements Questionnaire (SEEQ). SEEQ asks respondents to rate the importance of each of the essential elements of TC as practiced in their programs. SEEQ includes 139 questions, which are organized into six domains of therapeutic communities and further subdivided into 27 dimensions. The scoring for the first domain, the "TC Perspective," ranges from 0 to 5, with 0 representing "objectionable" and 5 representing "extremely important." In the remaining five domains, scoring ranged from 0

to 5, with 0 representing "not included/used in this program." Results are presented as mean scores and as the percentage of the maximum score for the domain or dimension. The higher the mean score and the percentage of the maximum score possible, the more likely the program is being implemented as a "pure" TC program.

Initial testing of SEEQ identified two clusters of scores (Melnick & De Leon, 1999). Higher scores were found among "traditional" TC programs, while lower scores were found in programs that had adapted TC to include other treatment modalities or had applied it to special populations. To help interpret the SEEQ scores of the OCCDTP staff, their scores are compared to those of the modified program cluster and traditional program cluster as presented by Melnick and De Leon. Since OCCDTP is implemented within a prison setting, it meets Melnick and De Leon's definition of a modified program. Therefore, it is expected that OCCDTP scores would be closer to those of the modified program cluster. Table 6 presents the percentage of maximum scores possible for the six domains across the three groups. Appendix 1 includes complete results for each of the three groups, including percentages, means scores and standard deviations, the six domains and all 27 dimensions, and t-test scores to identify statistical differences between the scores of OCCDTP and the modified TC programs and between those of OCCDTP and the traditional TC programs.

The results of the SEEQ testing, as found in Table 6 and Appendix 1, indicate that OCCDTP is implementing the TC model in a manner consistent with other TC programs. Across all six domains, the percentage of maximum possible scores of OCCDTP fell between those of modified TC programs and traditional TC programs. The highest OCCDTP percentage score was in the domain measuring the TC perspective, and included four dimensions: View of Addictive Disorders, View of the Addict, View of Recovery, and View of Right Living. The

lowest percentage score of the six domains was "Community as a Therapeutic Agent." Percentages were reduced in this domain in part because treatment staff and clients do not eat together in the same dining room, the program no longer convenes meetings of the entire facility, and treatment staff and clients do not participate in leisure activities together.

While SEEQ scores are only one measure of a TC program (i.e., staff perceptions of how TC is practiced at the program), the results are encouraging. Despite the change in treatment providers and the change in the therapeutic environment as a result of the no-smoking policy, OCCDTP staff have identified that the essential elements of TC continue to be implemented at OCC in a manner consistent with other TC programs.

In the focus groups, counselor supervisors and counselors specifically praised the intensive, high-quality training provided during the initial 3-year CSAT grant. One can confidently speculate that this training is largely responsible for the SEEQ scores falling in a range above other modified TC programs and being closer to pure TC programs.

TABLE 6
Comparison of the Percentage of Maximum SEEQ Score between OCCDTP (N=20), Modified TC Programs (N=8), and Traditional TC Programs (N=37)[1]

| | *OCCDTP* | *Modified TC Programs* | *Traditional TC Programs* |
|---|---|---|---|
| TC Perspective | 90% | 88% | 93% |
| The Agency: Treatment Approach and Structure | 86% | 76% | 94% |
| Community as a Therapeutic Agent | 78% | 71% | 94% |
| Educational and Work Activities | 86% | 70% | 94% |
| Formal Therapeutic Elements | 80% | 70% | 92% |
| Process | 80% | 80% | 94% |
| *Total* | *83%* | *76%* | *94%* |

Note 1: Comparative SEEQ scores were obtained from "Clarifying the Nature of Therapeutic Community Treatment: A Survey of Essential Elements" (Melnick & De Leon, 1999).

## IV. Characteristics of Program Participants

This section examines (a) changes in the characteristics of clients admitted to OCCDTP from Cohort 1 to Cohort 2, and (b) changes in the characteristics of clients who completed the program and those who dropped out of the program. This study originally was to compare the differences in characteristics of clients who did and did not participate in the OCC work release program. However, 97% of clients participated in work release; thus meaningful statistical analysis was not possible because of the low variance.

### A. Characteristics of Clients Admitted to OCCDTP

The following are characteristics of the 1,268 clients admitted to OCCDTP between February 1, 1994 and September 30, 1996. Cohort 1 included clients admitted between February 1, 1994 through June 30, 1995, which totaled 642 clients. Cohort 2 included clients admitted between July 1, 1995 through September 30, 1996, which totaled 626 clients. Appendix II contains complete results for each variable comparing Cohorts 1 and 2, including the applicable statistical tests.

#### *Demographic information*

Overall, 53.6% of the clients were white, 45.6% were black, and other races constituted less than 1% of clients. The majority of clients (58%) were never married, and only 18% were currently married. Half of the clients (50%) were between 21 and 30 years of age at the time of commitment, with an additional 31% being 31to 40 years of age. Differences between admission Cohorts 1 and 2 were small and not statistically significant for the three demographic characteristics.

***Medical/psychological information***

Overall, clients were medically and psychologically stable. Most clients (79%) required no medical care while imprisoned, with an additional 20% receiving only routine care. Six percent of clients were assessed as being emotionally stable, while 92% were assessed as having minimal impairments. One of the admission requirements to OCCDTP is that clients do not have a serious mental illness and do not take psychotropic medications. It would appear from this data that this requirement is largely being met. Finally, clients' mean IQ score was 92 (SD=12.0) and ranged from 59 to 130. It takes a moderate degree of cognitive functioning to participate in a TC program, and the mean scores indicate that most clients possess that ability. Once again, differences between admission Cohorts 1 and 2 were small and not statistically significant for the three factors in this section.

***Substance abuse information***

Substance abuse information was derived from two sources. First, DOC contracts for a range of testing on many inmates, one of which includes a measure of a client's alcohol proneness and alcohol related problems and a similar measure for drugs. The two scales range from 0 to 99, and are based upon a range factors including substance use, criminal history, and the association of the substance use with criminal acts. The alcohol and drug scale scores were available for 23% of clients from Cohort 1 (N=642) and 51% of clients from Cohort 2 (N=626). Second, during the initial 3-year CSAT grant period, the treatment provider completed a psychosocial assessment as clients entered OCCDTP, which included information on alcohol and drug usage. Data were available for 90% of the 642 Cohort 1 clients and 62% of the 626 Cohort 2 clients.

The mean alcohol and drug scale scores indicate a moderate level of risk, although considerable variation existed within each scale. The mean alcohol score was 55.6 (SD=39.2) and ranged from 0 to 99. The mean drug score was slightly higher at 61.1 (SD=42.0) and also ranged from 0 to 99. Differences between Cohorts 1 and 2 were small and not statistically significant.

Based upon the psychosocial assessments completed upon entry into the program, alcohol, marijuana, and cocaine/crack were the three most frequent substances used. Overall, 75.6% of clients had tried alcohol, with 52.5% using in the 6-month prior to incarceration, and 21.9% using daily during that time. Next, 69.0% of clients had tried marijuana, with 39.9% using in the 6-month period prior to incarceration, and 14.1% using daily during that time. The third highest substance used was cocaine/crack, which was tried by 52.3% of clients, with 29.6% using in the 6-month period prior to incarceration, and 13.0% using daily during that time. After alcohol, marijuana, and cocaine/crack use, usage of other drugs diminished. Other drugs included opiates (28.9%), stimulants (27.8%), hallucinogens (25.6%), tranquilizers (23.6%), PCP (16.8%), and inhalants (6.6%). When asked how serious clients thought their drug use problems were, 59% of the clients indicated it was not serious, while 24% indicated it was extremely serious.

