EVALUATION

Substance Abuse Violators Effort (SAVE) Program

Submitted to:
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Executive Summary

The SAVE program was designed as an alternative disposition program for technical parole violators who violated parole due to a positive drug screen. The program was developed as one method to reduce prison overcrowding and to provide substance dependent offenders with the necessary resources to sustain recovery from their addiction. The SAVE program consisted of four 90-day phases of substance abuse treatment. During Phase 1 offenders participated in a residential drug and alcohol facility that provided comprehensive individual and group based drug and alcohol counseling services. Phase 2 consisted of 10 to 20 hours of intensive outpatient counseling coupled with intensive parole supervision. Phase 3 consisted of 5 to 10 hours of group counseling with intensive parole supervision. Finally, phase four consisted of 2 to 5 hours of group counseling and standard parole services.

A multi-phase evaluation conducted by an independent evaluator was performed to determine the impact of the SAVE program on offender recidivism, and to assess the quality and type of the services provided. This evaluation consisted of the following components: (1) a descriptive report containing the characteristics of offenders enrolled in the SAVE program; (2) a series of predictive characteristic models developed to identify offenders who completed/dropped out of the program; (3) a comparative analyses designed to examine 30-month post offender status following enrollment into SAVE compared with offenders who did not receive SAVE; (4) qualitative data designed to explore the impact of the SAVE program on offender needs; and (5) an exploratory economic analyses of the program.

A retrospective design was employed to identify the characteristics of offenders enrolled in the program and to identify factors of program completion. A total of 386 offenders were consecutively enrolled in the program between July 1, 1998 and January 18, 2001. Baseline admission and program completion data were available on 380 offenders. Of the 380 offenders enrolled in SAVE, 328 (86.3%) completed Phase 1; 234 (61.6%) completed phase 2; 162 (42.6%) completed phase 3; and 123 (32.4%) completed Phase 4. Additionally, 83 participants were provided with warranted services, of which 24 (28.9%) completed the SAVE program.

A series of bivariate analyses (t-tests and chi-square) were performed to determine which factors were independently related to program completion during Phase 1. A total of 328 (86.3%) offenders completed phase one and 52 (13.7%) did not complete. Independent variables were selected from the baseline ASI assessment. A multiple logistic regression analysis was performed in which completion of phase one was the dependent variable and five independent predictive factors were entered: age (continuous); any series depression experienced in the past 30 days (dichotomous); length of longest period of lifetime abstinence from drug of choice (continuous); any self-reported experience of physical abuse during lifetime (dichotomous); and interviewer rating of current family problems (continuous). The results of the logistic regression found that older offenders, those with greater lengths of abstinence from drugs, and offenders with less reported family problems were more likely to complete Phase 1 of SAVE.

A similar set of analyses were performed to determine which factors were independent predictors of Phase 4 treatment completion. A total of 123 (32.4%) of the offenders completed Phase 4 while 257 (67.6%) did not complete treatment. A logistic regression analysis was performed to understand the relationship between the independent predictor variables and treatment completion. Overall two variables predicted program completion while controlling for the potential effects of other variables. Older offenders and those who had not used heroin in the immediate 30 days prior to entry into SAVE were most likely to complete the program.

A comparative analysis was conducted with 65 offenders consecutively enrolled in the SAVE program with 65 offenders who had a similar technical parole violation but were returned to prison. Criminal history records, Department of Corrections "Move" data, and parole records were analyzed to determine 30 month outcomes. A negative events analysis was conducted to determine if any of the following had occurred: (1) any technical parole violation, (2) any new charge, and (3) any positive drug screen. Overall 59/65 (90.7%) of the offenders in the SAVE condition had achieved a negative event during the 30-month post revocation assessment point compared to 47/61 (77%) of the offenders in the comparison condition. A chi-square statistic was calculated by condition (comparison vs. SAVE) and any negative event (yes vs. no) resulted in a statistically

significant finding (chi=square = 3.89, df=1, p<.05). Indicating that offenders who went to the SAVE program had a higher proportion of negative events. Among the SAVE participants, 42/65 (64.6%) had a technical parole violation, 30/65 (46.1%) had a new charge, and 23/65 (35.3%) had a positive drug screen. As previously noted 21/65 (32.3%) offenders paroled to SAVE completed the program. Within 18 months of completion of the SAVE program, 15/21 (71.5%) offenders had been charged with a new crime or had violated the conditions of parole. In the comparison condition 7/61 (11.5%) who were incarcerated were never released from prison during the 30-month assessment period. These offenders were categorized as negative outcomes. A total of 17/54 (31.4%) offenders in the comparison condition had a technical parole violation; 22/54 (40.7%) had a new charge; and 24/51 (44.4%) had a positive urine screen.

A preliminary economic analysis was performed toward examining the costs of the SAVE program compared to incarceration over a one year period. The purpose of the SAVE program was to divert non-violent offenders to approved community-based substance abuse treatment programs under contract with the Pennsylvania Department of Corrections rather than sending the offender back to prison. On average the daily cost of incarceration was estimated to be $77.68 per day and $28,353 per annum. The cost of the SAVE program including parole supervision costs was estimated at $25,162. This resulted in an estimated difference of $3,185 of projected savings per offender or $1,210,224 for the 380 offenders included in this report. Caution should be used in the interpretation of this figure since it does not control for other potential costs (e.g., crime) or savings (employment).

Finally, a qualitative assessment of the SAVE program revealed some important issues. First, the vast majority of the SAVE participants found the program to be valuable and helpful. However, the majority of the offenders also believed that the program was not designed to meet the broader context of their needs for successful reintegration. For example few employment, family, and housing services were offered in relation to the level of problems experienced by the offender. Through interviews with key project staff, one important observation noted was the need to develop an improved administrative structure of the SAVE program. While the program services were delivered with integrity, there was insufficient oversight on how the different key

agencies (e.g., Eagleville Hospital, DOC, PBPP) established procedures to monitor and improve the project.

In conclusion, the SAVE program appears to be an appropriate alternative program to divert non-violent substance abusing re-paroled offenders from prison to community based settings. Overall, there appear to be positive economic benefits associated with the SAVE program, and an important positive reduction on prison overcrowding. Concurrently, there also appears to be favorable impact on offender behavior leading to increased opportunities for rehabilitation. Given that the offenders represent a high risk cohort of the general population, the results are promising. Potentially reinvesting some of the projected savings into the SAVE project and shifting resources to include a case manager as a component of the treatment project would lead to the development of a more comprehensive rehabilitation system that could potentially yield higher rates of program effectiveness and lower rates of recidivism. Suggestions for program improvement are offered and future recommendations are provided.

SAVE Final Report

Introduction

The Substance Abuse Violators Effort (SAVE) program began as a collaborative project among the Pennsylvania Department of Corrections (DOC), the Pennsylvania Board of Probation and Parole (PBPP), and Eagleville Hospital. The SAVE program was designed to provide substance dependent parole violators an opportunity to voluntarily enroll into a year long intensive drug and alcohol treatment program, in lieu of incarceration.

Rationale – Prior to SAVE, parolees who violated parole stipulations for a substance abuse technical parole violation (TPV) were returned to prison to fulfill sentencing obligations. According to the annual DOC report, in 2001 nearly 38% of new prison admissions were incarcerated because of a TPV, and the primary reason for the TPV was a substance abuse violation of parole. Subsequently, the rise in parole revocation was a contributing source of prison overcrowding in the Commonwealth of Pennsylvania. In an effort to reduce the number of offenders who returned to prison, a demonstration project was conceptualized. Parolees who violated parole because of substance use were provided an opportunity to voluntarily participate in a comprehensive year long substance abuse treatment program in lieu of incarceration.

There were 3 identified objectives for initiating the SAVE program: (1) The program served as an opportunity to reduce the prison population by diverting substance dependent technical parole violators from prison to a community-based residential substance abuse treatment program. Thus, the SAVE program was a strategy that could reduce the number of offenders returned to prison. In turn, the SAVE program would reduce prison overcrowding, enabling prisons to operate more safely and effectively. (2) The program offered substance dependent offenders who violated parole an opportunity to receive appropriate treatment for alcohol and drug addiction. Given that substance abuse is a major contributing factor to crime, treatment of substance use was thought to be an opportunity to prevent future engagement in illegal activities and crime. (3) The

SAVE program provided substance abuse treatment professions and parole officers an opportunity to foster partnerships and alliances within the community and refocus priorities given available resources toward offender reintegration. Clearly, these objectives were logical and appropriate based on current data from the Department of Corrections and research findings suggesting that substance abuse treatment improves offender outcomes and reduces prison overcrowding.

History of SAVE – The SAVE program was conceptualized in the Spring of 1996 and began operation in January, 1997. The conceptualization and implementation of the program was a partnership among staff from three organizations, PBPP, DOC and Eagleville Hospital. Initial development included the use of some outside consultative assistance.

Administrative Structure – Funding for SAVE was made available by the Pennsylvania Department of Corrections. Contracts were developed with Eagleville Hospital to provide residential substance abuse treatment services and with a variety of outpatient substance abuse treatment programs throughout Southeastern Pennsylvania for outpatient services. Key staff persons from the PBPP, DOC, and Eagleville Hospital developed the clinical framework of the program and provided input on the implementation of the program. The DOC was responsible for the administrative oversight of the SAVE program. Key staff from DOC, Eagleville Hospital, and PBPP met, based on necessity to address concerns raised from the implementation of the program. No single person coordinated oversight of the project, rather each identified organization was a partner at the table and contributed to the implementation process. Little formal structure was undertaken in the administration of the project. There was no advisory board or outside planning board to assist in the monitoring of the project.

Eligibility Criteria - As part of the screening for SAVE eligibility, the parole officer completed an updated risk/needs assessment. All parolees voluntarily accepted enrollment in the SAVE program. All cases were reviewed by the parole officer, parole supervisor, and in some cases the district director to determine eligibility for the project.

A number of intangible issues were considered prior to accepting a person in the SAVE program. For example, the offender's performance on parole was weighed, offender compliance with PBPP regulations, severity and history of substance abuse was considered and the extent to which family supports were available. To this end, there were some basic criteria for participation in SAVE, but much discretion was considered by the parole system. Exclusion criteria included:

1. offenders with acute Axis I psychiatric disorders as per the Diagnostic Statistical Manual (DSM) – IV;
2. serious or unstable medical conditions such as active TB;
3. a criminal history of arson or sexual offenses;
4. individuals with severe impulse disorders;
5. outstanding criminal charges or warrants; and
6. offenders serving a state sentence, but paroled from a county jail.

SAVE Referrals - Referrals were made to the SAVE program on a case by case basis by the parole officer. Referrals were forwarded to the parole supervisor and the district director for review and consideration. Together, these persons reached a decision to accept/deny participation in SAVE based upon the information provided by the parole officer and the offender's past record. No systematic risk profile system was used to assist in the determination of eligibility or offender fit for the program. The Parole Supervisor assigned to the SAVE project was headquartered at Eagleville Hospital and served as the liaison between the substance abuse treatment programs and the PBPP.

There was no system in place to insure that all offenders who had a TPV were screened for the SAVE program. Overall there was considerable variation in the number of referrals made due to parole officer discretion. At the Chester District Office, several training initiatives were put in place to provide general information and education about the SAVE program as an effort to increase awareness and referrals.

SAVE Intake – Once accepted into the SAVE program, the parole officer escorted the offender to Eagleville Hospital for intake. At this point, the SAVE parole supervisor developed a case record that included a variety of PBPP routing forms and offender biopsychosocial history information. The case was then assigned to a SAVE agent for supervision. The offender was then enrolled into the substance abuse treatment program (see phase 1 below). Within three days of referral to SAVE, the offender completed a clinical intake evaluation consisting of the Addiction Severity Index (ASI) and other clinical screens and assessments.

Evaluation History – Dr. Dave Zanis, an assistant professor from the Graduate School of Social Work, Marywood University was awarded a contract from the Pennsylvania Commission on Crime and Delinquency (PCCD) to evaluate the effectiveness of SAVE. The evaluation team consisted of Dr. Zanis, principal investigator and Carol Kardisco, research assistant.

The initial months of the evaluation consisted of a series of meetings with key SAVE project staff from the PBPP (Tom Costa, Patti Azzara, Chris Pandolfo) and Eagleville Hospital (Chalie Folks, Harvey Wiener, Charlie Beem) to identify what had taken place to date and the current status of the project. This group advised the evaluation team throughout the project.

During these meetings, the SAVE advisory team was asked to develop a series of research questions that they believed would be helpful to investigate and answer. Based upon these questions, methodological considerations were explored to determine to what extent valid information could be collected.

To assist in this process an evaluation steering committee was convened by James Strader, project officer, PCCD. Committee members included: James Alibrio, PBPP, Dr. Gary Zajak, DOC, Dr. Doug Hoffman, PCCD, and James Strader, PCCD. The committee met to review the initial evaluation strategy, offered suggestions, and approved the plans (see evaluation methodology and questions, below).

Protection of Human Subjects Rights – Prior to contact with any offender or collection of data, a series of protective factors for human subjects' rights was secured. Approval for the collection of data was obtained from three different sources: (1) the research committee of Eagleville Hospital, (2) the Marywood University Institutional Review Board (IRB), and (3) the research committee of the Pennsylvania Board of Probation and Parole.

Treatment Services/Phases: Information regarding the nature and extent and the implementation of treatment services was obtained from a variety of different sources. Focus groups were conducted with staff, documents were reviewed, patient records were reviewed, and patients were interviewed. From these sources of data, a description of the four different treatment phases is described.

