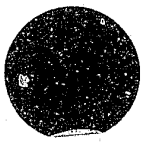

A COORDINATED APPROACH TO MANAGING THE DRUG INVOLVED OFFENDER

The Second Report of the Treatment Access Committee

A Permanent Committee of the Delaware Sentencing Accountability Commission

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March 11, 1994

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This report is submitted to the Sentencing Accountability Commission and the Delaware General Assembly in compliance with Chapter 65, Subchapter X Del. Code Title 11, Section 6582, which states in part that "The Treatment Access Committee shall report annually to SENTAC and the General Assembly on its activities and the status of substance abuse problems in Delaware." We have decided this year to focus on the results of our analysis of the substance abuse needs assessment conducted upon the population under control of the Department of Correction at all five SENTAC levels.

ACKNOWLEDGEMENTS

This assessment would not have been possible without the collaborative efforts of a number of people. Dorothy Lockwood, Ph.D. and James Inciardi, Ph.D. from the University of Delaware Center for Drug and Alcohol Studies were tireless in managing and interpreting a large volume of data. Jack O'Connell, Director of the Delaware Statistical Analysis Center, helped shape the information in this report so it would be useful to policymakers. Donna Reback from the Edna McConnell Clark Foundation stayed involved and provided assistance throughout the entire process. TASC Case Managers worked diligently to conduct over a thousand interviews in and out of correctional facilities, probation offices, halfway houses and treatment programs statewide. The staff and administration in the Department of Correction went out of their way to assist in the implementation of this project. Their commitment and contributions were invaluable. Finally, thank you to Kim Pahl from the Treatment AccesS Center who put it all together.

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EXECUTIVE SUMMARY

July 1992 saw the legislatively mandated formation of the Treatment Access Committee, a permanent committee of the Sentencing Accountability Commission (SENTAC). The Committee (TAC) is charged with expanding substance abuse treatment for offenders and improving and coordinating the delivery of that treatment. Over the past year, TAC has implemented a statewide substance abuse and other needs assessment of offenders under control of the Department of Correction at all five SENTAC levels; has received funding to establish WCI Village, a Therapeutic Community at the Women's Correctional Institution; and has implemented a system of treatment and case management services through the Treatment AccesS Center (TASC).

Data from the needs assessment demonstrates that:

- There is a high need for substance abuse treatment among the offender population in Delaware, regardless of whether incarcerated or punished through other sanctions.
- Most offenders who need treatment have had little or no treatment exposure.
- There is a high level of drug use in all five levels, according to both self-reporting and urine testing.
- Strict sanctions reduce the level of drug use in offender populations, as do treatment sanctions.
- Research shows that for drug-involved offenders, the effects of treatment sanctions are longer lasting at reducing drug use and crime than are sanctions alone.
- Large numbers of drug-involved offenders who could not function in strict community sanction settings and who did not receive or complete drug treatment remain in the system as probation violators in Level V. The most heavily drug-involved population identified in the incarcerated population is probation violators -- with a 70% need for residential treatment.
- Despite the high level of illicit drug abuse in the offender population, there is a large gap between services needed and services available.

Extensive research has shown that compulsory treatment -- using the coercive powers of the criminal justice system to maximize the benefits of treatment for offenders -- works. Offenders mandated into treatment do as well or better then clients who volunteer for treatment; those coerced into treatment tend to remain longer than voluntary commitments. Research also demonstrates that there is a strong link between drug use and crime, and that for addicted offenders, reducing the amount of drug use reduces the rate of crimes committed. Drug treatment works to reduce drug use both during and after treatment.

Long term client aftercare and monitoring are essential parts of treatment, and clients

who are matched to appropriate treatment programs have better outcomes than clients who are mismatched. A continuum of treatment options needs to be in place so clients can be matched to the appropriate primary intervention as well as receive aftercare, skills remediation and social support. Treatment Alternatives to Street Crime (TASC) is a proven case management model to bridge the criminal justice and treatment systems by providing identification, assessment, referral, case management and monitoring services for drug/alcohol dependent offenders accused or convicted of crimes, and ensuring that criminal justice decision makers remain informed about the progress of these cases.

INCREASING ACCOUNTABILITY

Integrating accountable and effective drug treatment into our system of punishment and supervision is a good crime control strategy. The creation of the Treatment Access Committee and the Treatment AccesS Center by the General Assembly has given us the structure to focus our efforts in a concerted fashion to coordinate our criminal justice and treatment resources, and to hold offenders accountable.

The Treatment Access Committee is committed to building a comprehensive system of treatment, ancillary services and case management over the course of the next three to five years by tying a full continuum of services to specific offender populations. TAC intends to demonstrate that an investment in this approach will impact a sizeable proportion of the drug-involved offender population and will result in documented cost savings and reductions in both relapse and criminal recidivism.

The system must include prison-based services, as well as a full range of community-based services to transition prisoners into the community, as well as to treat the large numbers of offenders on community supervision or waiting in prison for community-based treatment and sanctions.

The goal of TAC is to provide comprehensive accountable services for 10% of the criminal population by the year 2000, at a total cost of $12 to $15 Million. Achieving this goal will require the commitment and support of elected leaders and policymakers over an extended period of time.

- TAC is requesting $600,000 this year to fully implement projects started with SENTAC Treatment Initiatives during 1993.
- Annual budget requests will be submitted beginning next fiscal year.
- TAC will actively seek federal funds to augment these requests.
- TAC will submit annual reports describing the utilization and impact of all services under this initiative.
- TAC will work this year to implement a no-cost or low-cost plan to better utilize existing offender-dedicated resources.

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INTRODUCTION

A number of activities have begun in the last year which are moving Delaware toward more effective management of drug involved offenders. These activities occurred because thoughtful criminal justice and treatment policy makers have determined that substance abuse is a primary problem for the criminal justice system -- not a subsidiary one. The criminal justice system has a critical role to play in breaking the cycle of drug use and crime by reducing the criminality and drug dependency of offenders by maximizing the rehabilitative aspects of both substance abuse treatment and the criminal justice system.