Unlike the alcohol and drug scale scores, substantial differences in substance usage were found between Cohorts 1 and 2, with Cohort 2 reporting substantially less substance use. Among the three most frequently used substances, 85.8% of Cohort 1 clients reported ever trying alcohol compared to 60.5% of Cohort 2 clients ($\chi^2$=80.8, df=1, p=.000); 82.9% of Cohort 1 clients reported ever trying marijuana compared to 48.3% of Cohort 2 clients ($\chi^2$=129.4, df=1, p=.000); and 64.0% of Cohort 1 clients reported ever trying cocaine/crack compared to 34.9% of

Cohort 2 clients ($\chi^2$=78.9%, df=1, p=.000). These differences between the cohorts are also reflected in their perceptions of the seriousness of their problems. Among Cohort 1 clients, 47.7% reported their substance abuse problem was not serious compared to 75.7% among Cohort 2 clients; and 28.8% of Cohort 1 clients believed their problems were extremely serious compared to 16.3% among Cohort 2 clients.

One can only speculate as to the reasons for the discrepancy between the alcohol and drug scale scores finding no differences in risk between Cohort 1 and 2 and the psychosocial assessment finding a large decrease in substance usage among Cohort 2 clients. Additional work is needed to examine the reliability and validity of the two instruments, the data gathering process, and the degree of sampling bias that may have occurred since all clients did not complete either instrument. In addition, a close review of the alcohol and drug subscales are needed to determine their relationship to substance usage compared to other risk factors that may have changed.

*Vocational/educational information*

Almost all clients possessed the necessary educational skills to meaningfully participate in the TC program at OCC. Overall, 98% were assessed as having an 8th grade educational level or higher. There was a small increase from Cohort 1 to Cohort 2 in the percentage of clients assessed as having a 9th grade equivalency or higher, 74.1% to 80.7%, respectively ($\chi^2$=15.1, df=4, p=. 005). The initial 3-year CSAT grant required that clients accepted to OCCDTP function at a fifth grade educational level or higher. However, after the expiration of the grant period, DOC opened the program to all clients, regardless of their remedial educational level, and required the treatment provider to offer educational assistance as needed. Admission to Cohort 2 ended just prior to this policy change, so results will not reflect that in this study.

While clients may have been educationally prepared to participate in the TC program, almost half of clients (43.6%) had not graduated from high school or earned a GED when entering prison. Only 5.5% of clients had some college education, and only 0.6% had a college degree. Differences in formal education between Cohorts 1 and 2 were small and not statistically significant.

Clients' low educational levels are reflected in their vocational skills. Only 33% of clients were assessed as being vocationally trained, while 44% were semi-skilled, and 23% were unskilled. Only 22% had stable work histories, with Cohort 2 clients being less likely to have stable work histories, 18.5%, compared to 25.2% among Cohort 1 clients ($\chi^2$=12.3, df=4, p=.015). The overall poor educational and vocational skills reinforce the need for a strong work release program to provide clients with work experience prior to being released.

***Criminal history***

Most clients admitted to OCCDTP had committed prior criminal acts and were serving moderately long sentences. Overall, 40% of client had two or more probation occurrences, 40% had one, and 20% had none; and 18% had two or more previous incarcerations, 33% had one, and 49% had no previous incarcerations. Differences between the two cohorts were small and not statistically significant.

The largest single crime class among clients admitted to OCCDTP was Class C felonies, (48%), followed by Class B felonies (31%) and Class A felonies (11%). While the percentage of clients admitted to OCCDTP with Class C felonies were about the same for admission Cohorts 1 and 2, Cohort 1 clients were more likely than Cohort 2 clients to have committed Class A felonies, 13.2% and 9.4%%, respectively ($\chi^2$=16.9, df=4, p=.002). The five most frequently occurring types of crimes, using NCIC national crime categories, were dangerous drugs (24.8%),

burglary (22.4%), robbery (17.0%), larceny (9.6%), and assault (7.8%).

Reflective of the distribution of clients across crime classes, 50% of clients were sentenced to five years of imprisonment or less. Cohort 1 clients were less likely than those in Cohort 2 to have sentence lengths of between 6 and 10 years, 35.4% and 40.7%, respectively ($\chi^2$=8.8, df=3, p=.033).

***Prison/security information***

The custody rating and public and institutional risk of clients admitted to OCCDTP are reflective of what would be expected in a minimum security prison. The majority of clients (52%) had less than one year to serve when admitted to OCCDTP and another 34% had between one and four years. Almost half of the clients (46%) were rated as eligible for transfer to a Community Release Center (CRC), and an additional 41% had a low custody rating. Cohort 2 clients were more likely to be eligible for transfer to a CRC by 6% ($\chi^2$=9.8, df=4, p=.044). Finally, 78.3% of clients had an institutional risk rating of acceptable institutional adjustment, while an additional 16.2% were rated one level down for poor adjustment at a halfway house or continued level 2 conduct violations.

**B. Characteristics of OCCDTP Graduates and Dropouts**

This section includes 1,268 clients admitted during Cohorts 1 and 2, and compares those who successfully completed OCCDTP and those who dropped out of the program using the same variables that were reviewed in the previous section. When statistical differences exist between Cohorts 1 and 2, they will be described in the narrative. Appendix III contains complete results for each variable grouped by program graduates and dropouts.

Among the 1,268 clients, 693 clients (54.6%) graduated from the program, while the remaining 575 clients (45.4%) dropped out of the program. The percentage of clients who

dropped out of the program increased from Cohort 1 to Cohort 2, 38.4% to 51.4%, respectively ($\chi^2$=18.5, df=1, p=.000), which typically would not be expected in a maturing TC program. One can only speculate as to the reasons. One possible explanation relates to the inmates' dissatisfaction with the no-smoking policy and reports of increased mandatory transfers out of the program because of rule violations associated with the smoking policy. A second possible explanation focuses on the decrease in the percentage of clients from Cohort 1 to Cohort 2 who viewed themselves as having a substance abuse problem. If clients do not perceive they have a problem, they may be less willing to accept the rigors of the program.

***Demographic information***

Black clients were more likely to successfully complete the program than whites by a small margin. Blacks constituted 48.1% of the graduates and 42.6% of the dropouts, although this difference was not statistically significant ($\chi^2$=5.0, df=3, p=.174). Differences in marital status between the two groups were small and not statistically significant. Finally, program dropouts tended to be younger. While clients between the ages of 18 to 25 years constituted 28.7% of the graduates, they totaled 41.9% of the dropouts ($\chi^2$=30.7, df=9, p=.000). However, when comparing the relationship between age and program status within each cohort, the differences in age were much smaller in Cohort 2 and not statistically significant ($\chi^2$=13.9, df=9, p=.127). Differences in Cohort 1 continued to exist ($\chi^2$=30.9, df=9, p=.000).

***Medical/psychological information***

Differences between clients who graduated and dropped out of the program in the areas of medical care, mental health needs, and IQ were small and not statistically significant.

***Substance abuse information***

Differences in the mean alcohol and drug scale scores between program graduates and those who dropped out of the program were small and not statistically significant, overall and within Cohorts 1 and 2. However, several differences in the frequency of substance use were found between program graduates and dropouts. First, program graduates were more likely to have used alcohol than clients who dropped out of the program, 80.1% and 69.5%, respectively ($\chi^2$=14.6, df=1, p=.000). In addition, clients who graduated from the program were more likely to have ever tried marijuana, 71.9% and 65.0%, respectively ($\chi^2$=5.2, df=1, p=.022). However, when examining differences in marijuana use within each Cohort, differences were smaller and not statistically significant in Cohort 1 ($\chi^2$=0.3, df=1, p=.610), although they remained in Cohort 2 ($\chi^2$=4.2, df=1, p=.039). Differences in whether clients ever used the other drugs previously reviewed were small and not statistically significant.

Differences were also found between program graduates and those who dropped out of the program for alcohol consumption and use of cocaine/crack during the 6-month period prior to incarceration. Program graduates were more likely to have used alcohol during this period, 57.1% and 46.3%, respectively ($\chi^2$=14.2, df=4, p=.007). However, differences within cohorts were much smaller. They were only marginally significant in Cohort 1 ($\chi^2$=8.5, df=4, p=.075) and were not statistically significant in Cohort 2 ($\chi^2$=6.3, df=4, p=.175). Program graduates were also more likely to have used cocaine/crack during the 6-month period prior to incarceration, 33.5% to 24.4%, respectively ($\chi^2$=10.3, df=4, p=.035). However, once again, differences were much small and were not statistically significant within cohorts (Cohort 1, $\chi^2$=5.3, df=4, p=.256; Cohort 2, $\chi^2$=7.1, df=4, p=.131).