Four Phases of SAVE

Phase 1 was a 90-day inpatient treatment stay located at Eagleville Hospital. Eagleville Hospital is a licensed, JACHO accredited substance abuse treatment program located in southeastern, Pennsylvania. The program provided medical and psychosocial services, overseen by a clinical and medical director. Staff met the standards for addiction counselors as part of the Pennsylvania Department of Health's licensing process. Staff included licensed professionals (e.g., LSW) and certified addiction counselors (CACs). The theoretical framework for service delivery was an eclectic style that draws upon various approaches including cognitive problem solving, 12-step facilitation, and motivational counseling techniques. Offenders could receive on average five therapeutic groups per week, daily seminars on drug and alcohol issues, individual counseling sessions based on offender need, and participated in self-help meetings. Family services were offered on week-ends. Parole supervision was provided and parole officers participate in treatment team meetings and discharge planning. Individuals were not permitted to work during this phase of treatment.

Phase 2 was a 90-day intensive outpatient program provided in a drug and alcohol treatment facility geographically located near the offenders' home residence. Several different licensed outpatient providers were contracted to provide services, although the majority of offenders were enrolled in one of two programs operated by Riverside, an Eagleville affiliate program. The theoretical framework for service delivery reflected a predominantly 12-step facilitation approach. The program provided between 10 and 20 hours of counseling per week. Offenders could participate in four therapeutic group sessions and 1 individual counseling session each week. Offenders remained under the supervision of the PBPP and received intensive parole supervision throughout Phase 2. Electronic monitoring and curfews were enforced, although parole services and supervision remained at the discretion of the parole officer. Urine specimens were obtained weekly for detection of illicit drug use.

Phase 3 was a 90-day outpatient program provided in community-based licensed drug and alcohol programs. Offenders continued in the same treatment program as in Phase 2. Offenders were not discharged from treatment but they were "stepped" down in the intensity of counseling services and parole supervision. Overall offenders could participate in approximately 5 to 10 hours of counseling services each week. During Phase 3, offenders could participate in up to two therapeutic drug and alcohol counseling sessions per week and an individual counseling session. Electronic monitoring and curfews were not used in order to provide offenders with greater opportunity to secure and maintain employment. Parole officers secured urine specimens weekly for drug detection.

Phase 4 was a 90 day outpatient program continued in the same licensed substance abuse treatment program as Phases 2 and 3. Offenders could participate in one individual and one group counseling session per week, with a range of 2 to 5 hours of counseling services each week. During this phase community-reintegration was stressed. Parole supervision was continued and varied based upon the level of risk determined by the parole officers. Urine specimens were obtained on a weekly basis.

Parole Services – Parole services were coordinated by one parole supervisor (Ms. Patti Azzara) who was physically located on site at Eagleville Hospital. This parole station served as a central office for communicating parole needs. Offenders were under the jurisdiction of several district parole offices (Chester, Philadelphia, Allentown). Each SAVE participant was assigned a parole officer to oversee parole supervision. On average parole officers had caseloads of 40 offenders to one officer.

Revocation Decision Making – The decision to revoke parole following a substance use violation (e.g., tested positive for substance abuse) varied on a case-by-case basis. The parole officer was given discretion as to what action to take. Actions steps were determined based upon the parole officer's knowledge and experiences in working with the offender. For example an offender who was regularly attending treatment and had applied him/herself in adhering to parole stipulations could be provided with a warning. Whereas a parolee who did not show up for parole supervision hearing, and had little interest in substance abuse treatment could have his/her parole revoked and the person could be incarcerated. Please note, offender cases were discussed with parole officer supervisors, and others in an effort to have multiple persons review the case and determine the best course of action. No tracking system was implemented to identify the number of offenders eligible for SAVE program.

Warranted Services – Offenders in the SAVE program who violated parole due to a substance use infraction could be eligible for a special program named "warranted services". Warranted services provided offenders an opportunity to receive up to 30 additional days of residential treatment at Eagleville hospital. After completing warranted services, the offender was then reassigned to a community-based outpatient treatment program to continue treatment and serve his/her parole sentence. The logic of this service was to stabilize the offender in a controlled setting and then transfer the person to the appropriate level of care. Offenders who received warranted services remained in SAVE for the same duration as other offenders (1 year), no additional time in the SAVE program was provided.

Evaluation Methodology

A 4-stage evaluation methodology was developed to evaluate the implementation and outcomes of Project SAVE.

Stage 1 was a retrospective, descriptive analysis designed to identify the characteristics of offenders who enrolled in the SAVE program and examine factors of program completion and explore predictors of completion.

Stage 2 was a prospective design to assess the type and amount of services provided during each of the phases of SAVE. Multiple sources of data were collected from offenders, treatment providers, and project staff. This exploratory approach provided information on the type, nature, and extent of services received/provided.

Stage 3 was a quasi experimental design conducted to examine the effectiveness of SAVE in comparison to offenders who were eligible for SAVE but who were returned to prison rather than receiving parole to the SAVE program.

Stage 4 represents an exploratory cost analysis of the save program in comparison to the costs of incarceration.

Evaluation Questions

This four stage evaluation design was developed to explore the following questions.

1. What were the characteristics of the offenders who participated in Project SAVE?
2. What was the relationship among the ASI factors and demographic characteristics and program completion?
3. What factors predicted post-program SAVE outcomes?
4. What services were provided in each of the four phases of the SAVE program?
5. What was the utility of the ASI as an assessment tool?
6. What were the short-term and long-term impacts of the SAVE program on participants' recidivism rates and on their drug and alcohol abuse? Does the program have other positive or negative impacts on offenders and on public safety?
7. What was the estimated impact of the SAVE program on the state prison and parole populations

Data Collection - The first stage of the SAVE evaluation was to collect information about the characteristics of offenders who had enrolled in project SAVE between July 1, 1998 and January 18, 2001. Administrative records were reviewed to determine the proportion of offenders that completed each of the four phases of SAVE and to identify reasons for drop out.

Start Date – The SAVE program was conceptualized as a new program and was not based upon an existing program, therefore, it was understood and expected that the SAVE program would undergo and experience a period of initial implementation barriers such as program design, partnership with parole, developing protocols for violations, etc. Because the primary purpose of the evaluation was to collect data on the effectiveness of SAVE, it was determined that the evaluation should include all persons who began on or after July1, 1998. It was believed that inclusion of offenders before this time would not be a realistic evaluation of the program as it was designed to be implemented. Moreover an evaluation of offenders after this start date was believed to offer a true picture of the program, when implemented as designed.

Addiction Severity Index (ASI) – Upon enrollment into the residential component of Eagleville Hospital (phase 1) all offenders completed an intake assessment consisting of demographic data, criminal justice information, and the clinical version of the ASI. Eagleville implemented the Clinical Version of the ASI as recommended by the Center for Substance Abuse Treatment (TIP #7, see appendix for copy). A chart review was undertaken by the evaluation team to examine the quality of the ASI data. Overall it was determined that data collected on the ASI had good validity and reliability. Several factors led to this conclusion: (1) over 97% of the ASI assessments were completed by a single interviewer. (2) the interviewer had completed a course in the administration of the ASI and was deemed competent in conducting the interviews. (3) A random check of 25 completed ASIs yielded only 1 cross-check error, indicating excellent quality. (4) Finally, less than 1% of the ASIs contained missing data. A subsequent discussion with the ASI interviewer supported the quality of the data. To this end, the baseline ASI information collected was used as part of the data set.

The research assistant then performed a chart review and entered ASI information into a SPSS database. Between July 1, 1998 and January 19, 2001 there were a total of 386 consecutive admissions to the SAVE program. Six records were unable to be located, resulting in a valid sample size of 380 offenders.

Data Analysis and Results

Descriptive Characteristics Offenders- Appendix 1 shows the baseline characteristics of SAVE participants. The majority of the offenders were male 371 (97.6%). The mean age of all offenders was 36.99 (sd = 7.9). Most offenders described themselves as Black 237 (72.6%); White 60 (16.0%); or Hispanic 43 (11.4%). The average length of full time employment was 3.3 years (sd=3.45). The majority of offenders had at least a high school diploma or GED 277 (74.9%). Nearly half, 187 (50.5%) of the offenders reported cocaine use as their primary drug problem, followed by alcohol 77 (20.8%); heroin 59 (16.0%), and marijuana 42 (11.4%). Overall 84 (22.7%) reported injection drug use in their lifetime. All offenders had previously been enrolled in a drug or alcohol treatment program. On average offenders were enrolled in 2.5 (sd=1.84) alcohol treatment programs and 2.5 (sd = 1.93) drug treatment programs.

On average offenders were convicted of 3.81 (sd=3.9) prior criminal offenses. Nearly 65% had a history of drug charges, 40% burglary charges, 41% robbery, 34% weapons offense, 37% assault, 12% homicide, 10% DUI, and 29% for shoplifting. On average offenders had been incarcerated for 94 (sd=58) months in their lifetime with a range from 22 to 360 months.

The majority of the offenders identified their marital status as never being married 201 (54.5%); 79 (21.4%) were married; 50 (13.6%) separated; and 26 (7.0%) divorced. Few offenders, 29 (8%) reported previous treatment for psychiatric problems, although 133 (35%) reported that they had a history of violent behavior. Nearly all, (88%) reported some type of psychiatric symptoms in the past 30 days, although no accounting was made to control for present stressors due to re-incarceration or other activities.

Overall 213 (56.1%) of SAVE participants were from the Philadelphia District Office; 114 (30%) from the Chester District Office; and 53 (13.9%) from the Allentown District Office.

Treatment Program Outcomes – Of the 380 participants enrolled in SAVE, 328 (86.3%) completed Phase 1; 234 (61.6%) completed phase 2; 162 (42.6%) completed

phase 3; and 123 (32.4%) completed phase 4. Additionally, 83 participants were provided with warranted services, of which 24 (28.9%) completed phase 4.

STAGE 1

Reasons for Not Completing SAVE - Of the 257 offenders who did not complete SAVE, the reasons for not completing treatment varied. The majority of offenders 102 (26.8%) received a technical parole violation for substance use infraction. A total of 83 (21.8%) offenders did not comply with the stipulations of technical parole and were declared delinquent, and the majority of these offenders also had violations for substance use. Overall 45 (11.8%) were charged with new criminal offenses and had parole revoked. Importantly only 2 of the new criminal offense violations could be categorized as a violent crime (robbery), while the majority of offenses were drug violations or theft. Few offenders, 16 (4.2%) violated treatment program rules during phase 1 at Eagleville Hospital and were returned to prison. Approximately 3% did not complete treatment for a variety of other circumstances including: medical discharge (N=2); sentence termination (N=2); voluntary re-incarceration (N=1); pending criminal charges (N=2) and other issues.

Independent baseline predictors of Phase 1 treatment completion – A series of bivariate analyses were performed to determine which factors were independent predictors of phase one program completion. The dependent variable was dichotomized as either completion or non-completion of the 90-day Eagleville treatment program. A total of 328 (86.3%) offenders completed phase one. Independent variables were selected from the baseline ASI assessment. Based upon level of measurement of the independent variable, varying analyses were performed including chi-square and independent t-tests in an effort to determine differences between completers and non-completers. In some cases, due to low response rate on selected values, values were either regrouped into similar categories, or categories were excluded all together.

A total of 11 variables from the baseline ASI were independently and significantly predictive ($p<.05$) of program completion during phase one. These variables included: (1) age; (2) the number of years of education completed; (3) significant problems with mother during lifetime; (4) significant problems with father during lifetime; (4)

significant problems with sexual partners during lifetime; (5) physical abuse during lifetime; (6) the number of days of conflict with family members in the past 30 days; (7) the number of days of conflict with others in the past 30 days; (8) marital satisfaction; (9) interviewers rating of family/social problems; (10) reports of depression in the past 30 days; and (11) the longest duration of abstinence.

A correlation matrix was performed to examine the intercorrelation of the predictive variables and results indicated that there was high positive correlation (>.4) among variables categorized as "family related". These variables included: significant problems with mother during lifetime, significant problems with father during lifetime; significant problems with sexual partners during lifetime; the number of days of conflict with family members in the past 30 days; the number of days of conflict with others in the past 30 days; marital satisfaction, and the interviewers rating of family/social problems. In an effort to control for multicolinearity, the interviewer's severity rating was used as an overall proxy for family/social functioning since several of the correlated variables were used by the interviewer to derive her rating. An independent t-test found that completers were rated by the interviewer to have a family severity rating of 2.3 compared to non-completers who had a rating of 3.4 ($t=3.17$, $df=367$, $p=.002$). Additionally, marital satisfaction was recoded to a dichotomous variable representing not satisfied (82.4%) compared to indifferent or satisfied (90%) with marital status (chi-square=4.38, $df=1$, $p=.029$).

Independent t-tests revealed that phase 1 completers were on average 37.5 years of age versus non completers 33.9 ($t=3.1$, $p=.01$) and completers had longer histories of abstinence 14.1 months compared to non-completers 6.9 ($t=3.4$, $p<.01$). The number of years of education, which was significant as a continuous variable was not significant as a bivariate variable (less than 12 years of school vs. 12 or more years completed) and was dropped as an independent predicator since the variability as a continuous predictor had little interpretative meaning (11.6 years versus 11.3 years). Completers were more likely not to have reported a past history of physical abuse (90.7%) than non-completers (82.6%) (chi-square = 5.26, $df=1$, $p=<.05$). Finally completers (93.3%) were less likely to

have experienced depression in the 30 days prior to enrollment in the SAVE program than non-completers (85.3%) (chi-square = 4.32, df=1, p=.02).