We are again at a crossroads in our criminal justice system -- facing the prospect of having to build another new prison. The rapid growth we have recently experienced in our corrections population can be largely attributed to the increase in drug related crimes, drug-related arrests, convictions and penalties. Criminal case filings in Superior Court have tripled in the last four years. Drug arrests increased over 200% from 1986 to 1990, and do not appear to be abating. With a proposed increase in enforcement capabilities and new police officers, the rate of arrests should again jump significantly.

This report is designed to present a broad overview of the nature and extent of drug involvement in our correctional population. The data was not derived from long-term studies, and does not contain detailed information. It is designed to be useful for policy decisions, and as a starting place for structuring funding decisions. This report is one way to describe and to begin to measure the extent of the problem of drug abuse in the offender population; the prescription for its solutions will take years to develop and implement.

This report demonstrates that many offenders in our prisons and in community-based sanctions are heavily drug-involved, and that drug use and criminal activity are intertwined. Both national and local studies show that interrupting the drug activities of these persons substantially reduces their criminal activity. Providing effective drug treatment combined with effective criminal sanctions is a cost-effective and sensible crime control strategy. We are convinced that making an investment in this new coordinated approach will enhance the productivity of the offenders about which we speak, their families, their communities, and Delaware as a whole.

BACKGROUND

July 1992 saw the enactment of House Bill 588, which created a permanent Treatment Access Committee (TAC) of the Sentencing Accountability Commission. TAC is legislatively mandated to:

1. Supervise the establishment of a Treatment AccesS Center for substance abusing offenders...to coordinate the provision of substance abuse evaluation and treatment by public and private providers to criminal defendants and youths adjudicated delinquent or pending such adjudication; and,

2. Supervise the expenditure of funds from the Substance Abuse Rehabilitation, Treatment, Education and Prevention Fund...by making grants to the Treatment AccesS Center, and to other state and local public entities or agencies for substance abuse treatment, rehabilitation, education or prevention activities.

TAC has adopted a working mission to "expand and improve treatment services for offenders and supervise the establishment of a mechanism to coordinate the provision of substance abuse evaluations and effective compulsory treatment for criminal offenders". Compulsory treatment means that the coercive powers of the criminal justice system are utilized to maximize the benefits of treatment for offenders.

TAC is developing an organizational structure to:

- Expand treatment for offenders by conducting a needs assessment and ongoing analyses to better describe the offender population in terms of drug use and risk to the public, and to recommend the development of treatment programming;

- Provide ongoing data and information for use by Corrections, treatment, and other decisionmakers;

- Develop grant applications and otherwise access funding for treatment expansion and coordination in order to provide a funding stream so providers who embrace the philosophies and strategies associated with compulsory treatment can flourish;

- Provide policy development, goals and objectives;

- Provide support for providers of treatment and supervision so that policies, goals and objectives can be effectively implemented. This can be accomplished through training, information sharing, and establishing structures

to improve collaboration, cross-training *and* healthy competition among providers; and,

- Act as a point of contact for treatment advocacy with the Governor's office, Legislature, and other concerned groups.

An operational agency, the Treatment AccesS Center (TASC), has been established to work with both systems and among providers of supervision and treatment services. As an operational entity, TASC:

- Assesses, refers to treatment and provides case management services to offenders as they move through both the criminal justice and treatment systems;

- Provides case-based and aggregate information to decisionmakers;

- Establishes policies and procedures for urine monitoring;

- Provides client advocacy;

- Provides support to supervision and treatment providers to retain offenders in treatment by facilitating communication between the criminal justice and treatment systems.

During the past year, TASC staff worked with the University of Delaware Center for Drug and Alcohol Studies, the Department of Correction, and the Statistical Analysis Center to conduct a comprehensive needs assessment of the offender population to determine the kinds of treatment programming that needs to be put in place to establish an effective system of compulsory treatment.

Other activities of the Treatment Access Committee include:

- TASC is now operating on a pilot basis to provide assessment, referral and case management services for the Expedited Drug Case Management project (Drug Court) in Superior Court.

- The Treatment Access Committee applied for and received a grant from the Center for Substance Abuse Treatment to establish WCI Village: A Therapeutic Community for Incarcerated Women at the Women's Correctional Institute. This program is being run by Correctional Medical Systems and the Department of Correction; an evaluation is being conducted by the University of Delaware Center for Drug and Alcohol Studies.

- The Treatment Access Committee assisted in obtaining $580,000 in state funds for drug treatment for offenders. This funding, placed in the Department of Correction, is being utilized by TASC to provide a range of services including residential, intensive outpatient, and outpatient treatment for criminal offenders coming through the Superior Court Drug Court; to expand a continuum of services for offenders in Kent and Sussex Counties; and to provide bridge funding for the CREST Outreach Program until CREST is absorbed into the DOC 1995 operating budget.

- A small federally funded urine monitoring only project, again for offenders coming through the Drug Court, is being established through contract.

- A grant from the Edna McConnell Clark Foundation was received to hold an informational seminar on drug-involved offenders for legislators and other policymakers.

SUMMARY OF THE RESEARCH ON DRUG INVOLVED OFFENDERS

In order to understand the context of our research design and results, as well as our recommendations, we would like to summarize the logic and body of knowledge upon which our approach is based.

There is a large body of research available that indicates that there is a strong link between drug use and crime, and that for addicted offenders, reducing the amount of drug use reduces the rate of crimes committed (McBride and McCoy, 1993; Ball, 1981; Anglin and Hser, 1987; Anglin and Speckart, 1988). Addicted offenders often support their addictions by committing crimes and selling drugs, with some addicted offenders committing a disproportionate number of crimes (McBride and McCoy, 1993; Inciardi, McBride, McCoy and Chitwood [in press]).

Offenders mandated into treatment by the criminal justice system do as well or better than clients who volunteer for treatment. Those coerced into treatment tend to remain longer than voluntary commitments (Leukefeld and Tims, 1988; Hubbard et al., 1989; Platt et al., 1988; DeLeon, 1988).