Finally, graduates were more likely than dropouts to perceive they had a substance abuse problem, 44.5% and 36.0%, respectively ($\chi^2$=20.8, df=4, p=.000). These differences continued to exist in Cohort 1, 42.9% and 54.7%, respectively ($\chi^2$=21.0, df=4, p=.000), but were much less in Cohort 2, 71.5% and 76.4%, respectively ($\chi^2$=4.7, df=4, p=.324).

***Vocational/educational information***

Statistical differences were found between program graduates and dropouts in educational preparedness and work skills. Overall, program graduates were more likely than dropouts to have been educationally prepared at the 9th grade level or higher, 81.4% and 72.5%, respectively ($\chi^2$=14.5, df=4, p=.006). However, this difference was much smaller in Cohort 2 and was not statistically significant ($\chi^2$=1.6, df=4, p=.805). Program graduates were also more likely than dropouts to have a stable work history, 25.1% to 18.1%, respectively ($\chi^2$=19.1, df=4, p=.001). This difference remained in Cohort 2, but was much smaller in Cohort 1 ($\chi^2$=4.9, df=4, p=.299).

***Criminal history***

Differences between program graduates and dropouts were small and not statistically significant in three of the four areas included in criminal history. Program graduates were more likely to have had sentences longer than five years, 53.7% and 46.4%, respectively ($\chi^2$=7.5, df=3, p=.059). However, this difference was much smaller in Cohort 1 and not statistically significant ($\chi^2$=4.0, df=3, p=.263) and was only marginally significant in Cohort 2 ($\chi^2$=6.9, df=3, p=.076).

***Prison/security information***

Statistical differences were found between program graduates and dropouts in each of the four areas included in this section: custody rating, public risk, institutional risk, and conduct

violation. The percentage of clients with a custody rating of eligibility for transfer to a Community Release Center was lower among program graduates than for dropouts, 44.3% and 48.0%, respectively ($\chi^2$=27.4, df=4, p=.000). Similarly, program graduates were less likely than dropouts to have less than one year to serve, 54.0% and 41.4%, respectively ($\chi^2$=23.7, df=4, p=.000). Next, a higher percentage of program graduates had an acceptable institutional adjustment, 86.4% and 68.5%, respectively ($\chi^2$=71.0, df=4, p=.000). Finally, program graduates had a lower mean number of conduct violations, 10.0 and 18.6, respectively (t=-10.8, df=1266, p=.000), which is not unexpected since committing certain number of types of conduct violations can require clients to drop out of the program. Statistical differences continued to exist for each of the items within Cohort 1 and Cohort 2.

## V. Aftercare Services

Participation in community-based substance abuse treatment upon completion of prison-based TC programs has been found to reduce rearrest and relapse to a greater extent than participation in prison-based treatment only (Knight, Simpson, & Hiller, 1999; Martin et al., 1999; Wexler, Melnick et al., 1999). Given the importance of aftercare, this section examines the utilization of substance abuse aftercare services among clients who successfully completed OCCDTP and were released into the community. The 12-month follow-up survey conducted by staff from the SMSU Center for Social Research requested information about (a) the type of community-based services clients were utilizing; (b) their level of participation in them; and (c) their rating of these services. These 12-month survey data were available for 145 clients from release Cohort 1 (56%) and 144 clients from Cohort 2 (40%). This study originally was to compare the characteristics of clients who did and did not participate in aftercare and how that changed over time. However, almost all clients in the study group participated in aftercare, which usually was required as a condition of parole. The small number of clients not participating prevented meaningful statistical comparisons. Therefore, attention will focus only on the three issues listed above.

### A. Utilization of Aftercare Services

The 12-month follow-up survey sought information about four categories of aftercare services: (a) Alcoholics Anonymous or other self-help meetings for alcohol problems; (b) Narcotics Anonymous or other self-help meetings for drug additions; (c) residential treatment programs, and (d) outpatient treatment programs. Outpatient treatment (64.1%) and alcohol self-help groups (63.4%) were attended by the highest percentage of clients, followed by drug support groups (54.0%), and residential treatment (25.6%). Clients in Cohorts 1 and 2

participated at differential rates in two of the four service types. The percentage of clients participating in support groups for drug addictions increased from 44.8% among Cohort 1 clients to 63.4% among Cohort 2 clients ($\chi^2$=9.9, df=1, p=.002), while utilization of residential treatment programs decreased from 30.5% among Cohort 1 clients to 20.8% among Cohort 2 clients ($\chi^2$=3.5, df=1, p=.062).

Combining the two types of self-help groups and the two types of treatment program, 83.6% of clients participated in either alcohol or drug support groups, and 68.5% of clients participated in either outpatient or residential treatment programs. The rate of participation in support groups increased from 78.3% among Cohort 1 clients to 88.8% among Cohort 2 clients ($\chi^2$=5.7, df=1, p=.017). The rate of participation in treatment programs did not change from Cohorts 1 to 2.

Most clients participated in more than one type of aftercare service. Table 7 lists in matrix form the percentage of clients from each program who attended each other of other aftercare services. These results suggest that clients are taking advantage of multiple aftercare services.

TABLE 7
Percentage of Clients Participating in Four Types of Aftercare Services

| | | *AA* | *NA* | *OP* | *RES* |
|---|---|---|---|---|---|
| Self-Help Groups for Alcohol Problems (AA) | (N=181) | ----- | 54% | 61% | 28% |
| Self-Help Groups for Drug Additions (NA) | (N=153) | 63% | ----- | 71% | 31% |
| Outpatient Treatment Programs (OP) | (N=177) | 62% | 61% | ----- | 33% |
| Residential Treatment Programs (RES) | (N=73) | 66% | 66% | 81% | ----- |

## B. Level of Participation in Aftercare Services

The 12-month follow-up survey asked respondents the number of alcohol and drug self-help groups they attended in the one-year period following their release from OCC. As indicated in Table 8, about 30% of clients who attended either alcohol or drug self-help groups attended less than one meeting per month on average. A second third attended one to two meetings each month on average, while the remaining third attended more than twice monthly. The percentage of clients who attended 11 to 25 meetings and 26 to 100 meetings of alcohol groups increased between Cohorts 1 and 2 from 31.6% to 43.0% and from 22.1% to 30.2%, respectively ($\chi^2$=9.3, df=4, p=.053). The percentage of clients attending self-help groups for drug addictions decreased for clients attending only 1 to 5 meetings from 25.0% to 10.0%, while the percentage attending 11 to 25 meetings increased from 28.1% to 46.8% ($\chi^2$=10.2, df=4, p=.037). If self-help groups were the sole source of aftercare for these clients, the frequency of attendance may appear low. However, most clients participated in multiple activities, as was indicated in Table 7.

TABLE 8
Number of Self-Help Group Meetings Attended by Clients
in the One-Year Period Following Release from OCC

| *Number of Meetings:* | | *1-5* | *6-10* | *11-25* | *26-100* | *Over 100* |
|---|---|---|---|---|---|---|
| Self-Help Groups for Alcohol Problems (AA) | (N=181) | 16.6% | 13.8% | 37.0% | 26.0% | 6.6% |
| Self-Help Groups for Drug Additions (NA) | (N=154) | 16.2% | 14.3% | 39.6% | 23.4% | 6.5% |

The 12-month follow-up survey also requested information about the number of weeks clients participated in residential treatment programs. A total of 64 clients attended residential treatment programs. The mean number of weeks attended was 9.3 (SD=10.1) and ranged from one week to the full year. Less than one-fifth of the clients attended for one to three weeks, 30% attended four weeks, 34% attended five to 12 weeks, and the remaining 19% attended more than

12 weeks. The mean number of weeks of participation decreased between Cohorts 1 and 2 from 11.3 weeks (SD=12.3) to 7.1 weeks (SD=6.0) (t=1.7, df=62, p=.099). However, this largely can be accounted for by a decrease from 26% to 10% in the clients attending more than 12 weeks, while participation in four-week programs increased from 20% to 41%. The 12-month follow-up survey did not request information on the level of participation in outpatient treatment programs.