A multiple logistic regression analysis was performed in which completion of phase one was the dependent variable and five independent predictive factors were entered: age (continuous); any series depression experienced in the past 30 days (dichotomous); length of longest period of lifetime abstinence from drug of choice (continuous); any self-reported experience of physical abuse during lifetime (dichotomous); and interviewer rating of current family problems (continuous). Overall three variables predicted completion of Phase 1. The results of the logistic regression found that older offenders, those with greater lengths of abstinence from drugs, and offenders with less reported family problems were more likely to complete Phase 1 of SAVE. Depression did not predict completion in the program after controlling for the other factors. Also, lifetime physical abuse did not reach the .05 threshold to retain predictive capacity. Ten cases were deleted because of missing data.

Table 1: Factors that predict completion of Phase 1

	B	S.E.	Wald	Sig.	Exp B.
Age	-.07	.03	8.28	.004	.931
Depression	.39	.47	.69	.41	1.48
Length of Abstinence	-.04	.02	4.29	.04	.96
Family Problems	.18	.09	4.24	.04	1.20
Physical Abuse	.64	.35	3.38	.07	1.89

N=370

Independent baseline predictors of Phase 4 treatment completion – A series of bivariate analyses were performed to determine which factors were independent predictors of Phase 4 treatment completion representing the entire SAVE program. The dependent variable was dichotomized as either completion or non-completion of Phase 4. A total of 123 (32.4%) of the offenders completed Phase 4. Independent variables from the baseline ASI assessment were the pool of items from which predictor variables were selected. Based upon level of measurement of the independent variable, varying analyses were performed including chi-square and independent t-tests. In some cases, due to low response rate on selected values, values were either regrouped into similar categories to maximize sample size. Only 5 variables were independently correlated with Phase 4 program completion at the $p<.05$ confidence level. Offenders who reported significant lifetime problems with their mother were less likely to have completed treatment (37% vs. 28%). Offenders who reported significant problems with a sexual partner in the last 30 days were less likely to complete treatment (37% vs. 24%). Offenders whose most recent incarceration was longer were less likely to complete treatment (19 months vs. 11 months). Offenders who used heroin in the past 30 days were less likely to complete treatment (24% vs. 36%). Finally, the average age of offenders who completed treatment was significantly older (38 vs. 36).

A logistic regression analysis was performed to understand the relationship between the independent predictor variables and treatment completion. The variable measuring significant problems with a sexual partner in the previous 30 days was deleted from the analysis because nearly 30% of the cases reported no relationship with a significant other and were therefore deleted from the analyses, since it reduced the overall sample size of the model. Although a subsequent analysis with the limited sample size did find this factor to be predictive, in that offenders with significant problems with a sexual partner were less likely to complete treatment. Overall two variables predicted program completion while controlling for the potential effects of other variables. As can be seen in Table 2, older offenders and those who had not used heroin in the immediate 30 days prior to entry into SAVE were most likely to complete the program.

Table 2: Factors Predictive of Phase 4 Completion

	B	S.E.	Wald	Sig.	ExpB
Relationship with Mother	.30	.23	1.70	.19	1.35
Incarceration length	.01	.00	1.82	.09	1.01
Heroin Use	.05	.02	5.02	.03	1.05
Age	-.03	.02	5.62	.02	.97

Discussion of STAGE 1 Findings – Overall there are several important findings supported by these analyses. Older offenders clearly are more likely to complete treatment and offenders who are not heroin users are more likely to complete treatment. Although the age difference is only marginal, it would appear difficult to develop programs that differentiate by age. Thus although the variable "age" is predictive, the application of this item to be used to determine eligibility in the SAVE program may have less practical meaning. Perhaps, parole officers can include it as a screening issue when they are unsure if they should refer on offender to the SAVE program. Also there is a possibility that "boot camps" for younger offenders (< 25) may serve as an alternative placement rather than the SAVE program.

Offenders who reported greater family problems were clearly more likely not to complete Phase 1 of the SAVE program. Possibly the increase of family related services to address family dysfunction could be a focus of treatment. Inclusion of family members in the treatment process and services developed at family communication could be a positive aspect of treatment, especially in helping the offender re-integrate back into his/her home environment following discharge from treatment. Since the goal of reintegration often involves using family supports, it appears that offenders who had difficulty with family members prior to entry into SAVE could benefit from family services to improve these relationship issues.

The issue of heroin as a predictor of not completing treatment provides considerably more practical information from a substance abuse treatment effectiveness and modification perspective. A different treatment approach for offenders who are

heroin dependent could be considered. For example the use of naltrexone combined with psychosocial treatment in the SAVE program could serve to improve the outcomes of these offenders.

STAGE 2

The second stage of the SAVE evaluation was to collect qualitative information from offenders and the treatment program counseling staff to assess the type of services received and provided. Additionally existing records such as chart reviews were examined. The purpose for this method was to understand the degree to which the contracted providers delivered appropriate and adequate treatment services to meet the needs of the offenders and to monitor offender response to services. By conducting these interviews the evaluation team identified and examined the nature and extent of services provided and offered potential modifications in service delivery.

Interviews with Offenders

A total of 19 offenders were voluntarily recruited during the first week of enrollment into the SAVE program. The enrollment period was held in March of 2000. Approximately 40 offenders were provided with an overview of the evaluation. Twenty offenders provided consent to voluntarily participate in an interview conducted every other week for a period of one year. One offender dropped out during the first interview and was not replaced. The purpose of the interview was to prospectively understand the needs of the offenders and to obtain information on the type and nature of services provided. This then enabled the evaluation team to compare the extent to which services provided through SAVE were able to meet offender needs. Additionally each offender was contacted at 6 and 12 months post enrollment in the SAVE program to assess overall level of functioning.

On an every other week basis, offenders completed the Services Accountability Management Index (SAMI). The SAMI is a 10-minute semi-structured interview administered by a trained research assistant. The SAMI reviews ten areas of functioning: medical, employment, drug and alcohol, legal, family and peer relationships, mental health, spiritual, and an "other" category. The purpose of the SAMI was to: (1) assess the type of problems offenders experienced during the preceding two week period; (2) determine the severity of the problem and assess the offender's self identified need for

additional treatment services; (3) record the number of times that the offender received a unique treatment service for the need; and (4) rate the overall level of satisfaction of the services to help meet the offender's need.

Overall 19 (95%) offenders completed phase one, 14 (70%) completed phase 2, 11 (55%) completed phase 3; and 8 (40%) completed phase 4. These rates of phase and program completion are slightly higher than those of the overall cohort analysis. Reasons for non completion included were: discharged due to drug use (N=7); returned to prison for being delinquent (N=3); charged with a new criminal violation (N=1); and dropped out of the study (N=1).

Services received – Table 3 identifies the types of services received as reported by offenders during phase 1 (90 days of residential treatment). All 19 offenders completed phase 1 and participated in the bi-weekly interviews. The total number of offenders who experienced a problem in any of the assessment areas was identified. Additionally the average number and range of services provided (either group or individual) were reported.

An examination on the type, and number of services received by offenders found that the most common service provided during the inpatient stay was drug/alcohol services. On average offenders received 263 "units" of drug and alcohol service during the 90-day in-patient treatment stay. This information corresponds with the level of service reported by the treatment program. All offenders who reported a drug/alcohol problem received services as well as the two offenders who did not believe that they needed drug/alcohol intervention. The number of offenders who reported receiving other ancillary services was quite low. For example, of the 12 offenders who indicated that they had experienced employment problems such as lack of skills, and employment readiness, only 4 offenders received any services. Previous studies have demonstrated that improved patient outcomes across multiple domains of need are a function of matching services to meet patient needs. There is good scientific evidence to suggest that high "doses" of drug/alcohol counseling have no additional therapeutic effect as compared to a moderate number of services (McLellan, 1995), but a greater diversity of services appears to

improve functioning. Moreover, there appears to be a ceiling effect on the effectiveness of high doses of drug and alcohol counseling.

During interviews with offenders, there was concern expressed that certain services were not available. For example, one offender reported a toothache that he did not receive medical attention despite several requests. While there are limitations (e.g. medical insurance coverage and contractual issues) to the extent and nature of services that can be provided, there did not appear to be an adequate system or structure in place to assess offender needs and offender services.

Table 3: Services Received During Phase 1 (N=19)

Type of Service	Number who Experienced a Problem	Mean number of services received*	Service Range
Medical services	12	1.2	0 - 5
Employment	12	0.5	0 - 8
Drug/Alcohol	17	263	90-427
Legal	8	0	0
Family and Peer	10	2	0-9
Mental Health	10	2.6	0-22
Spiritual	8	2.5	0-27
Other	12	0.5	0-10

*Mean number of services is based on those offenders who reported a problem.

Interestingly, some offenders who reported no problems during the inpatient phase of treatment reported receiving services and offenders who reported significant problems received no services. All mental health services were reported to be delivered by therapists in group counseling and no mental health services were reported to be delivered by trained psychologists or psychiatrists. Employment services consisted of life skills training delivered in a group setting. Family services were delivered in group formats and only one offender reported family counseling with family present.

Satisfaction with services – Offenders were asked to rate the satisfaction level of the services received. The ratings ranged from 0=not at all; 1-slightly; 2-moderately; 3-considerably; and 4-extremely. Only those offenders who received services in the specific targeted area rated the service. As can be received below, the majority of offenders were satisfied with the quality of services received. The majority of offenders who received medical, employment, drug/alcohol, spiritual, and other services reported that they were considerably to extremely satisfied with the services received. One area of concern should be highlighted. Of the four offenders who received family services, all offenders rated the service as "not at all helpful". It is important to note that satisfaction of services is a broad rating and does not represent the effectiveness of services.

Table 4: Satisfaction of Services

	Number that Received Service	Average rating
Medical services	8	3.6
Employment	2	4.0
Drug/Alcohol	20	3.3
Legal	0	n/a
Family/Peer	4	0
Mental Health	4	2.0
Spiritual	6	3.3
Other	2	3.0

Tables 5, 6, and 7 illustrate the types of services received as a function of offenders who reported specific problems for phases 2, 3, and 4 of the SAVE program. As can be seen during the second phase of SAVE (Table 5) more ancillary services were provided. This would be expected since the transition from phase 1 to phase 2 of SAVE required offenders to go from an in-patient residential treatment facility to an outpatient treatment facility. It is also important to note that 5 of the 19 offenders dropped out during phase 2 and were returned to prison. Clearly the most common service provided was counseling for drug/alcohol problems. On average offenders received 146 units of counseling during

the 90-day phase 2 program. There appears to be slightly more ancillary services provided during phase 2 of SAVE compared to phase 1. Offenders reported receiving approximately 5 units of mental health counseling and 3 units of family counseling over the 90 day period of phase 2. Few employment services were provided, even though employment problems were cited as the top issue for which treatment services were desired. Again the number and type of services reported being received by offenders corresponds to the number and frequency of services described by the program during this phase.

Correspondence of Phase 2 services reported received by offenders with patient records

We compared the treatment records of ten patients from the Riverside program with the self-report of offenders and found that the offenders self-reported more drug and alcohol services and more ancillary services than were documented in the patient records. This serves as a type of concurrent validation that the self-reported data on services received by the offenders matches what counselors provided during the different phases of treatment at the Riverside facility.

Table 5: Services Received During Phase 2 (N=14)

Type of Service	Experienced a Problem	Average number of services received	Range
Medical services	11	0.3	0 - 2
Employment	12	0.8	0 - 5
Drug/Alcohol	11	146	8-273
Legal	8	5.0	0-22
Family and Peer	8	3.1	0-16
Mental Health	10	5.2	0-24
Spiritual	8	2.5	0-16
Other	9	1.6	0-8

During Phase 3 (Table 6), a total of 10 offenders were still in treatment and able to describe the type and amount of services received. Again the most common service received was drug and alcohol group counseling and few offenders received ancillary services despite a high reported need for additional counseling and intervention. A total of 8/10 offenders reported a need for employment services and none of these offenders reporting receiving any employment counseling. Similarly 6 of the 10 offenders identified a need for family services an no offenders received family counseling during Phase 3.

Table 6: Services Received During Phase 3 (N=10)

Type of Service	Experienced a Problem	Average number of services received	Range
Medical services	9	1.6	0 - 8
Employment	8	0	0
Drug/Alcohol	10	88	34-117
Legal	4	0	0
Family and Peer	6	0	0
Mental Health	8	2.8	0-16
Spiritual	6	1.8	0-10
Other	7	0	0

During phase 4, the final component of the SAVE program, 8 offenders reached this stage. All offenders reported a need for drug/alcohol counseling and all offenders received counseling. On average offenders received 112 counseling sessions over the 90 day counseling period. The range of units of drug and alcohol counseling varied from a low of 39 sessions to a high of 238 sessions. The amount of drug and alcohol services exceeds the planned number of services for phase 4. Ideally one group and one individual counseling session would be provided during this stage per week, or 28 sessions over a 14 week period. The lack of ancillary services (employment, mental

health, family, etc.) is concerning because the majority of offenders reported that they experienced problems of functioning in these specific domains.