Drug treatment works to reduce drug use both during and after treatment. Long-term client aftercare and monitoring are essential parts of treatment, and clients who are matched to appropriate treatment programs have better outcomes than clients who are mismatched (Blain et al. 1981; Ball and Corty, 1988; McLellan et al., 1982; Leukefeld and Tims, 1990). A continuum of treatment options needs to be in place so clients can be matched to the appropriate primary intervention as well as receive aftercare, skills remediation and social support.

Treatment Alternatives to Street Crime (TASC) is a proven case management model to bridge the criminal justice and treatment systems (Inciardi and McBride, 1991). TASC was created in 1972 and now operates in over 125 communities. The mission of TASC is to reduce the criminality of drug-dependent offenders by maximizing the rehabilitative aspects of both substance abuse treatment and the criminal justice system. TASC realizes this mission by functioning as a bridge between the criminal justice system, with its concern for community safety and legal sanctions, and the substance abuse treatment system, with its concern for therapeutic relationships and the alteration of individual behavior.

TASC provides identification, assessment, referral, case management and monitoring services for drug/alcohol dependent offenders accused or convicted of crimes, and ensures that criminal justice decision makers remain informed about the progress of these cases. TASC's effectiveness has been well documented in reducing drug abuse and keeping drug abusing offenders in treatment.

TREATMENT ACCESS COMMITTEE OPI NEEDS ASSESSMENT

The Treatment Access Committee decided that a thorough assessment of the drug use and other treatment needs of the offender population was in order to begin developing a more adequate treatment system, and to establish and maintain a dialogue with legislators and other policymakers about drug-involved offenders in Delaware. A grant was received from the Edna McConnell Clark Foundation in September 1992, to implement a comprehensive needs assessment of offenders in all levels and to develop recommendations for expanding and improving service delivery to appropriate offender populations.

NEEDS ASSESSMENT DESIGN

Our goal was to identify a sample of offenders in Levels I through V that would be representative of the offender population as a whole, and that would also be reflective of current drug use patterns among offenders in Delaware. In addition, we wanted to examine offenders sentenced under Title 16, Section 4753A (Drug Trafficking) in order to describe that population in terms of their drug use.

A total of 996 offenders in all five levels were successfully interviewed. Inmates were interviewed in prison. All inmates had been sentenced within the last year. Probationers were interviewed in probation offices, halfway houses and treatment programs. A few Level I offenders were interviewed in the TASC office. All information is self reported; to increase accuracy interviews of probationers were accompanied by urine screens to detect the presence of illegal drugs. Comparisons with the entire offender population by the Statistical Analysis Center indicated that we did, in fact, obtain a representative sample of the population, in terms of race, sex and offense classification and severity. Thus we are comfortable extrapolating information from the sample to the population as a whole.

METHODOLOGY

We selected the Offender Profile Index (OPI) as our assessment instrument for several reasons. First, it was developed for use with the criminal population, and takes criminal activity into account in its recommendations. Second, the instrument makes recommendations to specific treatment modalities -- long term residential treatment, short term residential, intensive or regular outpatient treatment, and urine monitoring only. Third, it can be administered by trained interviewers who are not clinicians in about 30 minutes.

Developed by an expert panel of clinicians and researchers in the fields of drug abuse and criminology, the OPI broadly "sorts" offenders into types of drug abuse treatment intervention based on a combination of drug severity and "stakes in conformity" -- such as educational attainment, employment status and history, and residential stability. According to the OPI User's Guide, research findings have indicated that individuals with *high* stakes in conformity have an investment in conventional behavior and are less likely to commit crimes than persons with low stakes in conformity. Data further indicate that persons with high stakes who do commit crimes are less likely to be recidivists than persons with low stakes, and therefore, require less supervision and fewer services.

The OPI was field tested at TASC sites in Birmingham, Alabama; Chicago, Illinois; and Phoenix, Arizona. Results of the field tests were positive, with treatment program officials indicating that "OPI-referred clients had been correctly referred".

The OPI does not make treatment recommendations for users of alcohol. While it indicates patterns of alcohol usage, an alcohol-specific treatment placement instrument should be used to determine treatment needs of offenders who only use alcohol.

A copy of the OPI instrument and user's guide is included in Appendix A.

Participation in the study was voluntary. Respondents agreeing to participate were asked to sign a consent form which described the project and explained the confidential nature of results from the interviews. All OPI's were assigned code numbers, and the University of Delaware received only coded information -- no names or identifying numbers were included. Interviews were conducted by TASC Case Managers. They are experienced interviewers, but are not part of any correctional or judicial organization. Training and orientation on the OPI, drug involved offenders, interviewing techniques, and other topics were provided and are ongoing. Our refusal rate was very low (less than 5 percent).

Each completed OPI was checked for accuracy and sent to the University of Delaware's Center for Drug and Alcohol Studies for coding, data entry and analysis. All data recorded on the OPI was entered into a database. The data entry program had been previously designed specifically for the OPI and includes logic checks and automatic scoring. Data analysis was conducted using SPSS (Statistical Package for Social Sciences).

The OPI sorts offenders into broad treatment categories or profiles according to the following criteria:

Long Term Residential Treatment (LTR) of a year or more is recommended for any client who uses illegal methadone or any drugs intravenously -- heroin, other narcotics, cocaine or amphetamines.

Intravenous (IV) drug use has been found to be the culmination of a drug-using career. Given the many psychological, behavioral and physical consequences associated with IV drug use, the intense supervision and services of long-term residential care are required.

Short Term Residential Treatment (STR) of a year or less is recommended for individuals who use non-IV stimulants or oral opiates on a weekly basis or more and require the services and supervision provided within the context of short-term residential care.

Intensive Outpatient Treatment (IOP) is the most stringent of the outpatient treatments. Often, intensive treatment is combined with educational remediation, job training and job search, and other program components that address other needs.