## C. Clients' Rating of Aftercare Services

Finally, the 12-month follow-up survey asked clients to rate their aftercare services. Table 9 includes the ratings for the two types of self-help groups. Overall, at least two-thirds of the clients found the self-help groups to be often or always helpful. Differences in ratings did not vary between Cohorts 1 and 2.

TABLE 9
Client Ratings of the Helpfulness of Self-Help Groups Attended during the One-Year Period Following Release from OCC

| *How often did you find the self-help meeting to be helpful?* | | *Never* | *Rarely* | *Sometimes* | *Often* | *Always* |
|---|---|---|---|---|---|---|
| Self-Help Groups for Alcohol Problems (AA) | (N=179) | 4.5% | 7.8% | 20.9% | 24.6% | 43.0% |
| Self-Help Groups for Drug Additions (NA) | (N=148) | 2.7% | 4.0% | 16.8% | 35.6% | 40.9% |

Clients also were asked to rate their residential treatment program. Among the 35 respondents, 37.1% rated their residential treatment program as Excellent, 37.1% rated it as Good, 14.3% rated it as Fair, and 11.4% rated it as Poor. (Clients were not asked to rate the outpatient treatment programs.) Overall, these findings suggest a high rate of satisfaction among participating clients.

## VI. Conclusion

### A. Characteristics of Program Participants

Overall, the characteristics of clients admitted to OCCDTP changed very little from Cohort 1 to Cohort 2. The majority of clients was white, was never married, and generally was admitted to OCCDTP during their mid-30s. Clients who dropped out of the program were younger than clients who graduated from the program. Clients had few health or mental health problems.

Mean scores on alcohol and drug scales were mid-range, and differences between Cohorts 1 and 2 and between program graduates and dropouts were small and not statistically significant. A survey of alcohol and drug usage found that alcohol, marijuana, and cocaine/crack were the most frequently used substances. Use of all substances was less among Cohort 2 clients, which was inconsistent with the mean alcohol and drug scores. Reasons for the differential findings from the two instruments are uncertain and warrant further examination.

Most clients possessed remedial educational skills, although just under half of the clients admitted to OCCDTP did not have a high school equivalency. Work experience was minimal among these clients, with only 22% having stable work histories. Clients' low educational levels and poor work experience puts these clients at risk upon discharge into the community, and reinforces the importance of the work release program to the success of OCCDTP clients.

Clients admitted to OCCDTP generally had committed crimes in the mid-range of seriousness (most committed Class C felonies) and were sentenced to prison for five years or less. About 80% had been on probation at least once prior to the current incarceration, and about half of the clients had been incarcerated at least once prior to the current incarceration. Program dropouts were more likely than those who graduated from the program to have a custody rating

of eligibility to transfer to a Community Release Center and to have less than one year remaining on their sentences. However, dropouts were more likely to have a history of disruptive behavior, and they committed a higher rate of conduct violations while imprisoned.

**B. Aftercare Services**

Clients' participation in self-help groups increased from 78% in Cohort 1 to 89% in Cohort 2. Participation in outpatient treatment programs was at 64% and did not change from Cohort 1 to Cohort 2. Participation in residential treatment programs decreased, shifting from 31% in Cohort 1 to 20% in Cohort 2. The results also indicate that most clients participated in more than one type of aftercare service.

The level of participation of aftercare services varied widely. About one-third of clients attended ten self-help meetings or less during their first year in the community, another third attended between 11 and 25 meetings, and the final third attended more than 25 meetings. Clients who participated in residential treatment programs spent a mean of nine weeks in those programs, with lengths of participation varying from one week to the full one-year follow-up period.

Overall, clients rated their aftercare services highly. At least two-thirds of clients indicated that they found the self-help groups to be often or always helpful, and 50% of clients rated their residential treatment programs to be excellent and 38% rated it as good. Client ratings were not gathered for outpatient treatment programs.

**C. Treatment Activities**

By the end of the initial 3-year CSAT grant, members of each of the focus groups believed that the TC program implemented at OCC was functioning at a high level and "had matured." Integral to the success of starting the program was the extensive staff training of

counselors and custody staff. Grant funding of the program at a flat monthly rate rather than on a fee-for-service basis afforded staff the time to receive extensive training about implementing a TC program in a prison setting and to phase-in implementation as training progressed.

Some of the progress that was made in the program has been lost. Focus group participants believed that the change to a new provider resulted in a setback for implementation of OCCDTP, primarily because of the staff turnover and shortages following the change. Consistent with these beliefs, the Missouri Department of Mental Health's Division of Alcohol and Drug Abuse (ADA) did not renew its certification of OCCDTP following a full certification review conducted in January 1998. The new treatment provider has appealed the program's de-certification and is awaiting the results. One DOC administrator noted that de-certification did not necessary mean that the new provider was not properly implementing the TC components of the program. He stated that ADA evaluates the program based upon a traditional treatment model rather than TC standards. This may explain why SEEQ scores, a measure of essential elements of TC programs, were high even though the program was de-certified.

Further disrupting the TC program was implementation of the no-smoking policy, which significantly diminished the sense of community. However, this policy was rescinded on April 1, 1998, and the program appears to be readjusting. One respondent believed that it would take a year for the program to reach the point it was prior to the start of the no-smoking policy and the change in treatment providers.

Despite these setbacks, the TC program at OCC has at least five strengths. First, even during the shortages in treatment staff that occurred following the change in treatment providers, program participants continued to receive a consistent range of group treatment activities. Second, as evidenced by SEEQ results, OCCDTP staff appears to be implementing the essential

elements of TC at a higher level than other types of modified TC programs. Third, clients expressed satisfaction with key program elements. Fourth, the program is receiving additional staff training through an RSAT grant. Finally, and perhaps most importantly, there remains a deep commitment to implementation of the TC model at OCC, which was expressed most strongly by members of the administrator focus group.

**D. Implications for Future TC Prison Programs**

OCC's experience with developing and implementing the TC program has implications for prisons considering initiating their own TC programs. First, implementation of TC programs requires that administrative, custody, and treatment staff assumes and enacts new roles. Extensive, high quality training is required to provide staff with the knowledge, skills, and attitudes to fulfil those roles. It is important that adequate time and resources be given to carry this out. In the case of OCCDTP, a CSAT grant provided funding for the program start-up, which included a comprehensive training component that was highly rated by staff.

Second, even when TC programs have matured, they still must contend on an ongoing basis with factors beyond their immediate control that can decrease program quality. In the case of OCCDTP, those factors were the enactment of the no-smoking policy and the change in treatment providers. Efforts are needed to anticipate possible unintended consequences of policies, even when not directly related to the operation of the program.

Third, it is important for the continuity of TC programs to minimize staff turnover. The turnover in OCCDTP staff that occurred as the result of the change in treatment providers set back the program at least a year. This has implications if treatment services are contracted out. The contracting process should take into consideration the importance of a stable workforce trained in the TC model and be mindful of the negative ramifications a change in providers can

have on the quality of the program. Therapeutic community treatment contracts may be one instance in which continuity of service takes precedence over marginal short-time financial savings; changing providers ultimately could lead to higher costs and poorer client outcomes.

Finally, ongoing administrative support is essential to the implementation of TC programs in prisons. This support is necessary when the program begins to ensure staff is willing and able to assume their new roles within the TC model. This support is also necessary given the large amount of time it takes for TC to mature, which focus group respondents estimated to be between two and three years. Lastly, administrative support is necessary to guide programs through the ongoing changes and challenges they are sure to face.