Table 7: Services Received During Phase 4 (N=8)

Type of Service	Experienced a Problem	Average number of services received	Range
Medical services	8	1.0	0 - 8
Employment	6	0.5	0 - 2
Drug/Alcohol	8	112	39-238
Legal	7	0	0
Family and Peer	8	0	0
Mental Health	8	.1	0-1
Spiritual	8	.3	0-3
Other	7	0	0

As can be seen from the services received data (Tables 5, 6, 7), during the outpatient phases of treatment, few services were provided other than drug/alcohol group counseling. Virtually no employment services or family services were provided despite significant reported need by offenders. Several conclusions could be drawn from these data. First, it appears that the treatment services were not individualized to meet the needs of the offender, rather general group counseling services that focused on drug/alcohol recovery served as the predominant manner of service delivery. It is important to note that the contract between the DOC and the substance abuse treatment programs did not stipulate that ancillary services would be provided or reimbursed based on a service delivery formula.

Considering the overall results of the SAVE program, it appears that offenders need more services to meet their overall functioning than drug and alcohol counseling. Despite the high intensity of drug and alcohol services provided, offenders continued to

use illicit substances. Possibly services offered to meet the self-reported unique needs of the offender could help to increase retention in treatment and effective reintegration of the offender to his/her community.

Focus Groups

Three focus groups were conducted for the purpose of obtaining qualitative data describing the treatment services provided to offenders in the SAVE Program and to understand from the participant's perspective opportunities to improve the program. The three groups represented (1) Eagleville Staff; (2) Outpatient Staff at Riverside; and (3) Offenders in treatment

Focus Groups with Eagleville Staff

The focus groups were held at Eagleville Hospital the inpatient provider for Phase I of the SAVE Program, and at Riverside Care in Philadelphia, the largest outpatient treatment provider for Phases II, III, and IV of the program. Riverside Care is an affiliate of Eagleville Hospital.

The program directors at each facility were contacted to identify clinical staff to participate in the focus groups. The focus groups were scheduled at the convenience of the treatment providers. Each group was approximately 1 ½ hours in length.

Twenty-one questions were developed prior to the focus groups by the evaluation team. The questions focused on treatment content, the clinical process, and the evolution of the SAVE program since its inception. The focus groups were conducted by two research associates familiar with substance abuse clinical service administration. One research associate asked the questions while the second clarified questions and probed for additional responses. The presence of two interviewers allowed for independent documentation of responses. The groups were facilitated so that each participant was given the opportunity to respond to each question.

Upon completion of the focus groups, each researcher independently coded the responses. Following collection of the data, a series of interpretation meetings were held to review responses and conduct a content analysis of the common themes from the data.

This process allowed for clarification and comparison of responses and provided an opportunity to increase inter-rater reliability. Finally a third, independent person (Dr. Zanis) reviewed materials and analyzed content. Discrepancy analyses were undertaken to determine different interpretations. The results of the final analyses are below.

Eagleville Staff

Two focus groups were conducted with Eagleville Staff. The first focus group involved clinical staff (N=11) who provided direct therapeutic services to SAVE offenders in the first Phase of SAVE. No management staff members were present so that clinical staff could speak openly about the services delivered. The staff was represented by six Master's and four Bachelor's level clinicians and one with a high school degree. Of the eleven staff members present, three were Certified Addictions Counselors. The average length of employment at Eagleville Hospital was 4.8 years. Years of experience in the field of addictions averaged 10 years.

The second focus group represented 10 staff members from the Riverside Program. The staff had various educational credentials including high school degrees (N=2); associates degrees (N=4); bachelors degree (N=2); and masters degrees (N=2). The average length of service at Riverside was 1.5 years. Years of overall experience in the field of addictions averaged 6 years.

Theoretical Approach to Treatment – Overall there was no single theoretical approach to the delivery of treatment services. Staff members reported utilizing the following approaches to counseling: cognitive behavioral and cognitive restructuring, reality therapy, behavioral conditioning, 12-step facilitation, and social restructuring. This lack of common strategies to provide treatment services does not provide a consistent framework for offenders to learn and apply techniques and approaches to manage daily functioning and is determined as a weakness in the overall SAVE program.

Relationship with Parole Officers – There were mixed impressions on the quality of the relationship with parole officers that varied by counselor. In general treatment staff were pleased with the involvement of parole officers in the monitoring of the offender.

Relationship Between Eagleville and Riverside Counseling Staff – Overall there appeared to be little communication between counselors across the inpatient and outpatient components of SAVE. This issue was raised by staff because they felt it reduced the continuity of care available to the offender who transitioned from Phase 1 to Phase 2. Greater emphasis should be placed on developing a system that permits communication of counselors during transition of the SAVE treatment phases. It is suggested that the use of a discharge planning conference that involved the identification of the new counselor could be instituted.

Increase the Mix of Services – All staff agreed that the type of services provided should include more family and employment counseling services. Staff also believed that "Life Skills" to help the offender re-integrate into the community needed greater emphasis in the treatment process. Staff also noted that there were discrepancies in how SAVE was administered compared to other program such as FIR, which caused some misunderstandings in how services were delivered at the Eagleville campus.

SAVE Administrative Meetings – Staff noted that they did not have a complete perspective on the implementation of the SAVE program because they were not updated on the project. Staff had a number of possible suggestions to improve the program, but felt that they did not have adequate opportunity to offer suggestions.

Offender Focus Groups

Approximately 15 offenders participated in one of two focus groups. Focus groups were administered by trained interviews and were designed to understand offender needs and how they could be addressed. Several themes emerged in these focus groups.

Housing after discharge from Eagleville

Offenders reported that they encountered barriers with housing issues following discharge from Phase 1. Some offenders had no permanent home environment to return and were placed in halfway houses. These houses were described by offenders as not conducive to support recovery because drugs were available in the houses and that the program staff did little to enforce programmatic rules. Other offenders were discharged to family home environments that did not have appropriate supportive family networks to

help the offender remain abstinent. In some cases other family members had addictive disorders or were currently involved in illegal behaviors. Few family therapy or counseling services were in place to help reintegrate the offender into the home setting. Offenders reported significant family stress for which the majority of offenders did not receive family counseling in subsequent stages.

Employment and Vocational Training

The majority of offenders expressed dissatisfaction with being unable to work following discharge from phase 1. Offenders reported that they felt pressure from family members to "bring in money" and to contribute to the household good. Few offenders reported receiving vocational or employment services.

Redundancy of services

All offenders interviewed noted that the drug and alcohol counseling services were redundant from Phase 1 through Phase 4 of SAVE. On average an offender who completed all four phases of SAVE received 609 units of drug and alcohol counseling. Offenders reported that groups focused on the problems of the participants with the participants guiding the group through "sharing". Offenders reported that they did not receive therapy or a framework on how to resolve problems, rather they learned from the experiences of others.

Group Issues

Offenders reported that they valued their attendance and participation in groups. They reported a therapeutic gain from participation. At the same time that also offered some comments on problems they experienced. All offenders believed groups were too large. Other problems experienced included the lack of trust that offenders had in the groups. Offenders reported that when new members came into the group, it seemed as if the group started over each time. They reported little continuity across groups. Offenders believed that the groups were more discussion about issues than developing skills to apply to help make change. Offenders wanted more individual therapy. They found individual counseling to be superior to group counseling. There were too many therapists

involved – hard to establish rapport. Also, the drug/alcohol counseling services were generic and did not focus on specific individual needs. For example, heroin users received the exact same type of counseling as cocaine users. There were no attempts to provide pharmaceutical interventions as an adjunct to psychosocial counseling.

Role of Parole in Treatment

The majority of the offenders reported a limited relationship with the parole officer. The typical interaction involved a monitoring check each week conducted at the outpatient clinic to determine if the offender was still enrolled in the program. The meeting was brief, lasting about 10 minutes during which time a urine sample was collected. There were no meetings among the offender, parole officer, and counseling staff unless the offender was to be revoked.

Coordination of Inpatient with Outpatient services

While offenders reported that they had positive, favorable experiences in the Eagleville program and the Riverside and Chester Crozier outpatient programs. There was little continuity in working on issues from inpatient to outpatient. For example, some offenders reported that the videos seen in the outpatient phase were the identical videos in the inpatient phase.

Treatment Schedule

Offenders agreed that the amount of treatment in the outpatient phases of SAVE was too much. They would have preferred to have some counseling and to spend more time on obtaining employment and moving ahead with life rather than rehashing problems. Also, the length of groups was too long. A three hour group appeared to be counterproductive. For example, it was reported that some group members fell asleep, while others talked about too many unimportant issues. Offenders felt that a 1.5 hour group could be more productive and would allow the offender the opportunity to work on other issues such as unemployment, family, etc.

STAGE 3

The third stage of the SAVE evaluation was designed to measure the criminal justice and substance abuse outcomes of offenders enrolled in the SAVE project with a comparison group of offenders who were eligible for SAVE but did not receive SAVE services.

Participants

SAVE Condition - The SAVE group consisted of all offenders enrolled in the SAVE program from January 1 to June 30, 1999 (N=65). The clinical admission charts from Eagleville Hospital and subsequent parole and treatment administrative records of these offenders were reviewed. Overall 21/65 (32%) of the offenders in the SAVE condition completed the four phases of the SAVE program.

Comparison Condition - The Comparison Condition was selected by reviewing administrative records from the PBPP. The following eligibility criteria were used to select the comparison group. (1) offenders were required to have a parole violation occur between January 1 and June 30, 1999. (2) the reason for the parole violation must have been a positive drug urinalysis. (3) the offender must have resided in the same 6-county geographical region as the SAVE participants: Philadelphia, Chester, Delaware, Montgomery, Berks, and Bucks Counties. (4) the number of past criminal convictions was controlled using an inclusion range of 2 to 9 past convictions. (5) the type of conviction was screened (e.g., excluding sexual offenses) to insure comparability with the SAVE cohort. Overall a total of 81 offenders met the inclusion criteria for the comparison group. From this group of 81, a total of 65 offenders were randomly selected as the comparison condition.

Design

Consent – Offenders in both the SAVE and Comparison conditions were mailed a consent form inviting participation in the follow-up assessment. A total of 22 offenders in the comparison condition and 27 offenders in the SAVE condition provided voluntary consent to participate in the interviews. The remaining offenders either declined to

participate (N=12) or could not be reached due to incarceration or invalid contact information. Administrative records were reviewed for all 65 offenders in the SAVE condition and 61/65 offenders in the comparison condition. Four comparison condition cases were deleted because their criminal history records were incomplete for analysis.

Administrative outcomes - Three types of administrative data sets were reviewed. Criminal history records were secured from the PCCD for offenders in both conditions. Technical parole violations and new charges and convictions were recorded (please see stage 1 for a description on analysis of these records). Additionally, DOC "move" sheets were analyzed to determine current and past incarceration histories. Finally, the PBPP provided data from their urine screens results database to determine if any parole urine screens were positive for illicit drug use.

Interviews – Follow-up interviews were conducted with the 22 offenders in the comparison condition and the 27 offenders in the SAVE condition. All offenders were contacted to participate in a 30-month follow-up interview conducted between November 2001 and February 2002 depending upon the anniversary discharge date of the offender. Of the 27 offenders in the SAVE condition, 23 were incarcerated and of the 22 offenders in the comparison condition, 16 were incarcerated. Unfortunately, due to the majority of offenders in confinement, the validity of the data obtained from the Addiction Severity Index (ASI) was substantially skewed and could not be used to valid draw conclusions. For example, questions on drug use were not considered accurate since offenders did not have access to drugs in prison as they would in the community. Therefore many of the behavioral questions were unable to be answered accurately by offenders. However, qualitative information was obtained from participants about the impact of the SAVE program. Again caution needs to be considered in the interpretation of this information.

Results of Administrative Data Set Analysis– A negative events analysis was conducted to determine if any of the following had occurred: (1) any technical parole violation, (2) any new charge, and (3) any positive drug screen. As can be seen in Table 8, 59/65 (90.7%) of the offenders in the SAVE condition had achieved a negative event during the

30 month post revocation assessment point compared to 47/61 (77%) of the offenders in the comparison condition. A chi-square statistic calculated by condition (comparison vs. SAVE) and any negative event (yes vs. no) resulted in a statistically significant finding (chi=square = 3.89, df=1, $p<.05$). Indicating that offenders who went to the SAVE program had a higher proportion of negative events. It is important to interpret this analysis with extreme caution for the following reasons. First, the number of drug screens varied between offenders by condition. Offenders in the SAVE condition received approximately 8 additional urine screens than the comparison condition. Also the categorization of "new" charges as a negative event remains controversial and should not be interpreted as a conviction. Similarly, the quality of the criminal history data was suspect since few convictions were recorded. Please note, this type of negative event analysis does conform to current methodological strategies supported by the National Institute on Justice (2002).

Among the SAVE participants, 42/65 (64.6%) had a technical parole violation, 30/65 (46.1%) had a new charge, and 23/65 (35.3%) had a positive drug screen. As previously noted only 21/65 (32.2%) offenders in SAVE completed the save program. Of the offenders who completed SAVE, only 6/21 (28.5%) had a negative event compared to 100% who did not complete the SAVE program. Within 18 months of completion of the SAVE program, 15/21 (71.5%) offenders had been charged with a new crime or had violated the conditions of parole. In the comparison condition 7/61 (11.5%) who were incarcerated were never released from prison during the 30-month assessment period. These offenders were categorized as negative outcomes. A total of 17/54 (31.4%) offenders had a technical parole violation; 22/54 (40.7%) had a new charge; and 24/51 (44.4%) had a positive urine screen.