IOP is recommended for persons who may be using several drugs regularly, yet may not yet need the more rigid monitoring of a short-term facility. It is also recommended for persons who are somehow able to maintain a job and stable living arrangements while using non-IV cocaine, crack, amphetamines or oral opiates on a weekly basis. These individuals require some level of intensive attention, but do not require residential treatment.

Outpatient Treatment (OP) generally involves one or two individual and/or group sessions a week. It is recommended for people who are daily users of alcohol and/or marijuana who also use one other drug and have low to moderate stakes in conformity. Clients who are poly-drug users are also recommended for outpatient treatment. Drug use for these persons has apparently progressed beyond experimental or social, recreational levels.

Urine Monitoring Only (UO) provides regular monitoring of urine to detect the presence of drugs. This is recommended for individuals who use only alcohol and/or marijuana, or use other drugs (including sedatives, inhalants, and hallucinogens) less than once a week. Individuals with high stakes in conformity and who use alcohol and/or marijuana plus one other drug (including sedatives, inhalants, and hallucinogens) daily also qualify for urine monitoring only.

A WORD OF CAUTION

Careful consideration should be given when interpreting the results that follow.

- The OPI is a broad sorting tool, not a clinical instrument that would be used to develop more specific and individualized treatment plans. Therefore, while our results indicate estimates of the overall need in the offender population, building a system of treatment services requires more thoughtful planning and development.

- All data is self-reported. Several studies have been conducted comparing self-reported information by addicts with verifiable records (Inciardi, Horowitz and Pottieger, 1993). These studies show that addict self-reports are surprisingly truthful, and that misrepresentation can be attributed to recall difficulties rather than intentional lying.

  We did find differences in self-reported drug use compared with urine monitoring results in the probation population. Although we assured respondents of confidentiality, because most interviews were conducted in probation offices, there was likely some hesitancy by respondents to be fully disclosive about the extent of their illegal drug use.

- Treatment profiles include the initial placement recommendation only. It is important that primary treatment be followed by aftercare, skills remediation and social support in order to maintain positive treatment effects. The reader would be wise to assume a course of intensive outpatient or outpatient treatment to follow every residential placement.

- The OPI, while it flags histories of major mental health problems, does not take dual diagnosis (the coexistence of substance abuse with mental health or other problems) into account. A growing proportion of drug involved persons are now being identified as having organic brain damage and other mental health disorders as a result of drug use.

RESULTS

The data obtained in our assessment and that is reported in the following few pages will demonstrate several things.

- There is a high need for substance abuse treatment among the offender population in Delaware regardless of whether incarcerated or punished through other sanctions.

- Most offenders who need treatment have had little or no treatment exposure.
- There is a high level of drug use in all five levels, according to both self-reporting and urine testing.
- Strict sanctions positively impact (i.e. reduce) the level of drug use in offender populations, as do treatment sanctions.
- Research shows that for drug-involved offenders, the effects of treatment sanctions are longer lasting at reducing drug use and crime.
- Large numbers of drug-involved offenders who could not function in strict community sanction settings and who did not receive or complete drug treatment remain in the system as probation violators in Level V.

Data will be presented for the entire population first. A separate discussion of Level V subpopulations, Level IV (which has some special characteristics), and probation Levels I through III will follow.

DEMOGRAPHICS

Table 1 shows the basic demographic makeup of the sample population. The total sample population was 996. Comparisons by crime type, ethnicity, and other factors indicate that the sample is representative of the entire DOC population, as verified by the Statistical Analysis Center.

The average educational attainment level is below 12th grade in all five sanction levels. It is also important to note that offenders in our sample have about as many children as does the general population.

TABLE 1
POPULATION DEMOGRAPHICS

VARIABLES	LEVEL I PROBATION	LEVEL II PROBATION	LEVEL III PROBATION	LEVEL IV HH,TX,HC*	LEVEL V PRISON	TOTAL
# of Respondents	41 (4.1%)	236 (23.7%)	220 (22.1%)	204 (20.5%)	295 (29.6%)	996 (100%)
Gender						
Male	73.2%	86.0%	84.6%	86.3%	85.4%	85.4%
Female	26.8%	14.0%	13.2%	13.7%	14.6%	14.5%
Ethnicity						
Black	61.0%	50.4%	52.7%	61.8%	67.5%	57.5%
Hispanic	4.8%	3.8%	4.1%	1.5%	2.7%	3.1%
White	31.7%	45.8%	42.7%	36.8%	28.8%	38.9%
Other	2.4%	---	.5%	---	---	.2%
Average Age						
Male	32.6	31.4	30.3	30.3	29.0	30.2
Female	32.1	29.9	29.6	29.2	30.0	
Average Highest Grade Completed						
Male	11.8	11.1	11.3	11.2	12.0	11.4
Female	10.5	11.7	11.1	10.6	11.0	
Avg. # Children	1.6	1.5	2.0	2.6	2.0	2.0

* HH = Halfway House, TX = Inpatient Treatment, HC = Home Confinement

The numbers of Delaware offenders who need at least outpatient treatment, compared to the total number of sentenced offenders, is shown in Chart 1. The number of offenders needing treatment in Levels I to IV may be low by as much as one-half when the percent of offenders with positive urine tests is considered.

Treatment profiles in Level IV are also low for some important reasons. Information was collected about current behavior and/or behavior within the last 90 days of the interview. Offenders in Level IV occupy slots in strict sanctions or in residential treatment programs; drug use during strict supervision and/or treatment may not be reflective of drug use prior to such program placement. In fact, all offenders currently in treatment had a treatment profile

for short or long-term residential treatment prior to program placement. Chart 2 describes the types of initial treatment interventions needed for offenders by level. Again, primary treatment interventions need to be followed by aftercare, social support and skills remediation, which is not reflected in this chart.