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**APPENDIX 1**
**Comparison of SEEQ Scores[1] between OCCDTP (N=20), Modified TC Programs (N=8), and Traditional TC Programs (N=37)[2]**

| | *OCCDTP* | | | *Modified TC Programs* | | | *Traditional TC Programs* | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Mean* | *SD* | *%* | *Mean* | *SD* | *%* | *Mean* | *SD* | *%* |
| **TC Perspective** | **67.7** | **3.1** | **90%** | **66.3** | **3.4** | **88%** | **69.5**** | **4.2** | **93%** |
| View of Addictive Disorders | 13.3 | 1.4 | 88% | 13.0 | 1.8 | 87% | 14.2** | 1.9 | 95% |
| View of Addict | 11.6 | 1.9 | 77% | 11.6 | 0.9 | 77% | 12.3 | 1.7 | 82% |
| View of Recovery | 24.0 | 1.4 | 96% | 23.8 | 2.1 | 95% | 24.1 | 1.6 | 97% |
| View of Right Living | 18.9 | 1.3 | 94% | 17.9** | 2.0 | 89% | 18.8 | 1.8 | 94% |
| **The Agency: Tx Approach & Structure** | **146.3** | **9.8** | **86%** | **129.8***** | **14.0** | **76%** | **159.5***** | **8.5** | **94%** |
| Agency Organization | 35.9 | 2.8 | 90% | 32.8*** | 3.6 | 82% | 37.2* | 3.1 | 93% |
| Agency Approach to Treatment | 49.7 | 4.6 | 90% | 47.5* | 5.4 | 86% | 53.4** | 2.2 | 97% |
| Staff Roles and Functions | 29.2 | 2.6 | 83% | 28.4 | 3.9 | 81% | 32.1*** | 2.7 | 92% |
| Clients Roles and Functions | 23.9 | 4.0 | 80% | 12.3*** | 8.7 | 41% | 27.7*** | 3.2 | 92% |
| Health Care | 7.7 | 1.5 | 77% | 8.9** | 1.7 | 89% | 9.1*** | 1.7 | 91% |
| **Community as a Therapeutic Agent** | **113.7** | **9.5** | **78%** | **103.3***** | **26.9** | **71%** | **136.2***** | **7.3** | **94%** |
| Peers as Gatekeepers | 27.0 | 2.5 | 90% | 25.3** | 3.0 | 84% | 29.0** | 1.6 | 97% |
| Mutual Help | 13.2 | 1.7 | 88% | 10.9*** | 1.4 | 73% | 13.9 | 1.2 | 93% |
| Enhancement of Community Belonging | 26.3 | 4.5 | 58% | 28.1 | 12.1 | 63% | 41.4*** | 3.6 | 92% |
| Outside Community Contact | 6.9 | 1.6 | 69% | 6.0* | 3.8 | 60% | 8.8 *** | 2.0 | 88% |
| Community/Clinical Mgt-Privileges | 8.3 | 1.7 | 83% | 5.9*** | 4.1 | 59% | 9.4** | 1.0 | 94% |
| Community/Clinical Mgt-Sanctions | 23.1 | 1.7 | 92% | 20.1*** | 8.4 | 81% | 24.5*** | 0.9 | 98% |
| Community/Clinical Mgt-Surveillance | 9.0 | 0.9 | 90% | 7.0*** | 3.3 | 70% | 9.2 | 1.4 | 92% |
| **Educational and Work Activities** | **72.8** | **8.0** | **86%** | **59.6***** | **19.0** | **70%** | **80.0***** | **5.2** | **94%** |
| Formal Educational Elements | 16.6 | 3.5 | 83% | 16.0 | 4.8 | 80% | 18.7** | 2.0 | 93% |
| Therapeutic-Educational Elements | 26.5 | 2.6 | 88% | 26.0 | 4.5 | 87% | 28.3** | 2.7 | 94% |
| Work as Therapy | 29.7 | 3.7 | 85% | 17.6*** | 13.7 | 50% | 33.0*** | 2.3 | 94% |
| **Formal Therapeutic Elements** | **79.6** | **8.6** | **80%** | **69.6***** | **5.6** | **70%** | **92.2***** | **5.5** | **92%** |
| General Therapeutic Techniques | 26.8 | 2.1 | 89% | 25.9 | 3.7 | 86% | 28.9*** | 1.5 | 96% |
| Groups as Therapeutic Agents | 15.4 | 1.9 | 77% | 11.8*** | 3.7 | 59% | 17.7*** | 2.1 | 88% |
| Counseling Techniques | 31.0 | 5.6 | 75% | 23.8*** | 9.8 | 59% | 37.0*** | 2.8 | 92% |
| Role of the Family | 7.3 | 2.3 | 73% | 8.3 | 1.8 | 83% | 8.6** | 2.3 | 86% |
| **Process** | **96.4** | **8.8** | **80%** | **96.4** | **22.7** | **80%** | **112.7***** | **8.3** | **94%** |
| Stages of Treatment | 13.3 | 1.9 | 88% | 9.4*** | 5.1 | 63% | 14.4** | 1.2 | 96% |
| Introductory Period | 18.1 | 1.9 | 90% | 17.6 | 3.4 | 88% | 19.4** | 1.3 | 97% |
| Primary Treatment Stage | 39.8 | 3.9 | 88% | 36.6** | 6.8 | 81% | 42.9** | 2.2 | 95% |
| Community Reentry Period | 25.3 | 5.0 | 63% | 32.8*** | 9.6 | 82% | 36.1*** | 6.1 | 90% |
| **Total** | **576.3** | **40.7** | **83%** | **524.9***** | **73.8** | **76%** | **650.0***** | **26.6** | **94%** |

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$ Statistical differences are calculated between the mean scores of OCCDTP and the Modified TC Programs and between OCCDTP and the Traditional TC Programs using 2-tailed t-tests.

Note 1: % refers to the percentage of the maximum score possible for a particular section or subsection.
Note 2: Comparative SEEQ scores were obtained from "Clarifying the Nature of Therapeutic Community Treatment: A Survey of Essential Elements" (Melnick & De Leon, 1999)

# APPENDIX H
## Characteristics of Client Admitted to OCCDTP Grouped by Cohorts 1 and 2

| *Demographic Information* | *Cohort 1* | *Cohort 2* |
|---|---|---|
| Race | | |
| White | 54.8% | 52.4% |
| Black | 44.4 | 46.8 |
| Hispanic | 0.8 | 0.2 |
| Native American | 0.0 | 0.6 |
| *Total* | *100.0%* | *100.0%* |
| | *(N=642)* | *(N=626)* |
| Marital status | | |
| Never married | 54.8% | 59.7% |
| Married | 17.8 | 17.7 |
| Divorced | 22.6 | 17.3 |
| Separated | 4.5 | 5.0 |
| Widowed | 0.3 | 0.3 |
| *Total* | *100.0%* | *100.0%* |
| | *(N=642)* | *(N=626)* |
| Age at time of commitment | | |
| Ages 16 - 17 years | 2.0% | 1.9% |
| Ages 18 - 20 years | 8.6 | 9.1 |
| Ages 21 - 25 years | 26.8 | 24.9 |
| Ages 26 - 30 years | 24.1 | 23.2 |
| Ages 31 - 35 years | 17.9 | 20.4 |
| Ages 36 - 40 years | 12.9 | 11.5 |
| Ages 41 - 45 years | 4.7 | 6.2 |
| Ages 46 - 50 years | 1.7 | 2.2 |
| Ages 51 - 55 years | 0.9 | 0.3 |
| Ages 56 - 60 years | 0.3 | 0.2 |
| *Total* | *99.9%* | *99.9%* |
| | *(N=642)* | *(N=626)* |
| ***Medical/Psychological Information*** | ***Cohort 1*** | ***Cohort 2*** |
| Medical and health care needs | | |
| None | 80.4% | 76.7% |
| Routine | 18.5 | 22.0 |
| Clinical care | 0.8 | 0.8 |
| Limited infirm | 0.3 | 0.3 |
| Chronic care | 0.0 | 0.2 |
| *Total* | *100.0%* | *100.0%* |
| | *(N=642)* | *(N=626)* |
| Mental health care needs | | |
| Emotionally stable; no identified impairment | 7.5% | 5.0% |
| Minimal impairment | 90.5 | 93.5 |
| Mild impairment | 1.9 | 1.1 |
| Moderate impairment; requires medication | 0.2 | 0.3 |
| Severe impairment; special psychiatric treatment | 0.0 | 0.2 |
| *Total* | *100.1%* | *100.1%* |
| | *(N=642)* | *(N=626)* |