Table 8: Negative events 30 months post initial parole revocation by condition

Condition	TPV	New Charge	Drug screen Positive	Any Negative Event
SAVE (N=65)	42 (64.4%)	30 (46.1%)	23 (35.3%)	59 (90.7%)
Comparison (N=54*)	17(31.4%)	22 (40.7%)	24 (44.4%)	47/61 (77%)

*A total of 54/61 offenders were paroled. Seven offenders in the comparison condition were never paroled and these subjects were classified as negative events.

As can be seen in Table 8, 44.4% of the offenders in the comparison condition had a positive drug screen compared to 35.3% in the SAVE condition. As previously noted, SAVE offenders received on average 8 additional urine screens over the history of there parole, potentially increasing the risk of a positive drug screen. Only 31.4% of the offenders in the comparison condition had a TPV compared to 64.4% of the SAVE offenders. This proportion was statistically significant (chi-square = 9.21, df=1, $p<.001$). It is important to note that all offenders in the SAVE condition who had a positive urine screen also had a technical parole violation, whereas only 12 (50%) of the offenders in the comparison condition had a technical parole violation.

Although offenders in the SAVE condition had an overall higher negative event rate than offenders who were returned to prison, there was no statistically significant difference in the level of new crime committed between conditions. Offenders paroled to SAVE had a much higher rate of TPV than offenders paroled from prison. Nearly half of the offenders (N=20) paroled from prison were released after having served their maximum sentence and were not placed on parole. When factoring in the proportion of offenders in the comparison condition who were placed on parole, 17/34 (50%) had a technical parole violation. This difference was still statistically significant when compared against the proportion of SAVE offenders who had a subsequent TPV (chi-

square = 3.43, df=1, p<.05). It should also be noted that there was no control for the level of parole supervision offered to the comparison condition. Offenders in the SAVE condition had weekly contact with parole officers and these parole officers had regular access to attendance records from the substance abuse treatment programs. In many cases, parole officers had up to 3 supervision checks per week with offenders in the SAVE program. This level of increased or intensive parole supervision may have increased the likelihood that the offender was identified as having violated a parole stipulation.

Similarly, the number of parole contacts between the parolee and parole officer in the comparison condition was believed to be lower because the number of urine screens obtained was substantially lower. If this is the case, the proportion of positive urine screen may have been higher in the comparison condition. Controlling for the amount of time and number of parole contacts/urine screens are an important area for future research.

Qualitative Analysis - Offenders who were enrolled in SAVE were asked to comment about the strengths of the program and areas for program improvement. Please note, although these comments are retrospective covering a period of up to 30 months, they do offer insight about how the program was able to impact the offender's lifestyle especially over a longer time period. Comments were categorized by Dr. Zanis to reflect general opinion of the offenders.

Areas for Improvement: The majority of the residents noted that SAVE (particularly the inpatient phase) provided offenders with the necessary tools for recovery. One halfway house was described by five offenders as a contributing factor leading to relapse. Drugs were commonly available, especially cocaine. There was open drug dealing, residents had weapons such as guns, and the environment was hostile and intimidating. One resident reportedly absconded from the halfway house in an effort to regain "self-preservation" because of the negative environment.

Subjects reported that the SAVE program focused too much on addiction and not enough on helping to provide skills for a successful lifestyle. Services such as individual

counseling to help the offender focus on self improvement would be more helpful than drug and alcohol educational sessions. Offenders want more personal guidance and reported lack of a therapeutic relationship with counseling staff. One offender stated, “It was as if they were there to tell us what to do rather than to help us understand ourselves.”

Stage 4

Cost Analysis of the SAVE Program

What are the potential cost savings of the SAVE program? Although the present evaluation was not designed to undertake a cost benefit or cost effectiveness analysis of the SAVE program, it is important that cost issues are explored and included in the overall interpretation of the results of the SAVE program. Three types of cost data were compiled: (1) the cost of the substance abuse treatment services for the SAVE program; (2) the cost of parole services; and (3) the costs of imprisonment.

One of the primary aims of the project was to divert non-violent offenders from prison and to provide appropriate rehabilitative and community safety services to assist reintegrating the offender back into the community. According to the Pennsylvania Department of Corrections, the average cost per day per inmate across institutions during FY 00/01 was $74.30 for all institutions and $81.06 for the Chester Institution designed to provide alcohol and drug services for offenders. The average cost of these two institution rates ($77.68) was selected since offenders would have been assigned to both prisons. Therefore, on an annual basis, the costs of incarceration for an offender are estimated to be $28,353.00.

The costs for substance abuse treatment in the SAVE program were extracted from the contracts between the Pennsylvania Department of Corrections and Eagleville Hospital and the Riverside Inc. program. The rates for substance abuse treatment vary by the different phases in SAVE. For phase 1, the cost per day is $109 for the 90-day inpatient stay at Eagleville hospital. For phase 2, the cost is $75 per intensive outpatient group per day per offender. The costs for phases 3 and phases 4 are $45 per offender per group per day.

The Pennsylvania Board of Probation and Parole estimated that the annual cost per paroled case would be approximately $3,032 per offender in the SAVE program per year or approximately $8.31 per day.

To calculate the cost of the SAVE program across the sample of 380 offenders in the present study, a formula was developed that accounted for the varying costs of substance abuse treatment, parole, and incarceration and re-incarceration over a one year period. As can be seen in Table 9, the average savings per offender enrolled in SAVE compared to an offender incarcerated over a one year period was $3,185 per offender. As a diversion program, the SAVE program appears to have a general net cost benefit. However, it is important to note that the formula is an estimate of costs based on information derived from the Department of Corrections, Pennsylvania Board of Probation and Parole, and Eagleville Hospital. No independent verification was performed to validate these costs. Additionally, other potential factors were not included that would permit an actual cost-effectiveness or cost-benefit analysis. For example, the costs of crime committed by parolees over the one year period were not calculated, nor were the costs for subsequent judiciary procedures for processing new convictions. Similarly the benefits of employment secured by parolees and other social and economic impact issues could not be derived.

Table 9: Projected Comparative Costs for SAVE vs. Incarceration

SAVE Costs

	RATE	Units	Cost
Phase 1			
328 completers	Treatment $109day	90 days =	$3,217,680
	Parole $8.31 day	90 days =	$ 245,311
52 non-completers	Treatment $109	54 days =	$ 306,072
	Parole $8.31	54 days =	$ 23,334
	Prison $77.68 day	311 days =	$1,256,241
Phase 2			
234 completers	Treatment $300 week	12.8 weeks =	$ 898,560
	Parole $8.31	90 days =	$ 175,009
94 non-completers	Treatment $300 week	6.4 weeks =	$ 180,,480
	Parole $8.31	45 days =	$ 35,151
	Prison $77.68 day	225 days =	$1,642,932
Phase 3			
162 completers	Treatment $90 week	12.8 weeks =	$ 186,624
	Parole $8.31	90 days =	$ 121,160
72 noncompleters	Treatment $90 week	6.4 weeks =	$ 41,472
	Parole $8.31	45 days =	$ 26,942
	Prison $77.68 day	135 days =	$ 755,050
Phase 4			
123 completers	Treatment $45 week	12.8 weeks =	$ 70,848
	Parole $8.31	90 days =	$ 91,992
39 non-completers	Treatment $45 week	6.4 weeks =	$ 11,232
	Parole $8.31	45 days =	$ 14,584
	Prison $77.68 day	45 days =	$ 136,328
Warranted Services			
83 participants	Treatment $51 day (adjusted)*	30 days =	$ 126,990
	Total Annualized Cost of SAVE Program		$ 9,563,992

Comparative Annualized Imprisonment Costs

380 offenders	Prison $77.68 day	365 days	$10,774,216
		Difference	$ 1,210,224
		Per Offender Difference	$ 3,185

* $109 daily inpatient rate minus average outpatient daily rate ($58) = $51 net.

(N=380)

Discussion

The purpose of the evaluation was to examine both the processes and the outcomes of the SAVE program and to provide recommendations about the future direction of the SAVE program.

Limitations of the Evaluation – Prior to drawing conclusions and recommendations from the data, it is important to point out the limitations experienced in the current evaluation. Although the evaluation sought to obtain as many valid sources of data as possible regarding offender outcomes, no single source of data was definitive, and varied sources of existing records were analyzed to draw conclusions. We did not have the benefit of a prospective, experimental design but used quasi-experimental designs to analyze data and draw conclusions. As previously noted, some data sources such as criminal history records were incomplete. No attempts were made to speculate on outcomes, in fact all data was reported as is, with no statistical adjustments. Finally, reports from offenders should only be generalized to those offenders interviewed and not all offenders who have participated in SAVE.

The SAVE program was designed to address 3 general goals. Below is a discussion on the success of the program to meet these goals.

Goal 1: To reduce the prison population by diverting substance dependent technical parole violators from a potential return to prison to a community-based residential substance abuse treatment program. In turn, the SAVE program would reduce prison overcrowding, enabling prisons to operate more safely and effectively. Discussion: Clearly, all technical parole violators enrolled in SAVE were diverted from prison for short periods of time, and 132 (32%) of those who enrolled in SAVE remained out of prison for at least one year. This reduction in prison overcrowding may also have been a contributing factor to lower rates of both inmate on inmate assaults and inmate on staff assaults since there were significant reductions in both types of assaults between the years 1997 to 2001 (DOC, 2002).

Goal 2: To provide substance dependent offenders who violated parole an opportunity to receive appropriate treatment for addiction. Discussion: Based on the evaluation, the SAVE program provided substance abuse counseling services to meet some of the substance abuse counseling needs of the offender. However, the program did not provide other important services such as family counseling, employment services, housing services, and other services to meet the needs of the offender. Greater emphasis should be placed on expanding services to meet offender vocational and community reintegration needs.

Goal 3: To provide parole officers an opportunity to foster partnerships and alliances within the community and refocus priorities given available resources toward offender reintegration. Discussion: Parole officers were able to forge productive partnerships with substance abuse treatment staff and agencies. No additional information on the quality or capacity of these relationships was available.

In addition to the 3 general goals of the SAVE program, the SAVE evaluation team was asked to answer seven basic questions proposed by the PCCD.

(1) What are the characteristics of the offenders who participated in Project SAVE?
The offenders enrolled in the SAVE program were all drug dependent individuals with moderate histories of criminal involvement throughout their lifetime. On average offenders had 4 previous convictions and were incarcerated for an average of 94 months. Additionally offenders in the SAVE program had extensive substance abuse histories, including an average of 5 previous treatment episodes for substance abuse. Please note, the severity of both substance abuse and legal histories of the SAVE participates is greater than the average offender incarcerated in Pennsylvania and of offenders in the National Institute on Justice report of recidivism rates for state offenders (2002). Please see appendix 1 for a complete description of characteristics based on the Addiction Severity Index and criminal justice records.

(2) What is the relationship among the ASI factors and demographic characteristics and program completion? Older offenders were most likely to complete the SAVE program. Offenders who had used heroin in the 30 days prior to enrollment in the SAVE program and those with the longest periods of incarceration were also significantly less likely to complete the program. Potentially issues of readjustment back into the community may have contributed to both criminal recidivism and substance use since offenders who had longest periods of incarceration were most likely to be recidivists. Additionally, offenders who did not complete the first phase of the SAVE program were more likely to have significant family dysfunction, were younger in age, and had shorter periods of abstinence from substance use. Thus both demographic factors and ASI factors were able to predict treatment completion. Please note, there are other factors that the ASI does not assess that could impact program completion. For example, Lang and Belenko (2000) found that offenders who had more felony drug convictions, and high drug dealing income were less likely to complete treatment. Also offenders who had less need for employment counseling were more likely to complete treatment.

(3) What factors predicted post-program outcomes? The most predictive factor for positive post program outcome was completion of all four phases of SAVE. Additionally among those SAVE offenders who completed treatment, those who had secured employment appeared to have the most improved functioning. In this respect, employment training or vocational services may be an important component to add to treatment services as an opportunity to improve offender outcomes. Please note, due to the small sample size of offenders interviewed at the 30-month follow-up period (N=22), we were unable to analyze data quantitatively and based our interpretation on the qualitative responses from the offenders.

(4) What services are provided in each of the four stages of the SAVE program? As has been described in earlier tables (see tables 3, 4, 5, and 6), services in the four

phases were mostly unidimensional (drug and alcohol counseling only) and these counseling sessions were often redundant across all four phases of SAVE. Only 8/380 (2%) offenders reported receiving any services in the community other than those provided by counselors in the SAVE program. Based on interviews with counseling staff, most counselors did not refer offenders to outside professional health or social service agencies to address other offender needs.

(5) What is the utility of the ASI as an assessment tool? Overall the ASI is both a good screening tool and clinical assessment tool to recognize and measure the needs of offenders enrolled in the SAVE program. It is suggested that the ASI should be modified to address the needs of the SAVE program. For example, issues such as drug dealing, housing, violence, and post parole reintegration issues should be assessed in more detail. A critical issue for consideration is not the ASI assessment itself, but how the information derived from the ASI is used to meet the needs of the treatment program and the criminal justice systems. In the present evaluation, the ASI was not used as a screening instrument for the study since it was completed after the offender was accepted into the SAVE program. It is recommended that the parole officer or the clinical treatment team use a corresponding assessment instrument that monitors offender progress and issues during different stages of the treatment and parole process, especially when transitioning from one phase to a second phase. Potentially an independent case management system could offer a type of checks and balance approach of offender behavior and needs by which corresponding services are provided. For example, an offender who expressed family problems would be referred to an agency trained to deliver family services. Efforts should be made to develop an individualized treatment approach in which appropriate parole sanctions are used in a productive manner to deliver services and maintain public safety.