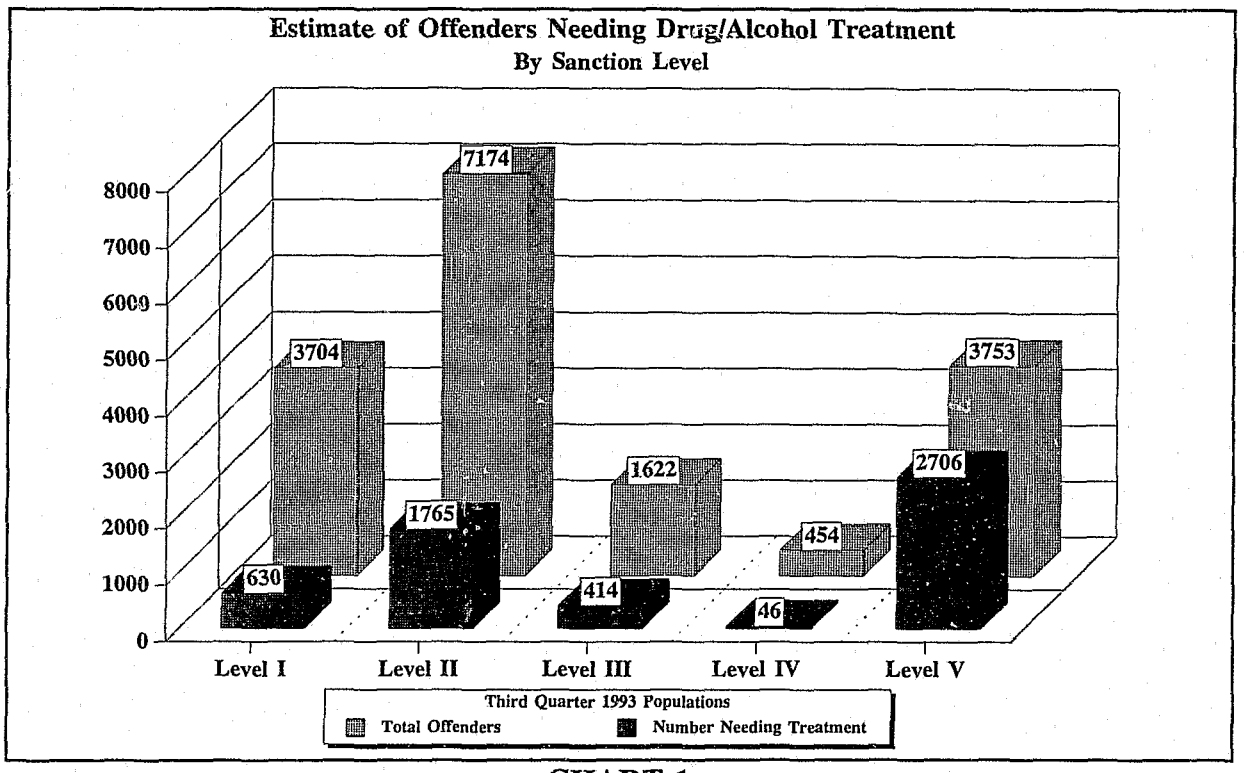
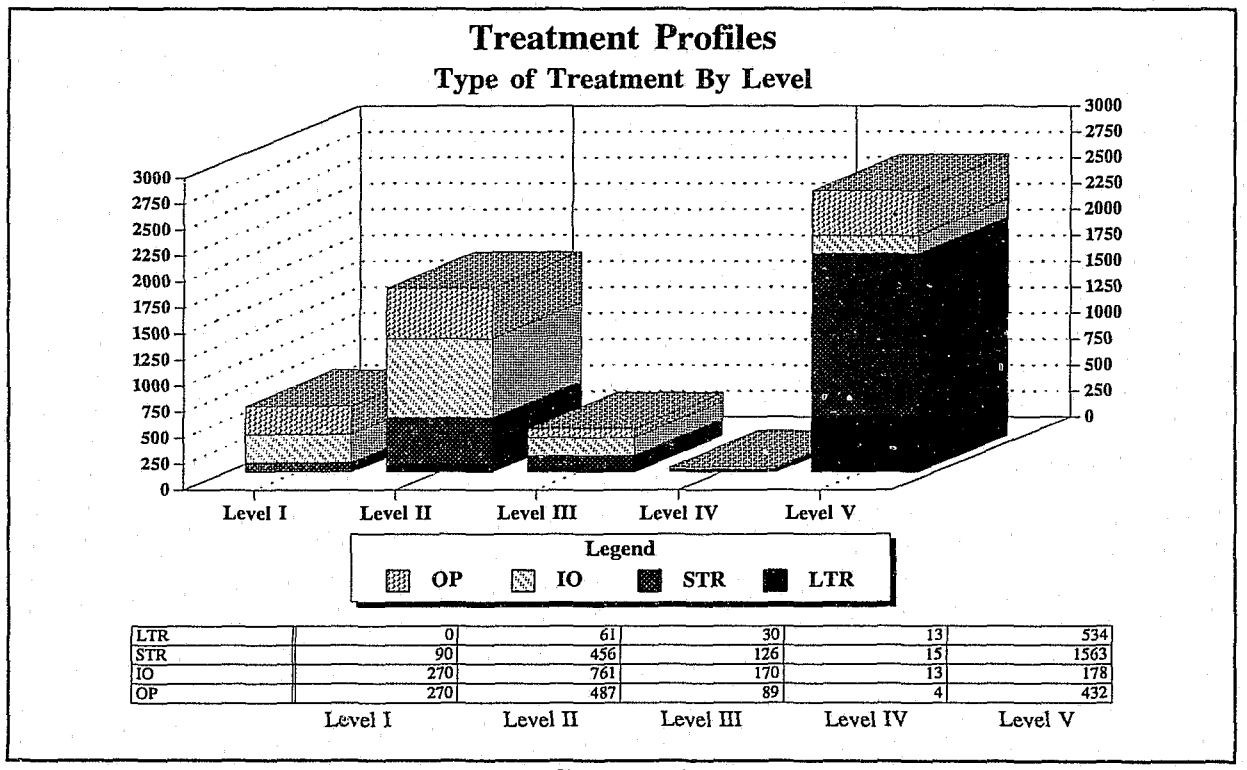


CHART 1



	Level I	Level II	Level III	Level IV	Level V
LTR	0	61	30	13	534
STR	90	456	126	15	1563
IO	270	761	170	13	178
OP	270	487	89	4	432

CHART 2

LEVEL V (INCARCERATED) POPULATIONS

The number of drug-involved offenders and the severity of their drug use in Delaware's prisons is overwhelming, as is the level of unmet substance abuse treatment need. The Level V population is the most heavily drug-involved, compared to other levels. While this appears comforting to some extent, the fact is that most of these offenders will leave our Level V facilities without any exposure to drug education or treatment, and are likely to return to a drug-crime lifestyle.