| | | | |
|---|---|---|---|
| Mean IQ | 91.9<br>(SD=12.2)<br>*(N=528)* | 92.4<br>(SD=11.9)<br>*(N=402)* | |
| ***Substance Abuse Information*** | ***Cohort 1*** | ***Cohort 2*** | |
| Alcohol Scale<br>(ranges from 0 – 99, with 99 most severe) | 53.2<br>(SD=40.0)<br>*(N=147)* | 56.7<br>(SD=38.8)<br>*(N=322)* | |
| Drug Scale<br>(ranges from 0 – 99, with 99 most severe) | 59.6<br>(SD=42.7)<br>*(N=147)* | 61.8<br>(SD=41.8)<br>*(N=322)* | |
| Percent of clients ever using the following substances | | | |
| Alcohol | 85.8% | 60.5% | $\chi^2$=80.8, df=1, p=.000 |
| Marijuana | 82.9% | 48.3% | $\chi^2$=129.4, df=1, p=.000 |
| Cocaine/crack | 64.0% | 34.9% | $\chi^2$=78.9, df=1, p=.000 |
| Stimulants/amphetamines | 38.1% | 12.4% | $\chi^2$=75.7, df=1, p=.000 |
| Barbiturates/tranquilizers | 32.0% | 11.1% | $\chi^2$=56.1, df=1, p=.000 |
| Hallucinogens | 35.3% | 11.1% | $\chi^2$=71.2, df=1, p=.000 |
| Opiates | 38.4% | 14.7% | $\chi^2$=63.2, df=1, p=.000 |
| Inhalants | 9.3% | 2.6% | $\chi^2$=17.1, df=1, p=.000 |
| PCP | 24.95<br>*(N=578)* | 4.7%<br>*(N=387)* | $\chi^2$=68.1, df=1, p=.000 |
| Frequency of use of alcohol in the 6-month period prior to incarceration | | | |
| Never | 37.9% | 61.8% | |
| A few times | 11.2 | 7.2 | |
| 1 to 3 times per month | 9.7 | 4.1 | |
| 1 to 5 times per week | 16.4 | 9.3 | |
| Daily | 24.7 | 17.6 | |
| *Total* | *99.9%*<br>*(N=578)* | *100.0%*<br>*(N=387)* | $\chi^2$=55.4, df=4, p=.000 |
| Frequency of use of marijuana in the 6-month period prior to incarceration | | | |
| Never | 51.4% | 73.1% | |
| A few times | 15.2 | 10.6 | |
| 1 to 3 times per month | 7.4 | 2.8 | |
| 1 to 5 times per week | 8.5 | 4.4 | |
| Daily | 17.5 | 9.0 | |
| *Total* | *100.0%*<br>*(N=578)* | *99.9%*<br>*(N=387)* | $\chi^2$=48.0, df=4, p=.000 |
| Frequency of use of cocaine/crack in the 6-month period prior to incarceration | | | |
| Never | 66.1% | 76.7% | |
| A few times | 8.5 | 4.1 | |
| 1 to 3 times per month | 4.8 | 3.4 | |
| 1 to 5 times per week | 6.1 | 5.2 | |
| Daily | 14.5 | 10.6 | |
| *Total* | *100.0%*<br>*(N=578)* | *100.0%*<br>*(N=387)* | $\chi^2$=14.5, df=4, p=.006 |

| | | | |
|---|---|---|---|
| Frequency of use of stimulants/amphetamines in the 6-month period prior to incarceration | | | |
| Never | 83.9% | 92.5% | |
| A few times | 5.4 | 2.8 | |
| 1 to 3 times per month | 1.9 | 0.5 | |
| 1 to 5 times per week | 3.8 | 2.3 | |
| Daily | 5.0 | 1.8 | |
| *Total* | *100.0%* | *99.9%* | |
| | *(N=578)* | *(N=387)* | $\chi^2$=16.6, df=4, p=.002 |
| Frequency of use of barbiturates/tranquilizers in the 6-month period prior to incarceration | | | |
| Never | 89.3% | 95.3% | |
| A few times | 4.8 | 3.6 | |
| 1 to 3 times per month | 2.1 | 0.5 | |
| 1 to 5 times per week | 2.9 | 0.5 | |
| Daily | 0.9 | 0.0 | |
| *Total* | *100.0%* | *99.9%* | |
| | *(N=578)* | *(N=387)* | $\chi^2$=15.9, df=4, p=.003 |
| Frequency of use of hallucinogens in the 6-month period prior to incarceration | | | |
| Never | 91.0% | 94.6% | |
| A few times | 5.4 | 3.9 | |
| 1 to 3 times per month | 2.1 | 0.8 | |
| 1 to 5 times per week | 1.0 | 0.8 | |
| Daily | 0.5 | 0.0 | |
| *Total* | *100.0%* | *100.1%* | |
| | *(N=577)* | *(N=387)* | |
| Frequency of use of opiates in the 6-month period prior to incarceration | | | |
| Never | 89.4% | 96.1% | |
| A few times | 2.2 | 2.6 | |
| 1 to 3 times per month | 1.7 | 0.3 | |
| 1 to 5 times per week | 2.9 | 0.3 | |
| Daily | 3.6 | 0.8 | |
| *Total* | *99.8%* | *100.1%* | |
| | *(N=578)* | *(N=387)* | $\chi^2$=22.2, df=4, p=.000 |
| Entering the program, how serious do you think your drug use problems are? | | | |
| Not serious at all | 47.7% | 75.7% | |
| Slightly serious | 5.7 | 1.6 | |
| Moderately serious | 7.8 | 1.6 | |
| Considerably serious | 10.1 | 4.9 | |
| Extremely serious | 28.8 | 16.3 | |
| *Total* | *100.1%* | *100.1%* | |
| | *(N=577)* | *(N=387)* | $\chi^2$=80.9, df=4, p=.000 |

| *Vocational/Educational Information* | *Cohort 1* | *Cohort 2* | |
|---|---|---|---|
| Educational needs | | | |
| Educationally prepared (9th grade equiv. or higher) | 74.1% | 80.7% | |
| Minimal impairment (8th grade equivalency) | 22.0 | 18.4 | |
| Mild impairment (6th to 7th grade equivalency) | 2.3 | 0.5 | |
| Moderate impairment (3rd to 5th grade equivalency) | 0.9 | 0.3 | |
| Severe impairment (below a 3rd grade equivalency) | 0.6 | 0.2 | |
| *Total* | *99.9%* | *100.1* | |
| | *(N=642)* | *(N=626)* | *$\chi^2$=15.1, df=4, p=.005* |
| Educational level achievement | | | |
| 8 grade of less | 10.0% | 10.6% | |
| Some high school | 32.4 | 34.1 | |
| High school graduate or GED | 50.4 | 50.3 | |
| Some college | 6.9 | 4.2 | |
| College graduate | 0.3 | 0.8 | |
| *Total* | *100.0%* | *100.0%* | |
| | *(N=639)* | *(N=624)* | |
| Vocational education | | | |
| Vocationally trained | 7.6% | 7.7% | |
| Skilled | 23.8 | 27.0 | |
| Semi-skilled | 43.9 | 43.9 | |
| Unskilled | 15.7 | 12.8 | |
| No skills training | 8.9 | 8.6 | |
| *Total* | *99.9%* | *100.0%* | |
| | *(N=642)* | *(N=626)* | |
| Work skills | | | |
| Stable work history; completed training | 2.3% | 2.4% | |
| Stable work history; undergoing training | 22.9 | 16.1 | |
| Sporadic work history; unskilled | 64.2 | 69.0 | |
| Poor work history | 8.3 | 8.1 | |
| Very poor work attitude or refuses to work | 2.3 | 4.3 | |
| *Total* | *100.0%* | *99.9%* | |
| | *(N=642)* | *(N=626)* | *$\chi^2$=12.3, df=4, p=.015* |
| ***Criminal History*** | ***Cohort 1*** | ***Cohort 2*** | |
| Incidents of probation prior to current incarceration | | | |
| None | 19.6% | 20.6% | |
| One | 38.6 | 40.7 | |
| Two or more | 41.7 | 38.7 | |
| *Total* | *99.9%* | *100.0%* | |
| | *(N=642)* | *(N=626)* | |
| Incidents of incarceration prior to current incarceration | | | |
| None | 47.8% | 50.2% | |
| One | 34.4 | 30.8 | |
| Two or more | 17.8 | 19.0 | |
| *Total* | *100.0%* | *100.0%* | |
| | *(N=642)* | *(N=626)* | |