(6) What are the short-term and long-term impacts of the SAVE program on participants' re-offense rates and on their drug and alcohol abuse? Does the

program have other positive or negative impacts on offenders and on public safety? Overall nearly half of the offenders who were paroled to the SAVE program had a positive urine screen while enrolled in treatment. Given that all offenders were in a controlled environment for a 3-month inpatient stay during which there was restricted access to substances, the rate of substance use was higher than expected. Of the 328 offenders who completed phase 1 of SAVE and were released into the community, almost 60% had tested positive for an illicit drug. Considering that all offenders clearly understood that they would be drug tested on a random basis, once per week, and any violation could be a return to jail, the rates of drug usage were high. It should be noted that some offenders believed that the "warranted service" program was a safety gap measure, providing an opportunity for drug use without severe consequence since they would not be returned to prison for their first drug use violation. Overall 45 (11%) offenders had committed a new crime during participation in the SAVE program. Of the 65 offenders tracked over a period of 30 months, 30/65 (46.1%) had committed a new crime. When compared to the 22/54 (40.1%) offenders in the comparison condition, there was no statistically significant difference between offenders in SAVE and those returned to prison over the three year period.

The present evaluation was not designed as a cost-benefit or cost-effective evaluation. Preliminary data suggests that the SAVE program is $3,100 less costly than incarceration over a one-year period and reduces prison overcrowding.

(7) What is the estimated impact of the SAVE program on the State prison and parole populations? The data available are not adequate to determine the overall impact of the SAVE program on the State prison and parole populations. However the data found that with 12 months of parole to SAVE, the majority (68%) of offenders and within 30 months of parole to SAVE, 90.7% of the offenders were returned to prison. Given that offenders who were paroled to SAVE were placed on intensive parole supervision services it would appear that the impact on parole officers increases in terms of the number of offenders supervised and those under

special or intensive supervision. One goal of the program was to divert drug dependent technical parole violators out of prison in an effort to reduce prison overcrowding. In the short-term this program certainly accomplished this objective, but the majority of offenders were returned to prison and nearly all were required to serve the remainder of their sentence.

Overall, 9.2% of offenders had not been charged with a new crime or a technical parole violation within 30 months following parole to the SAVE program. Additionally, the evaluation found that 32% of offenders referred to the SAVE program completed the 12-month substance abuse treatment program. The majority of the offenders were re-incarcerated because of a technical parole violation due to substance use. Thus, despite completion of a 3-month residential program, participation in outpatient drug and alcohol services, and external pressures to not use drugs with threat of re-incarceration for drug use, the majority of offenders continued to use illicit drugs. Despite the low rates of program completion, the offenders diverted to the SAVE program represent an offender population with substantial substance dependence and extensive criminal histories. Thus, the outcomes are favorable and suggest that nearly 10% of offenders who enroll in the SAVE program will complete parole, maintain abstinence from drug use while on parole, and not be arrested for new criminal involvement for a minimum of 30 months.

These findings suggest that the nature and extent of substance abuse treatment services and parole service should be changed to reflect the reintegration needs of offenders enrolled in the program. Based upon current information available from scientific journals and provided by offenders, and treatment staff it could be concluded that the drug and alcohol services were adequate to educate and make offenders aware of their drug and alcohol problems. However, there was little integration of other services such as case management, employment training, family counseling, and mental health services available to assist the offender to reintegrate back into the community. Considering that the offender had been incarcerated for an average of 94 months, these types of reintegration services would potentially be helpful. Further, factors such as problems with spouse and family were predictive of program non-completion suggesting

that these psychosocial stressors may have contributed to offender's inability to reconnect into the community.

Recommendations

Based on the data collected for this report, the following recommendations are offered for consideration. Overall, it is recommended that the SAVE program undergo a series of modifications to revise the SAVE program and an evaluation of these modifications should be undertaken to determine the impact of the modifications on program improvement.

Recommendations:

1. It is recommended that the SAVE program develop an administrative structure that monitors program implementation, tracks program outcomes, and institutes quality improvement protocols – During the course of the evaluation, it became apparent that there was an inadequate administrative structure of the SAVE program. Although the State Department of Corrections bore the majority of the financial costs by paying for treatment services, little oversight regarding program administration was provided. This lack of administrative structure to provide oversight and to engage in problem solving across various systems (parole, treatment, and community based resources) appears to be a weakness in the overall organizational health of the project. The current management philosophy appears to be a reactive approach. When a problem arises, different key persons come together to address the concern. What would be advantageous to the SAVE program would be the formation of an administrative structure that provides a system of checks and balances on the integrity of the program. Typical activities to be included in an administrative unit would include at minimum: (1) a monthly meeting of key persons to review the status of the project and address problems from a systematic perspective; (2) develop a monthly report that includes standard reports to track offender progress, reasons for discharge, parole status post treatment discharge, urine results, attendance, etc.; (3) identify a project director for the SAVE program that is accountable for the implementation of the program; (4) Develop a budget, goals, objectives, and overall project plan that is

reviewed and modified based on program monitoring. Contractually the DOC should develop reimbursement rates that specify the type of service provided. For example reimbursement for a group service does not provide sufficient reinforcement for the treatment provider to engage in innovative practices to address offender needs. It is also suggested that the program seek the opinion of offenders enrolled in the program to learn of their perspective, this type of consumer advisory position would strengthen the capacity of the program to address offender needs.

2. Modify the residential and outpatient phases of substance abuse treatment – The duration of the SAVE program of 1 year appears appropriate, however the type and amount of services would benefit from restructuring. There was tremendous redundancy in the type of services offered throughout the different phases of the program. There is ample scientific data to support that it is not the number of drug and alcohol sessions, but rather the match of services to meet the offender's needs that results in improved levels of functioning. It is suggested that the residential stage (Phase 1) should remain 12 weeks in duration. One component of Phase 1 should include a 4-week community reintegration program that includes activities geared to helping the offender: (1) reunite with family and peer supports; (2) secures appropriate housing; (3) initiates employment search and prepares offenders for competitive employment by developing soft job skills. The remaining 9 months of the outpatient SAVE services (Phases 2, 3, and 4) should be restructured to include an intensive outpatient program (one individual counseling session and two 1.5 hour group counseling sessions each week) for a period of 4 weeks followed by standard outpatient counseling (one individual counseling session and one 1.5 hour group counseling session each week) for 36 weeks. Please note that the intensive outpatient stage could be longer, but the determination for this should be based upon clinical need and not a standard mandate for all offenders. Importantly, in addition to the reduction in the amount of time in outpatient counseling, offenders should be assigned a case manager who would assist the offender in accessing community resources such as

employment training. The case manager should meet each week with the offender to review offender integration into the community and address issues such as employment, family reunification, etc. As noted above all group counseling sessions should be reduced in time to a maximum of 90 minutes. No group counseling session should exceed this limit.

3. Provide employment, family, and mental health services – It is recommended that a shift in the nature and extent of services provided in Phase 1 of SAVE include the following types of services: a vocational readiness and training program; weekend family program; and increased availability of mental health counseling and other ancillary services. There exists a variety of effective curriculums for use with offender populations and these are available from several sources. The Institute of Behavioral Research (Texas) has developed several models of therapy that have demonstrated efficacy for delivery of parenting services, employment readiness, etc. Employment services should be provided prior to discharge from phase 1 and throughout phases 2, 3, and 4. Eagleville Treatment staff and parole officers should encourage employment and support job acquisition. It is further recommended that the outpatient phases of treatment should be modified to enable offenders to work during standard business hours and expand treatment services during evening or weekend hours. Currently during phase 2, offenders are banned from working for 30 days. It is suggested that this ban is removed and permit offenders to engage in employment. Concurrently employment counseling should be provided to help offenders transition and include substance abuse treatment with their new work role. It is recommended that during Phase 1, staff should encourage transition from Phase 1 to Phase 2 by allowing offenders to search for and apply for employment positions while enrolled in phase 1.

4. Standardize screening process - The PBPP should develop a standard protocol for parole officers to screen offenders for SAVE in all TPV cases to determine eligibility. For example, all offenders who violate parole because of drug use should be screened for the SAVE program or other disposition program.

Documentation of reasons for discretionary exclusion and inclusion criteria should be identified and recorded. This information would be helpful to understand program effectiveness and procedural issues as to who receives SAVE and who is returned to prison. Additionally, when paroled SAVE participants test positive for drug use, there should be a data collection system that reports the disposition for the violation and documents why the disposition was imposed. Quantitative collection of this type of data would be useful in helping to understand possible trends in parole officer practice.

5. Case Management and Team Integration - Use of an independent case management system to monitor offender progress, assess need, and help integrate offender into community is suggested. The Case Management system should be separated from the substance abuse treatment system and parole. This type of system provides for an adequate type of checks/balance in helping offenders to make adequate change and develop resources. Although there are many models of case management to consider at minimum the services provided by the case manager would focus on helping the offender access community based resources to help the offender secure services such as: housing, child care, family services, employment, etc. Please see CSAT Treatment Improvement Protocol (TIP) #30 for a review of other diversion projects that have successfully implemented case management. Please note: The cost of developing a case management system would by offset by the reduction in the number and type of services provided during the outpatient phase of treatment. Thus, a cost-shift in resources is recommended from outpatient to case-management. It is also suggested that Inpatient and Outpatient treatment staff meet and engage in a team planning session when transitioning staff from Phase 1 to Phase 2. Individuals included in this transition should be the inpatient staff counselor, outpatient staff counselor, offender, parole officer and case manager. It is critical that this meeting occur to increase continuity of treatment services and develop clear expectations with the offender for the next phases of treatment.

6. Screen for personality disorders – Overall 11 variables were predictive of drop-out and 8 of these variables are characteristics of personality disorder: significant problems with mother during lifetime, significant problems with father during lifetime; significant problems with sexual partners during lifetime; the number of days of conflict with family members in the past 30 days; the number of days of conflict with others in the past 30 days; marital satisfaction, and the interviewers rating of family/social problems. Potentially screening out persons with severe personality disorders could improve the success rate of treatment. Consequently one of the common comments from offenders was that several participants had very negative views of treatment and often disrupted the quality of the treatment. An example of an appropriate personality inventory to consider is the HARE psychopathy checklist (1991).

References

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Appendices

Demographic Characteristics of SAVE Participants (N=380)

	N	%	Mean	SD
Gender				
Male	371	97.6%		
Female	9	2.4%		
Age			36.9	7.9
Race				
Caucasian	60	16.0%		
African American	273	72.6%		
Hispanic	43	11.4%		
Current Sentence Minimum			3.6	2.4
Current Sentence Maximum			9.7	6.2
Employment/Education				
Years of school completed			11.6	1.5
Have a Skill or Profession				
Yes	252	68.1%		
No	118	31.9%		
Longest full time job (months)			39	38
Substance Use				
Primary substance used				
Alcohol	77	20.8%		
Heroin	55	14.9%		
Cocaine	187	50.5%		
Marijuana	42	11.4%		
Other	9	3.3%		
Longest period of voluntary abstinence (months)			13	21
Number of times treated for alcohol problems			2.5	1.8
Number of times treated for drug problems			2.5	1.9

Demographic Characteristics of SAVE Participants (N=380)

	N	%	Mean	SD
Legal Status				
Mean number of convictions			3.8	3.9
Number of months incarcerated			94.3	58.3
Length of most recent incarceration			42.0	37.4
Reason for most recent incarceration				
Shoplifting	8	2.2%		
Parole violation	116	31.4%		
Drug Charge	94	25.5%		
Forgery	2	.5%		
Weapons Offense	2	.5%		
Burglary	35	9.5%		
Robbery	47	12.7%		
Assault	38	10.3%		
Arson	2	.5%		
Homicide	17	4.6%		
Prostitution	3	.8%		
Other	5	1.4%		
Family Social Factors				
Marital Status				
Married	79	21.4%		
Widowed	13	3.5%		
Separated	50	13.6%		
Divorced	26	7.0%		
Single	201	54.5%		
Victim of Physical Abuse Lifetime	144	38.9%		
Victim of Sexual Abuse Lifetime	27	7.3%		
Victim of Emotional Abuse Lifetime	176	47.8%		
Mental Health Factors				
Lifetime Depression	358	96.8%		
Anxiety	351	94.9%		
Hallucinations	17	4.6%		
Controlling violent behavior	133	35.9%		
Attempted suicide	17	4.6%		
Prescribed a medication	32	8.4%		
Reasons for Discharge				
Declared Delinquent	83	21.8%		
Broke Program Rules	16	4.2%		
Drug Use	102	26.8%		
New Criminal Charge	45	11.8%		
Completed Treatment	123	32.4%		
Other	11	2.7%		

Addiction Severity Index

Addiction Severity Index 5th Edition

Clinical/Training Version

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Deni Carise, Ph.D.
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Remember: This is an interview, not a test

≈Item numbers circled are to be asked at follow-up.≈
≈Items with an asterisk * are cumulative and should be rephrased at follow-up.≈

INTRODUCING THE ASI: Introduce and explain the seven potential problem areas: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychiatric. All clients receive this same standard interview. All information gathered is confidential; explain what that means in your facility; who has access to the information and the process for the release of information.

There are two time periods we will discuss:

1. The past 30 days
2. Lifetime

Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.