Treatment profiles for needs of the male and female incarcerated populations follow in Chart 3.

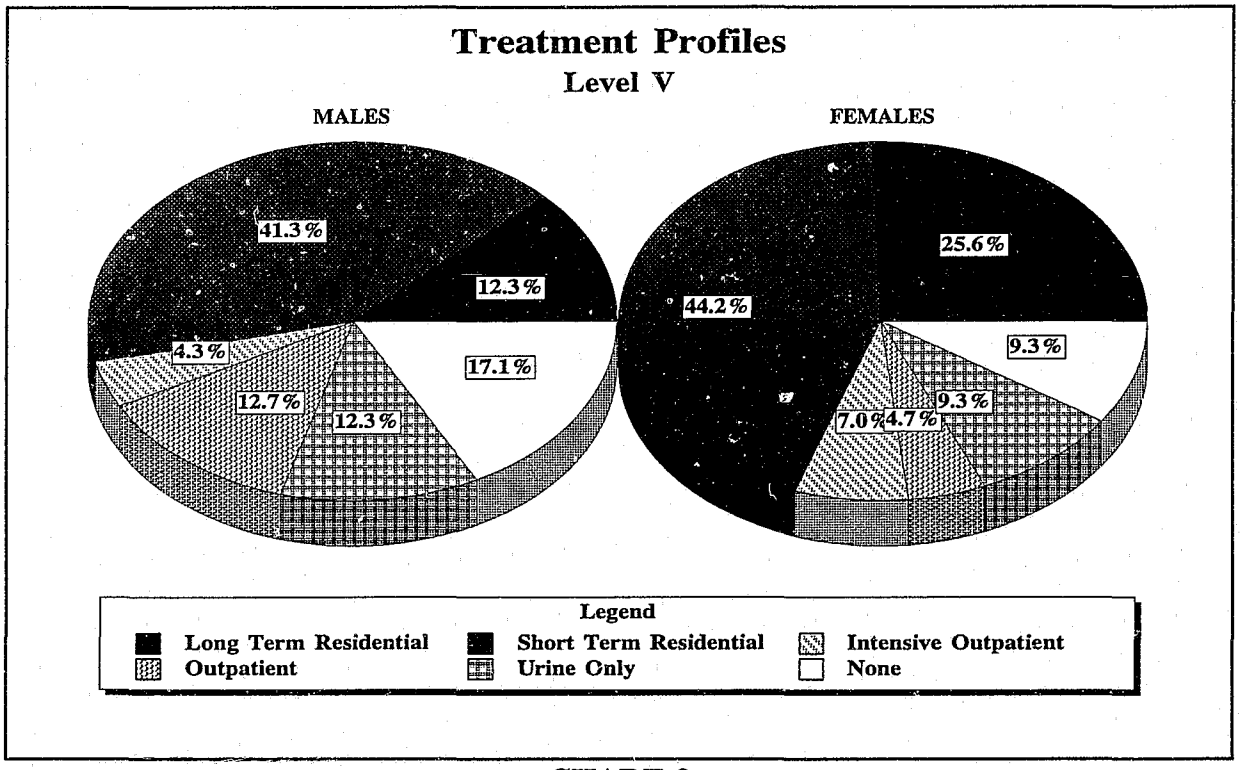
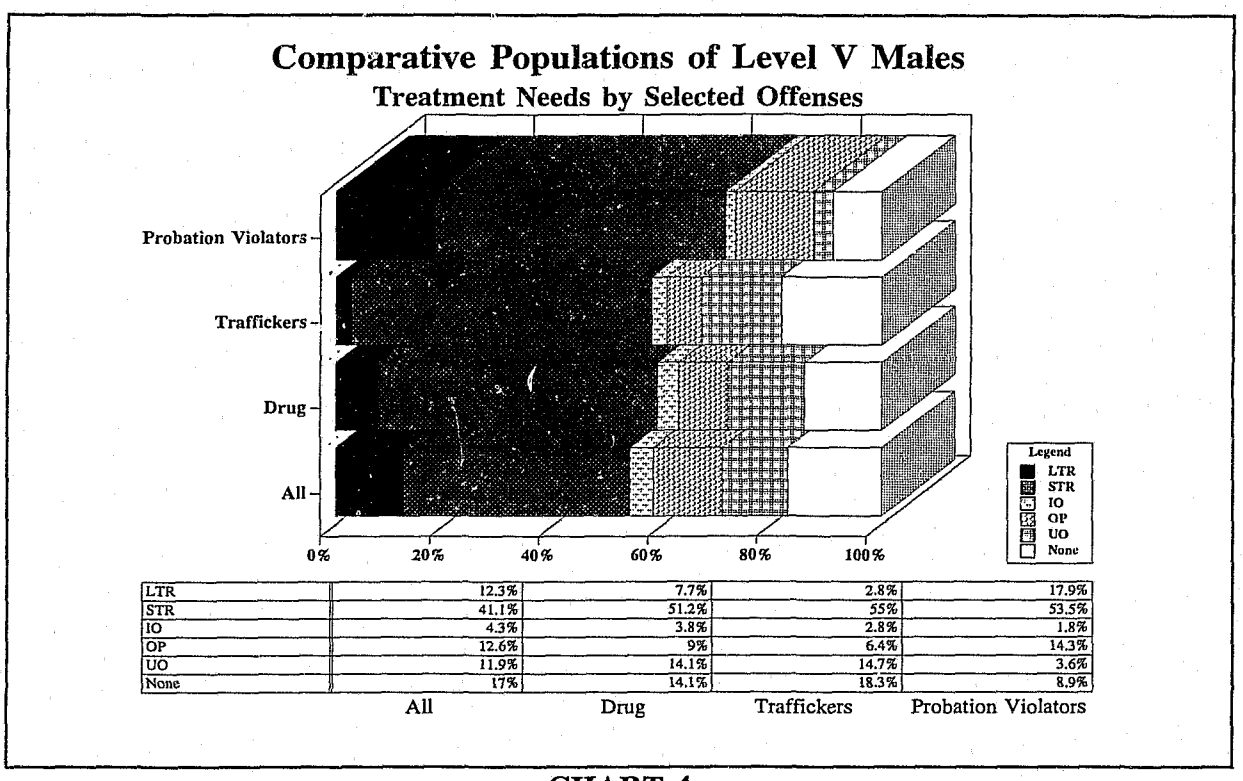