| | | | |
|---|---|---|---|
| Class of committing crime | | | |
| Class A felony | 13.2% | 9.4% | |
| Class B felony | 30.2 | 32.6 | |
| Class C felony | 46.0 | 49.7 | |
| Class D felony | 6.7 | 7.3 | |
| Non-classified | 3.9 | 1.0 | |
| *Total* | *100.0%* | *100.0%* | |
| | *(N=642)* | *(N=626)* | *$\chi^2$=16.9, df=4, p=.002* |
| Length of longest sentence | | | |
| 4 years of less | 18.1% | 16.0% | |
| 5 years | 31.9 | 33.2 | |
| 6 - 10 years | 35.4 | 40.7 | |
| 11 years or more | 14.6 | 10.1 | |
| *Total* | *100.0%* | *100.0%* | |
| | *(N=642)* | *(N=626)* | *$\chi^2$=8.8, df=3, p=.033* |
| ***Prison / Security Information*** | ***Cohort 1*** | ***Cohort 2*** | |
| Custody rating | | | |
| Eligible for transfer to a Community Release Center | 43.0% | 49.0% | |
| Low | 43.6 | 39.0 | |
| Medium | 8.1 | 5.1 | |
| Medium high | 4.2 | 5.6 | |
| Maximum | 1.1 | 1.3 | |
| *Total* | *100.0%* | *100.0%* | |
| | *(N=642)* | *(N=626)* | *$\chi^2$=9.8, df=4, p=.044* |
| Public risk | | | |
| Less than 1 year to serve | 48.9% | 54.6% | |
| 1 –4 years to serve and/or misdemeanor filed | 35.8 | 31.9 | |
| 4 - 7 years to serve and/or prior sex offender | 10.0 | 7.7 | |
| 7 – 10 years to serve and/or current sex offender | 2.8 | 2.6 | |
| 10+ years to serve and/or detainer for capital offense | 2.5 | 3.2 | |
| *Total* | *100.0%* | *100.0%* | |
| | *(N=642)* | *(N=626)* | |
| Institutional risk | | | |
| Acceptable institutional adjustment | 77.1% | 79.6% | |
| Poor adjustment at halfway house or continued level 2 conduct violations | 17.4 | 14.9 | |
| Substance abuse or continued level 3 conduct violations | 2.3 | 1.8 | |
| Assaulted inmates, threatened staff or inmates, or continued level 4 conduct violations | 2.3 | 3.0 | |
| Assaulted staff or has a supervised escape or other major conduct violations | 0.8 | 0.8 | |
| *Total* | *99.9%* | *100.1%* | |
| | *(N=642)* | *(N=626)* | |
| Mean number of conduct violations | 14.1 | 13.7 | |
| | (SD=16.3) | (SD=12.6) | |
| | *(N=642)* | *(N=626)* | |

# APPENDIX III
## Characteristics of OCCDTP Graduates and Dropouts

| *Demographic Information* | *Graduates* | *Dropouts* | |
|---|---|---|---|
| Race | | | |
| White | 51.4% | 56.3% | |
| Black | 48.1 | 42.6 | |
| Hispanic | 0.4 | 0.5 | |
| Native American | 0.1 | 0.5 | |
| *Total* | *100.0%* | *99.9%* | |
| | *(N=693)* | *(N=575)* | |
| Marital status | | | |
| Never married | 56.4% | 58.3% | |
| Married | 17.7 | 17.7 | |
| Divorced | 20.2 | 19.7 | |
| Separated | 5.3 | 4.0 | |
| Widowed | 0.3 | 0.3 | |
| *Total* | *99.9%* | *100.0%* | |
| | *(N=693)* | *(N=575)* | |
| Age at time of commitment | | | |
| Ages 16 - 17 years | 1.7% | 2.3% | |
| Ages 18 - 20 years | 6.6 | 11.5 | |
| Ages 21 - 25 years | 22.1 | 30.4 | |
| Ages 26 - 30 years | 24.2 | 23.0 | |
| Ages 31 - 35 years | 22.1 | 15.7 | |
| Ages 36 - 40 years | 13.4 | 10.8 | |
| Ages 41 - 45 years | 6.6 | 4.0 | |
| Ages 46 - 50 years | 2.2 | 1.7 | |
| Ages 51 - 55 years | 0.7 | 0.5 | |
| Ages 56 - 60 years | 0.3 | 0.2 | |
| *Total* | *99.9%* | *100.1%* | |
| | *(N=693)* | *(N=575)* | $\chi^2=30.7$, $df=9$, $p=.000$ |
| ***Medical/Psychological Information*** | ***Graduates*** | ***Dropouts*** | |
| Medical and health care needs | | | |
| None | 78.2% | 79.0% | |
| Routine | 21.1 | 19.3 | |
| Clinical care | 0.6 | 1.0 | |
| Limited infirm | 0.1 | 0.5 | |
| Chronic care | 0.0 | 0.2 | |
| *Total* | *100.0%* | *100.0%* | |
| | *(N=693)* | *(N=575)* | |
| Mental health care needs | | | |
| Emotionally stable; no identified impairment | 6.6% | 5.7% | |
| Minimal impairment | 92.2 | 91.7 | |
| Mild impairment | 1.0 | 2.1 | |
| Moderate impairment; requires medication | 0.1 | 0.3 | |
| Severe impairment; special psychiatric treatment | 0.0 | 0.2 | |
| *Total* | *99.9%* | *100.0%* | |
| | *(N=693)* | *(N=575)* | |

| | | | |
|---|---|---|---|
| Mean IQ | 92.3 (SD=11.7) *(N=520)* | 91.9 (SD=12.5) *(N=410)* | |
| ***Substance Abuse Information*** | ***Graduates*** | ***Dropouts*** | |
| Alcohol Scale (ranges from 0 – 99, with 99 most severe) | 57.4 (SD=40.2) *(N=220)* | 53.9 (SD=38.3) *(N=249)* | |
| Drug Scale (ranges from 0 – 99, with 99 most severe) | 62.0 (SD=42.3) *(N=220)* | 60.3 (SD=41.9) *(N=249)* | |
| Percent of clients ever using the following substances | | | |
| Alcohol | 80.1% | 69.5% | $\chi^2=14.6$, $df=1$, $p=.000$ |
| Marijuana | 71.9% | 65.0% | $\chi^2=5.2$, $df=1$, $p=.022$ |
| Cocaine/crack | 54.4% | 49.5% | |
| Stimulants/amphetamines | 29.3% | 25.7% | |
| Barbiturates/tranquilizers | 23.8% | 23.4% | |
| Hallucinogens | 25.6% | 25.6% | |
| Opiates | 29.0% | 28.8% | |
| Inhalants | 5.5% | 8.1% | |
| PCP | 17.4% *(N=559)* | 16.0% *(N=406)* | |
| Frequency of use of alcohol in the 6-month period prior to incarceration | | | |
| Never | 42.9% | 53.7% | |
| A few times | 9.7 | 9.6 | |
| 1 to 3 times per month | 7.3 | 7.6 | |
| 1 to 5 times per week | 14.8 | 11.8 | |
| Daily | 25.2 | 17.2 | |
| *Total* | *99.9%* *(N=559)* | *99.9%* *(N=406)* | $\chi^2=14.2$, $df=4$, $p=.007$ |
| Frequency of use of marijuana in the 6-month period prior to incarceration | | | |
| Never | 59.0% | 61.6% | |
| A few times | 14.7 | 11.6 | |
| 1 to 3 times per month | 5.7 | 5.4 | |
| 1 to 5 times per week | 7.0 | 6.7 | |
| Daily | 13.6 | 14.8 | |
| *Total* | *100.0%* *(N=559)* | *100.1%* *(N=406)* | |
| Frequency of use of cocaine/crack in the 6-month period prior to incarceration | | | |
| Never | 66.5% | 75.6% | |
| A few times | 7.0 | 6.4 | |
| 1 to 3 times per month | 5.0 | 3.2 | |
| 1 to 5 times per week | 6.6 | 4.4 | |
| Daily | 14.8 | 10.3 | |
| *Total* | *99.9%* *(N=559)* | *99.9%* *(N=406)* | $\chi^2=10.3$, $df=4$, $p=.035$ |