The scale is:
0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

Inform the client that he/she has the right to refuse to answer any question. If the client is uncomfortable or feels it is too personal or painful to give an answer, instruct the client not to answer. Explain the benefits and advantages of answering as many questions as possible in terms of developing a comprehensive and effective treatment plan to help them.

Please try not give inaccurate information!

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.
2. Make plenty of Comments (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions of his/her problems).
3. X = Question not answered.
   N = Question not applicable.
4. Terminate interview if client misrepresents two or more sections.
5. When noting comments, please write the question number.
6. Tutorial/clarification notes are preceded with "•".

HALF TIME RULE: If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

CONFIDENCE RATINGS:
⇒ Last two items in each section.
⇒ Do not over-interpret.
⇒ Denial does not warrant misrepresentation.
⇒ Misrepresentation = overt contradiction in information.

Probe, cross-check and make plenty of comments!

HOLLINGSHEAD CATEGORIES:

1. Higher execs, major professionals, owners of large businesses.
2. Business managers if medium sized businesses, lesser professions, i.e., nurses, opticians, pharmacists, social workers, teachers.
3. Administrative personnel, managers, minor professionals, owners/proprietors of small businesses, i.e., bakery, car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.
4. Clerical and sales, technicians, small businesses (bank teller, bookkeeper, clerk, draftsperson, timekeeper, secretary).
5. Skilled manual - usually having had training (baker, barber, brakeperson, chef, electrician, fireman, machinist, mechanic, paperhanger, painter, repairperson, tailor, welder, police, plumber).
6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).
7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter, including unemployed).
8. Homemaker.
9. Student, disabled, no occupation.

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor
Methadone:	Dolophine, LAAM
Opiates:	Pain killers = Morphine, Diluaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Robitussin, Fentanyl
Barbiturates:	Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Xanax, Miltown, Other = ChloralHydrate (Noctex), Quaaludes Dalmane, Halcion
Cocaine:	Cocaine Crystal, Free-Base Cocaine or "Crack, and "Rock Cocaine"
Amphetamines:	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis:	Marijuana, Hashish
Hallucinogens:	LSD (Acid), Mescaline, Mushrooms (Psilocybin), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstacy
Inhalants:	Nitrous Oxide, Amyl Nitrate (Whippits, Poppers), Glue, Solvents, Gasoline, Toluene, Etc.

Just note if these are used: Antidepressants,
Ulcer Meds = Zantac, Tagamet
Asthma Meds = Ventoline Inhaler, Theodur
Other Meds = Antipsychotics, Lithium

ALCOHOL/DRUG USE INSTRUCTIONS:

The following questions refer to two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days.

⇒30 day questions only require the number of days used.
⇒Lifetime use is asked to determine extended periods of use.
⇒Regular use = 3+ times per week, binges, or problematic irregular use in which normal activities are compromised.
⇒Alcohol to intoxication does not necessarily mean "drunk", use the words “to feel or felt the effects", “got a buzz”, “high”, etc. instead of intoxication. As a rule of thumb, 3+ drinks in one sitting, or 5+ drinks in one day defines “intoxication".
⇒ How to ask these questions:
→ “How many days in the past 30 have you used....?”
→ "How many years in your life have you regularly used....?"

Addiction Severity Index, Fifth Edition

(Clinical/Training Version)

GENERAL INFORMATION

G1.ID No.: ☐☐☐☐☐☐☐☐☐☐☐

G2. SS No. : ☐☐☐- ☐☐- ☐☐☐☐

G4. Date of Admission ☐☐/ ☐☐/ ☐☐

G5. Date of Interview: ☐☐/ ☐☐/ ☐☐

G6 Time Begun: (Hour: Minutes) ☐☐ :☐☐

G7. Time Ended: (Hour:Minutes) ☐☐ :☐☐

G8. Class: 1. Intake 2. Follow-up ☐

G9. Contact Code: 1. In person
2. Telephone (Intake ASI must be in person) ☐

G10. Gender: 1. Male 2. Female ☐

G99. Treatment Episode No.: ☐☐

G11. Interviewer Code No./ Initials: ☐☐☐

G12. Special: 1. Patient terminated
2. Patient refused 3. Patient unable to respond ☐

_____
Name

_____
Address 1

_____
Address 2

_____ (____)_____
City State Zip Code Telephone Number

G14. How long have you lived at this address? ☐☐ / ☐☐
Years Months

G15. Is this address owned by you or your family? 0-No 1-Yes ☐

G16. Date of birth: (Month/Day/Year) ☐☐ / ☐☐ / ☐☐

G17. Of what race do you consider yourself? ☐
1. White (not Hisp) 5. Asian/Pacific 9. Unknown
2. Black (not Hisp) 6. Hispanic-Mexican
3. American Indian 7. Hispanic-Puerto Rican
4. Alaskan Native 8. Hispanic-Cuban

G18. Do you have a religious preference? ☐
1. Protestant 3. Jewish 5. Other
2. Catholic 4. Islamic 6. None

G19. Have you been in a controlled environment in the past 30 days? ☐
1. No 4. Medical Treatment
2. Jail 5. Psychiatric Treatment
3. Alcohol/Drug Treat. 6. Other: _____
- A place, *theoretically*, without access to drugs/alcohol.

G20. How many days? ☐☐
- "NN" if Question G19 is No. Refers to total number of days detained in the past 30 days.

ADDITIONAL TEST RESULTS

_____	☐☐☐
_____	☐☐☐
_____	☐☐
_____	☐☐☐
_____	☐☐
_____	☐☐☐
_____	☐☐☐
_____	☐☐☐
_____	☐☐☐

PROBLEMS	SEVERITY PROFILE									
	0	1	2	3	4	5	6	7	8	9
MEDICAL										
EMP/SUP										
ALCOHOL										
DRUGS										
LEGAL										
FAM/SOC										
PSYCH										

GENERAL INFORMATION COMMENTS

(Include the question number with your notes)

MEDICAL STATUS

M1. * How many times in your life have you been hospitalized for medical problems? ☐☐

- Include O.D.'s and D.T.'s. Exclude detox, alcohol/drug, psychiatric treatment and childbirth (if no complications). Enter the number of ***overnight*** hospitalizations for medical problems.

M2. How long ago was your last hospitalization for a physical problem? ☐☐ Yrs. ☐☐ Mos.

- If no hospitalizations in Question M1, then this is coded "NN".

M3. Do you have any chronic medical problems which continue to interfere with your life? 0 -No 1 - Yes ☐

- ***If "Yes", specify in comments.***
- A chronic medical condition is a serious physical condition that requires regular care, (i.e., medication, dietary restriction) preventing full advantage of their abilities.

M4. Are you taking any prescribed medication on a regular basis for a physical problem? 0 - No 1 - Yes ☐

- ***If Yes, specify in comments.***
- Medication prescribed by a MD for medical conditions; ***not psychiatric medicines***. Include medicines prescribed whether or not the patient is currently taking them. The intent is to verify chronic medical problems.

M5. Do you receive a pension for a physical disability? 0 - No 1 - Yes ☐

- ***If Yes, specify in comments.***
- Include Workers' compensation, exclude psychiatric disability.

M6. How many days have you experienced medical problems in the past 30 days? ☐☐

- Include flu, colds, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, abscesses from needles, etc.).

For Questions M7 & M8, ask the patient to use the Patient Rating scale.

M7. How troubled or bothered have you been by these medical problems in the past 30 days? ☐

- Restrict response to problem days of Question M6.

M8. How important to you now is treatment for these medical problems? ☐

- If client is currently receiving medical treatment, refer to the need for ***additional*** medical treatment by the patient.

INTERVIEWER SEVERITY RATING

M9. How would you rate the patient's need for medical treatment? ☐

- Refers to the patient's need for ***additional*** medical treatment.

CONFIDENCE RATINGS

Is the above information significantly distorted by:

M10. Patient's misrepresentation? 0 - No 1 - Yes ☐

M11. Patient's inability to understand? 0 - No 1 - Yes ☐

MEDICAL COMMENTS

(Include question number with your notes)

EMPLOYMENT/SUPPORT STATUS

E1.* Education completed:
- GED = 12 years, note in comments.
- Include formal education only.

Yrs. ☐☐ Mos. ☐☐

E2.* Training or Technical education completed:
- Formal/organized training only. For military training, only include training that can be used in civilian life (i.e., electronics, computers)

Mos. ☐☐

E3. Do you have a profession, trade, or skill? 0 - No 1 - Yes ☐
- Employable, transferable skill acquired through training.
- If "Yes" (specify) _____

E4. Do you have a valid driver's license? 0 - No 1 - Yes ☐
- Valid license; not suspended/revoked.

E5. Do you have an automobile available? 0 - No 1 - Yes ☐
- If answer toE4 is "No", then E5 must be "No". Does not require ownership, only requires availability on a regular basis.

E6. How long was your longest full time job? Yrs. ☐☐ Mos. ☐☐
- Full time = 35+ hours weekly; does not necessarily mean most recent job.

E7.* Usual (or last) occupation? (specify) _____ ☐
(use Hollingshead Categories Reference Sheet)

E8. Does someone contribute to your support in anyway? 0 - No 1 - Yes ☐
- Is patient receiving any regular support (i.e., cash, food, housing) from family/friend. Include spouse's contribution; exclude support by an institution.

E9 Does this constitute the majority of your support? 0 - No 1 - Yes ☐
- If E8 is "No", then E9 is "N" .

E10. Usual employment pattern, past three years? ☐
1. Full time (35+ hours)
2. Part time (regular hours)
3. Part time (irregular hours)
4. Student
5. Service
6. Retired/Disability
7. Unemployed
8. In controlled environment
- Answer should represent the majority of the last 3 years, not just the most recent selection. If there are equal times for more than one category, select that which best represents the current situation.

EMPLOYMENT/SUPPORT COMMENTS
(Include question number with your notes)

EMPLOYMENT/SUPPORT (cont.)

E11. How many days were you paid for working in the past 30 days? ☐☐
- Include "under the table" work, paid sick days and vacation.

For questions E12-17: How much money did you receive from the following sources in the past 30 days?

E12. Employment? ☐☐☐☐☐
- Net or "take home" pay, include any "under the table" money.

E13. Unemployment Compensation? ☐☐☐☐☐

E14. Welfare? ☐☐☐☐☐
- Include food stamps, transportation money provided by an agency to go to and from treatment.

E15. Pensions, benefits or Social Security? ☐☐☐☐☐
- Include disability, pensions, retirement, veteran's benefits, SSI & workers' compensation.

E16. Mate, family, or friends? ☐☐☐☐☐
- Money for personal expenses, (i.e. clothing), include unreliable sources of income. Record ***cash*** payments only, include windfalls (unexpected), money from loans, legal gambling, inheritance, tax returns, etc.).

E17. Illegal? ☐☐☐☐☐
- ***Cash*** obtained from drug dealing, stealing, fencing stolen goods, illegal gambling, prostitution, etc. ***Do not*** attempt to convert drugs exchanged to a dollar value.

E18. How many people depend on you for the majority of their food, shelter, etc.? ☐☐
- Must be regularly depending on patient, do include alimony/child support, do not include the patient or self-supporting spouse, etc.

E19. How many days have you experienced employment problems in the past 30 ? ☐☐
- Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.

For Questions E20 & E21, ask the patient to use the Patient Rating scale.

E20. How troubled or bothered have you been by these employment problems in the past 30 days? ☐
- If the patient has been incarcerated or detained during the past 30 days, they cannot have employment problems. In that case an "N" response is indicated.

E21. How important to you now is counseling for these employment problems? ☐
- Stress help in finding or preparing for a job, not giving them a job.

INTERVIEWER SEVERITY RATING

E22. How would you rate the patient's need for employment counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

E23. Patient's misrepresentation? 0-No 1-Yes ☐

E24. Patient's inability to understand? 0-No 1-Yes ☐

EMPLOYMENT/SUPPORT COMMENTS

(Include question number with your notes)

ALCOHOL/DRUGS

Route of Administration Types:

1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV

• *Note the usual or most recent route. For more than one route, choose the most severe. The routes are listed from least severe to most severe.*

		Past 30 Days	Lifetime (years)	Route of Admin
D1	Alcohol (any use at all)	☐☐	☐☐	■
D2	Alcohol (to intoxication)	☐☐	☐☐	■
D3	Heroin	☐☐	☐☐	☐
D4	Methadone	☐☐	☐☐	☐
D5	Other Opiates/Analgesics	☐☐	☐☐	☐
D6	Barbiturates	☐☐	☐☐	☐
D7	Sedatives/Hypnotics/ Tranquilizers	☐☐	☐☐	☐
D8	Cocaine	☐☐	☐☐	☐
D9	Amphetamines	☐☐	☐☐	☐
D10	Cannabis	☐☐	☐☐	☐
D11	Hallucinogens	☐☐	☐☐	☐
D12	Inhalants	☐☐	☐☐	☐
D13	More than 1 substance per day (including alcohol)	☐☐	☐☐	■

D14. According to the interviewer, which substance(s) is/are the major problem? ☐☐

- Interviewer should determine the major drug or drugs of abuse. Code the number next to the drug in questions 01-12, or "00" = no problem, "15" = alcohol & one or more drugs, "16" = more than one drug but no alcohol. Ask patient when not clear.

D15. How long was your last period of voluntary abstinence from this major substance? ☐☐ Mos.

- Last attempt of at least one month, not necessarily the longest. Periods of hospitalization/incarceration ***do not count***. Periods of antabuse, methadone, or naltrexone use during abstinence ***do count***.
- "00" = never abstinent

D16. How many months ago did this abstinence end? ☐☐ Mos.