CHART 3

Male offenders were broken down into subcategories for comparison purposes, and to begin to identify populations that were likely crime and drug involved and could benefit from a treatment intervention. A comparison of the treatment profiles of the general population, offenders convicted of drug crimes, offenders convicted of drug trafficking, and offenders incarcerated for probation violations follows in Chart 4.

The data indicates that a sizeable portion of offenders incarcerated for drug offenses, including drug trafficking, are heavy drug users. It is important to underscore the similarities

in drug use and treatment profile among drug traffickers, other offenders convicted of drug crimes such as possession, and the incarcerated population as a whole. This similarity clearly



	All	Drug	Traffickers	Probation Violators
LTR	12.3%	7.7%	2.8%	17.9%
STR	41.1%	51.2%	55%	53.5%
IO	4.3%	3.8%	2.8%	1.8%
OP	12.6%	9%	6.4%	14.3%
UO	11.9%	14.1%	14.7%	3.6%
None	17%	14.1%	18.3%	8.9%

CHART 4

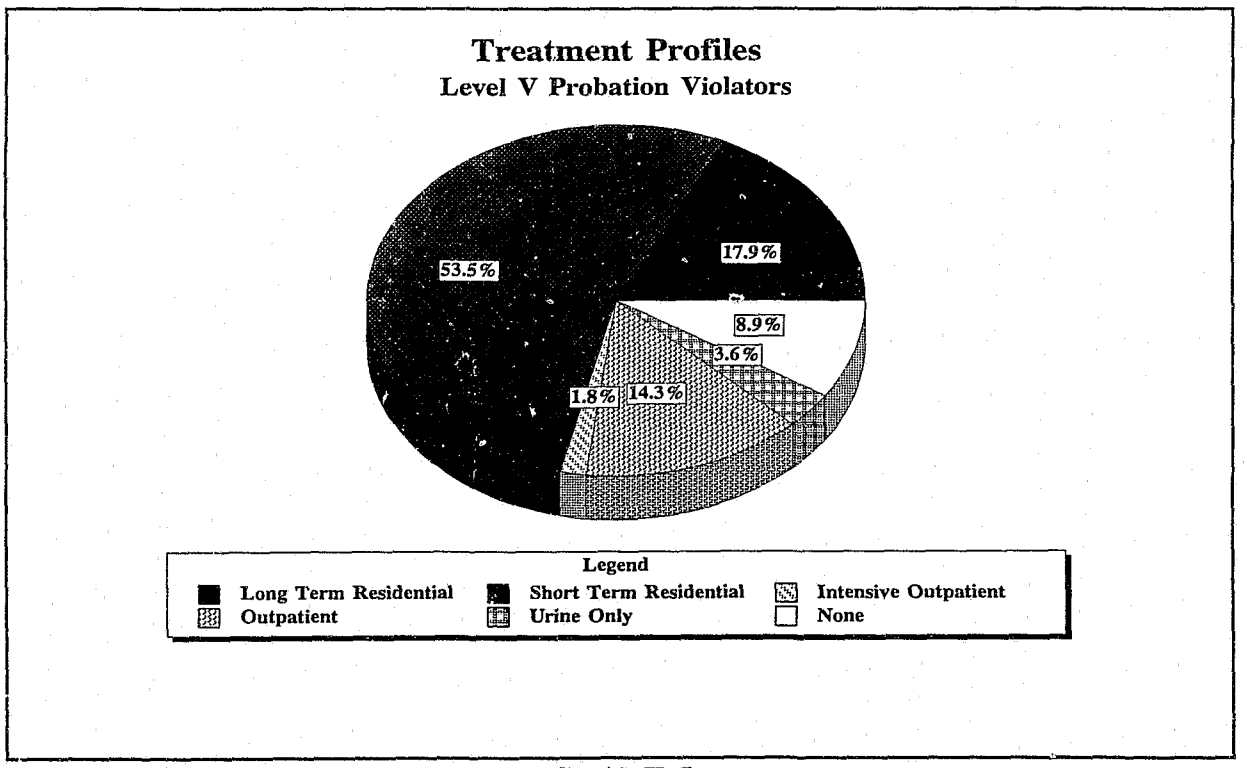


CHART 5

indicates that drug traffickers are often heavy drug users; as such, many are in need of and maybe appropriate for drug treatment.

The most heavily drug-involved population identified in the incarcerated population is probation violators -- offenders who committed a new crime or technical violation while on probation or parole and who have been incarcerated as a result of that violation. Probation violators are a large and rapidly growing segment of the prison population; in 1993, probation violators made up 23.2% of all prison admissions. Chart 5 shows the treatment profile for this population. Over 70% of this population has a treatment profile for *residential* services.

It is significant to note that the offenders in this population were at one time in community-based sanctions, after completing a prison sentence or as the result of a direct sentence for their offense. It is clear that many of these people ended up incarcerated or re-incarcerated because their drug use remained unaddressed and led to an inability to comply with the conditions of supervision or to renewed criminal activity.

LEVEL IV

Level IV, quasi-incarceration, is a special population for a variety of reasons. Placement at Plummer Center or Sussex Halfway House, Home Confinement with electronic monitoring, and Residential Drug Treatment are all considered Level IV sanctions, even though the programs and sanctions are quite different.