| | | | |
|---|---|---|---|
| Frequency of use of stimulants/amphetamines in the 6-month period prior to incarceration | | | |
| Never | 86.9% | 87.9% | |
| A few times | 4.8 | 3.7 | |
| 1 to 3 times per month | 1.4 | 1.2 | |
| 1 to 5 times per week | 2.9 | 3.7 | |
| Daily | 3.9 | 3.4 | |
| *Total* | *99.9%* | *99.9%* | |
| | *(N=559)* | *(N=406)* | |
| Frequency of use of barbiturates/tranquilizers in the 6-month period prior to incarceration | | | |
| Never | 91.6% | 91.9% | |
| A few times | 4.5 | 4.2 | |
| 1 to 3 times per month | 1.8 | 1.0 | |
| 1 to 5 times per week | 1.8 | 2.2 | |
| Daily | 0.4 | 0.7 | |
| *Total* | *100.1%* | *100.0%* | |
| | *(N=559)* | *(N=406)* | |
| Frequency of use of hallucinogens in the 6-month period prior to incarceration | | | |
| Never | 93.2% | 91.4% | |
| A few times | 5.0 | 4.4 | |
| 1 to 3 times per month | 1.1 | 2.2 | |
| 1 to 5 times per week | 0.5 | 1.5 | |
| Daily | 0.2 | 0.5 | |
| *Total* | *100.0%* | *100.0%* | |
| | *(N=558)* | *(N=406)* | |
| Frequency of use of opiates in the 6-month period prior to incarceration | | | |
| Never | 92.1% | 92.1% | |
| A few times | 2.0 | 3.0 | |
| 1 to 3 times per month | 0.9 | 1.5 | |
| 1 to 5 times per week | 2.1 | 1.5 | |
| Daily | 2.9 | 2.0 | |
| *Total* | *100.0%* | *100.1%* | |
| | *(N=559)* | *(N=406)* | |
| Entering the program, how serious do you think your drug use problems are? | | | |
| Not serious at all | 55.2% | 64.0% | |
| Slightly serious | 4.5 | 3.4 | |
| Moderately serious | 3.8 | 7.4 | |
| Considerably serious | 10.0 | 5.2 | |
| Extremely serious | 26.5 | 20.0 | |
| *Total* | *100.0%* | *100.0%* | |
| | *(N=558)* | *(N=406)* | $\chi^2$=20.8, df=4, p=.000 |

| *Vocational/Educational Information* | *Graduates* | *Dropouts* | |
|---|---|---|---|
| Educational needs | | | |
| Educationally prepared (9th grade equiv. or higher) | 81.4% | 72.5% | |
| Minimal impairment (8th grade equivalency) | 16.7 | 24.3 | |
| Mild impairment (6th to 7th grade equivalency) | 1.0 | 1.9 | |
| Moderate impairment (3rd to 5th grade equivalency) | 0.6 | 0.7 | |
| Severe impairment (below a 3rd grade equivalency) | 0.3 | 0.5 | |
| *Total* | *100.0%* | *99.9%* | |
| | *(N=693)* | *(N=575)* | $\chi^2=14.5$, $df=4$, $p=.006$ |
| Educational level achievement | | | |
| 8 grade of less | 9.6% | 11.2% | |
| Some high school | 31.9 | 34.9 | |
| High school graduate or GED | 51.2 | 49.4 | |
| Some college | 6.8 | 4.0 | |
| College graduate | 0.6 | 0.5 | |
| *Total* | *100.1%* | *100.0%* | |
| | *(N=690)* | *(N=573)* | |
| Vocational education | | | |
| Vocationally trained | 7.9% | 7.3% | |
| Skilled | 25.8 | 24.9 | |
| Semi-skilled | 45.0 | 42.6 | |
| Unskilled | 13.6 | 15.1 | |
| No skills training | 7.6 | 10.1 | |
| *Total* | *99.9%* | *100.0%* | |
| | *(N=693)* | *(N=575)* | |
| Work skills | | | |
| Stable work history; completed training | 3.0% | 1.6% | |
| Stable work history; undergoing training | 22.1 | 16.5 | |
| Sporadic work history; unskilled | 65.7 | 67.7 | |
| Poor work history | 5.8 | 11.1 | |
| Very poor work attitude or refuses to work | 3.5 | 3.1 | |
| *Total* | *100.1%* | *100.0%* | |
| | *(N=693)* | *(N=575)* | $\chi^2=19.1$, $df=4$, $p=.001$ |
| ***Criminal History*** | ***Graduates*** | ***Dropouts*** | |
| Incidents of probation prior to current incarceration | | | |
| None | 20.2% | 20.0% | |
| One | 38.1 | 41.6 | |
| Two or more | 41.7 | 38.4 | |
| *Total* | *100.0%* | *100.0%* | |
| | *(N=693)* | *(N=575)* | |
| Incidents of incarceration prior to current incarceration | | | |
| None | 48.5% | 49.6% | |
| One | 32.9 | 32.3 | |
| Two or more | 18.6 | 18.1 | |
| *Total* | *100.0%* | *100.0%* | |
| | *(N=693)* | *(N=575)* | |

| | | | |
|---|---|---|---|
| Class of committing crime | | | |
| Class A felony | 11.5% | 11.1% | |
| Class B felony | 33.0 | 29.4 | |
| Class C felony | 45.2 | 51.0 | |
| Class D felony | 7.6 | 6.3 | |
| Non-classified | 2.6 | 2.3 | |
| *Total* | *99.9%* | *100.1%* | |
| | *(N=693)* | *(N=575)* | |
| Length of longest sentence | | | |
| 4 years of less | 15.6% | 18.8% | |
| 5 years | 30.7 | 34.8 | |
| 6 - 10 years | 39.8 | 35.8 | |
| 11 years or more | 13.9 | 10.6 | |
| *Total* | *100.1%* | *100.0%* | |
| | *(N=693)* | *(N=575)* | $\chi^2=7.5$, $df=3$, $p=.059$ |
| ***Prison / Security Information*** | ***Graduates*** | ***Dropouts*** | |
| Custody rating | | | |
| Eligible for transfer to a Community Release Center | 44.3% | 48.0% | |
| Low | 46.3 | 35.3 | |
| Medium | 5.6 | 7.8 | |
| Medium high | 3.3 | 6.8 | |
| Maximum | 0.4 | 2.1 | |
| *Total* | *99.9%* | *100.0%* | |
| | *(N=693)* | *(N=575)* | $\chi^2=27.4$, $df=4$, $p=.000$ |
| Public risk | | | |
| Less than 1 year to serve | 46.0% | 58.6% | |
| 1 –4 years to serve and/or misdemeanor filed | 37.2 | 29.9 | |
| 4 - 7 years to serve and/or prior sex offender | 10.4 | 7.0 | |
| 7 – 10 years to serve and/or current sex offender | 3.6 | 1.6 | |
| 10+ years to serve and/or detainer for capital offense | 2.7 | 3.0 | |
| *Total* | *99.9%* | *100.1%* | |
| | *(N=693)* | *(N=575)* | $\chi^2=23.7$, $df=4$, $p=.000$ |
| Institutional risk | | | |
| Acceptable institutional adjustment | 86.4% | 68.5% | |
| Poor adjustment at halfway house or continued level 2 conduct violations | 11.8 | 21.4 | |
| Substance abuse or continued level 3 conduct violations | 0.9 | 3.5 | |
| Assaulted inmates, threatened staff or inmates, or continued level 4 conduct violations | 0.7 | 5.0 | |
| Assaulted staff or has a supervised escape or other major conduct violations | 0.1 | 1.6 | |
| *Total* | *99.9%* | *100.0%* | |
| | *(N=693)* | *(N=575)* | $\chi^2=71.0$, $df=4$, $p=.000$ |
| Mean number of conduct violations | 10.0 | 18.6 | |
| | (SD=10.7) | (SD=17.0) | |
| | *(N=693)* | *(N=575)* | $t=-10.8$, $df=1266$, $p=.000$ |