- If D15 = "00", then D16 = "NN".
- "00" = still abstinent.

D17 * How many times have you had: Alcohol DT's? ☐☐

- ***Delirium Tremens*** (DT's): Occur 24-48 hours after last drink, or significant decrease in alcohol intake, shaking, severe disorientation, fever, hallucinations, they usually require medical attention.

D18 * Overdosed on Drugs? ☐☐

- ***Overdoses*** (OD): Requires intervention by someone to recover, not simply sleeping it off, include suicide attempts by OD.

ALCOHOL/DRUGS COMMENTS

(Include question number with your notes)

ALCOHOL/DRUGS (cont.)

How many times in your life have you been treated for :

D19. * Alcohol abuse? ☐☐

D20. * Drug abuse? ☐☐

- Include detoxification, halfway houses, in/outpatient counseling, and AA or NA (if 3+ meetings within one month period).

How many of these were detox only:

D21. * Alcohol? ☐☐

D22. * Drugs? ☐☐

- If D19 = "00", then question D21 is "NN"
  If D20 = '00', then question D22 is "NN"

How much money would you say you spent during the past 30 days on:

D23. Alcohol? ☐☐☐☐☐

D24. Drugs? ☐☐☐☐☐

- Only count actual ***money*** spent. What is the financial burden caused by drugs/alcohol?

D25. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days? ☐☐

- Include AA/NA

How many days in the past 30 have you experienced:

D26. Alcohol problems? ☐☐

D27. Drug problems? ☐☐

- Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For Questions D28-D31, ask the patient to use the Patient Rating scale.
The patient is rating the need for additional substance abuse treatment.

How troubled or bothered have you been in the past 30 days by these:

D28. Alcohol problems? ☐

D29. Drug problems? ☐

How important to you now is treatment for these:

D30. Alcohol problems? ☐

D31. Drug problems? ☐

INTERVIEWER RATING

How would you rate the patient's need for treatment for:

D32. Alcohol problems? ☐

D33. Drug problems? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

D34. Patient's misrepresentation? 0-No 1-Yes ☐

D35. Patient's inability to understand? 0-No 1-Yes ☐

ALCOHOL/DRUGS COMMENTS

(Include question number with your notes)

LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system? 0 - No 1 -Yes ☐
- Judge, probation/parole officer, etc.

L2. Are you on parole or probation? 0 - No 1 - Yes ☐
- Note duration and level in comments.

How many times in your life have you been arrested and charged with the following:

L3 * Shoplift/Vandal	☐☐	L10* Assault	☐☐
L4 * Parole/Probation Violations	☐☐	L11* Arson	☐☐
L5 * Drug Charges	☐☐	L12* Rape	☐☐
L6 * Forgery	☐☐	L13* Homicide/Mansl.	☐☐
L7* Weapons Offense	☐☐	L14* Prostitution	☐☐
L8* Burglary/Larceny/B&E	☐☐	L15* Contempt of Court	☐☐
L9 * Robbery	☐☐	L16* Other: _____	☐☐

- Include total number of counts, not just convictions. Do not include juvenile (pre-age 18) crimes, unless they were charged as an adult.
- Include formal charges only.

L17* How many of these charges resulted in convictions? ☐☐
- If L3-16 = 00, then question L17 = "NN".
- Do not include misdemeanor offenses from questions L18-20 below.
- Convictions include fines, probation, incarcerations, suspended sentences, guilty pleas, and plea bargaining.

How many times in your life have you been charged with the following:

L18.* Disorderly conduct, vagrancy, public intoxication? ☐☐

L19.* Driving while intoxicated? ☐☐

L20.* Major driving violations? ☐☐
- Moving violations: speeding, reckless driving, no license, etc.

L21* How many months were you incarcerated in your life? ☐☐ Mos.
- If incarcerated 2 weeks or more, round this up to 1 month. List total number of months incarcerated.

L22. How long was your last incarceration? ☐☐ Mos.
- Of 2 weeks or more. Enter "NN" if never incarcerated.

L23. What was it for? ☐☐
- Use code 03-16, 18-20. If multiple charges, choose most severe. Enter "NN" if never incarcerated.

L24. Are you presently awaiting charges, trial, or sentence? 0 - No 1 - Yes ☐

L25. What for? ☐☐
- Use the number of the type of crime committed: 03-16 and 18-20
- Refers to Q. L24. If more than one, choose most severe.

L26. How many days in the past 30, were you detained or incarcerated? ☐☐
- Include being arrested and released on the same day.

LEGAL COMMENTS
(Include question number with your notes)

LEGAL STATUS (cont.)

L27. How many days in the past 30 have you engaged in illegal activities for profit? ☐☐

- Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc. May be cross checked with Question E17 under Employment/Family Support Section.

For Questions L28-29, ask the patient to use the Patient Rating scale.

L28. How serious do you feel your present legal problems are? ☐

- Exclude civil problems

L29. How important to you now is counseling or referral for these legal problems? ☐

- Patient is rating a need for ***additional*** referral to legal counsel for defense against criminal charges.

INTERVIEWER SEVERITY RATING

L30. How would you rate the patient's need for legal services or counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

L31. Patient's misrepresentation? 0 - No 1- Yes ☐

L32. Patient's inability to understand? 0 - No 1 - Yes ☐

LEGAL COMMENTS
(Include question number with your notes)

FAMILY HISTORY

Have any of your blood-related relatives had what you would call a significant drinking, drug use, or psychiatric problem? Specifically, was there a problem that did or should have led to treatment?

Mother's Side	Alcohol	Drug	Psych.
H1.Grandmother	☐	☐	☐
H2.Grandfather	☐	☐	☐
H3.Mother	☐	☐	☐
H4.Aunt	☐	☐	☐
H5.Uncle	☐	☐	☐

Father's Side	Alcohol	Drug	Psych.
H6. Grandmother	☐	☐	☐
H7. Grandfather	☐	☐	☐
H8. Father	☐	☐	☐
H9. Aunt	☐	☐	☐
H10. Uncle	☐	☐	☐

Siblings	Alcohol	Drug	Psych.
H11. Brother	☐	☐	☐
H12. Sister	☐	☐	☐

0 = Clearly No for any relatives in that category **X = Uncertain or don't know**
1 = Clearly Yes for any relatives in that category **N = Never was a relative**

- In cases where there is more than one person for a category, record the occurrence of problems for *any* in that group. Accept the patient's judgment on these questions.

FAMILY HISTORY COMMENTS

FAMILY/SOCIAL STATUS

F1. Marital Status: ☐
1-Married 3-Widowed 5-Divorced
2-Remarried 4-Separated 6-Never Married
- Common-law marriage = 1. Specify in comments.

F2. How long have you been in this marital status (Q #F1)? ☐☐ Yrs. ☐☐ Mos.
- If never married, then since age 18.

F3. Are you satisfied with this situation? 0-No 1-Indifferent 2-Yes ☐
- Satisfied = generally liking the situation.
- Refers to Questions F1 & F2.

F4.* Usual living arrangements (past 3 years): ☐
1-With sexual partner & children
2-With sexual partner alone
3-With children alone
4-With parents
5-With family
6-With friends
7-Alone
8-Controlled Environment
9-No stable arrangement

- Choose arrangements most representative of the past 3 years. If there is an even split in time between these arrangements, choose the most recent arrangement.

F5. How long have you lived in these arrangements? ☐☐ Yrs. ☐☐ Mos.
- If with parents or family, since age 18.
- Code years and months living in arrangements from Question F4.

F6. Are you satisfied with these arrangements? 0-No 1-Indifferent 2-Yes ☐

Do you live with anyone who:

F7. Has a current alcohol problem? 0-No 1-Yes ☐

F8 Uses non-prescribed drugs? 0-No 1-Yes ☐
(or abuses prescribed drugs)

F9. With whom do you spend most of your free time? 1-Family 2-Friends 3-Alone ☐
- If a girlfriend/boyfriend is considered as family by patient, then they must refer to them as family throughout this section, not a friend.

F10. Are you satisfied with spending your free time this way? 0-No 1-Indifferent 2-Yes ☐
- A satisfied response must indicate that the person generally likes the situation. Referring to Question F9.

F11. How many close friends do you have? ☐
- Stress that you mean ***close***. Exclude family members. These are "reciprocal" relationships or mutually supportive relationships.

Would you say you have had a close reciprocal relationship with any of the following people:

F12. Mother ☐ F15 Sexual Partner/Spouse ☐

F13. Father ☐ F16 Children ☐

F14 Brothers/Sisters ☐ F17 Friends ☐

0 = Clearly No for all in class X = Uncertain or "I don't know
1 = Clearly Yes for any in class N = Never was a relative
- By reciprocal, you mean "that you would do anything you could to help them out and vice versa".

FAMILY/SOCIAL COMMENTS
(Include question number with your notes)

FAMILY/SOCIAL (cont.)

Have you had significant periods in which you have experienced serious problems getting along with:

	0 - No 1 - Yes Past 30 days	In Your Life
F18. Mother	☐	☐
F19. Father	☐	☐
F20. Brother/Sister	☐	☐
F21. Sexual Partner/Spouse	☐	☐
F22. Children	☐	☐
F23. Other Significant Family (specify)_____	☐	☐
F24. Close Friends	☐	☐
F25. Neighbors	☐	☐
F26. Co-workers	☐	☐

- "Serious problems" mean those that endangered the relationship.
- A "problem" requires contact of some sort, either by telephone or in person. If no contact code "N"

Has anyone ever abused you?

	0- No 1-Yes Past 30 days	In Your Life
F27. Emotionally? • Made you feel bad through harsh words.	☐	☐
F28. Physically? • Caused you physical harm.	☐	☐
F29. Sexually? • Forced sexual advances/acts.	☐	☐

How many days in the past 30 have you had serious conflicts:

F30. With your family? ☐☐

F31. With other people (excluding family)? ☐☐

For Questions F32-35, ask the patient to use the Patient Rating scale.

How troubled or bothered have you been in the past 30 days by:

F32. Family problems ? ☐

F33. Social problems? ☐

How important to you now is treatment or counseling for these:

F34. Family problems
- Patient is rating his/her need for counseling for family problems, not whether they would be willing to attend. ☐

F35. Social problems
- Include patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient rating should refer to dissatisfaction, conflicts, or other serious problems. ☐

INTERVIEWER SEVERITY RATING

F36. How would you rate the patient's need for family and/or social counseling? ☐

CONFIDENCE RATING

Is the above information significantly distorted by:

F37. Patient's misrepresentation? 0-No 1-Yes ☐

F38. Patient's inability to understand? 0-No 1-Yes ☐

FAMILY/SOCIAL COMMENTS

(Include question number with your notes)

PSYCHIATRIC STATUS

How many times have you been treated for any psychological or emotional problems:

P1* In a hospital or inpatient setting? ☐☐

P2* Outpatient/private patient? ☐☐

- Do not include substance abuse, employment, or family counseling. Treatment episode = a series of more or less continuous visits or treatment days, not the number of visits or treatment days.
- Enter diagnosis in comments if known.

P3. Do you receive a pension for a psychiatric disability? 0-No 1-Yes ☐

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:

		0-No 1-Yes Past 30 Days	Lifetime
P4.	Experienced serious depression-sadness, hopelessness, loss of interest, difficulty with daily function?	☐	☐
P5.	Experienced serious anxiety/ tension-uptight, unreasonably worried, inability to feel relaxed?	☐	☐
P6.	Experienced hallucinations-saw things/ heard voices that others didn't see/hear?	☐	☐
P7.	Experienced trouble understanding, concentrating, or remembering?	☐	☐
P8.	Experienced trouble controlling violent behavior including episodes of rage, or violence? • Patient can be under the influence of alcohol / drugs.	☐	☐
P9.	Experienced serious thoughts of suicide? • Patient seriously considered a plan for taking his/her life. Patient can be under the influence of alcohol/drugs.	☐	☐
P10.	Attempted suicide? • Include actual suicidal gestures or attempts. • Patient can be under the influence of alcohol / drugs.	☐	☐
P11.	Been prescribed medication for any psychological or emotional problems? • Prescribed for the patient by a physician. Record "Yes" if a medication was prescribed even if the patient is not taking it.	☐	☐

P12. How many days in the past 30 have you experienced these psychological or emotional problems? ☐☐

- This refers to problems noted in Questions P4-P10.

For Questions P13-P14, ask the patient to use the Patient Rating scale

P13. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? ☐

- Patient should be rating the problem days from Question P12.

P14. How important to you now is treatment for these psychological or emotional problems? ☐

PSYCHIATRIC STATUS COMMENTS

(Include question number with your comments)

PSYCHIATRIC STATUS (cont.)

The following items are to be completed by the interviewer:

At the time of the interview, the patient was:	**0-No 1-Yes**
P15. Obviously depressed/withdrawn	☐
P16. Obviously hostile	☐
P17. Obviously anxious/nervous	☐
P18. Having trouble with reality testing, thought disorders, paranoid thinking	☐
P19. Having trouble comprehending, concentrating, remembering	☐
P20. Having suicidal thoughts	☐

INTERVIEWER SEVERITY RATING

P21 . How would you rate the patient's need for psychiatric/psychological treatment? ☐

CONFIDENCE RATING

Is the above information significantly distorted by:

P22 Patient's misrepresentation?	0-No 1-Yes ☐
P23. Patient's inability to understand?	0-No 1-Yes ☐

PSYCHIATRIC STATUS COMMENTS

(Include question number with your notes)