At the Halfway Houses, residents are under constant supervision during initial placement and later transition into the community. Regular urine monitoring is conducted, and positive urines usually result in violations and placement to Level V. Some Halfway House residents also participate in outpatient drug treatment.

In Home Confinement, offenders have their curfews tightly monitored, but are only under direct supervision while meeting with their Level IV officers. Urine monitoring is not conducted on a frequent basis due primarily to budgetary constraints.

Residential treatment is a 24 hour-a-day placement, with time allowed in the community during the later phases of treatment. In some programs, urines are not routinely monitored, while in others urine monitoring is an integral part of the treatment regime. Regardless, offenders in residential treatment are in a drug-free environment surrounded by people who can identify the effects of drug use should it occur.

Chart 6 shows the treatment profiles for offenders who need treatment in Level IV programs.

Chart 6 indicates a very low treatment need in this population. This is because

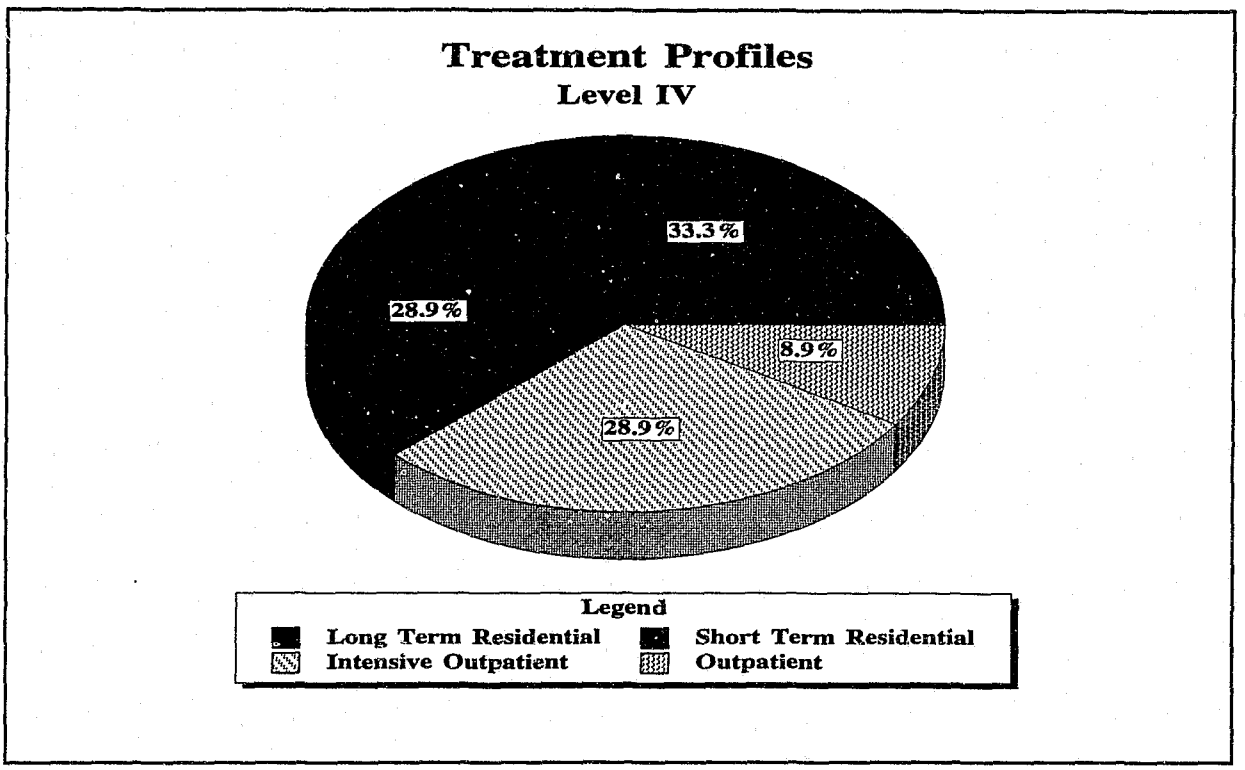


CHART 6

respondents indicated their behavior during the last 90 days -- for the people in Level IV, most or all of the last 90 days they were in a structured supervision or treatment program. This does not reflect their treatment needs prior to their present placement.

The offenders in Level IV Residential Treatment all have drug use and social histories that indicate a need for short or long-term residential treatment. It is important to note that at least while these offenders are in treatment, their drug use stops, and we know from the literature that these gains can be long term.

The University of Delaware Center for Drug and Alcohol Studies is beginning to establish longer-term recidivism and relapse rates for offenders in Delaware who have completed the KEY (a prison based therapeutic community) and CREST (a work release therapeutic community) Programs. A 6-month follow-up of offenders completing these programs indicates that of those who graduated from the KEY and then graduated from CREST, 90.9% were drug free (Inciardi, Lockwood and Hooper, Corrections Today, February 1994). Further longitudinal analysis of this population is ongoing.

Something different is likely occurring in the Halfway House population. Offenders that successfully complete Halfway House sentences without treatment are either not drug-involved or can control their drug usage while in a tightly structured environment. Offenders

who cannot control their drug usage are likely to appear in the incarcerated probation violation population. As part of the Center for Drug and Alcohol Study described above, a comparison group of Halfway House residents not involved in residential drug treatment, but with similar drug use and criminal histories was established. For this comparison group, only 32.3% were drug free at the 6-month follow-up.

These data demonstrate that strict supervision can reduce the drug use of offenders who are not heavily drug-involved. Treatment along with supervision also reduces drug use, and can sustain that reduced drug use over time, for offenders who are drug-involved.

LEVELS I THROUGH III

According to self-report, 17.1% of Level I offenders, 20.3% of Level II offenders, and 25.5% of Level III offenders need at least outpatient drug treatment. This represents approximately 2,809 individuals.

Chart 7 shows the treatment profiles for offenders who need treatment in the Level I-III probation populations.

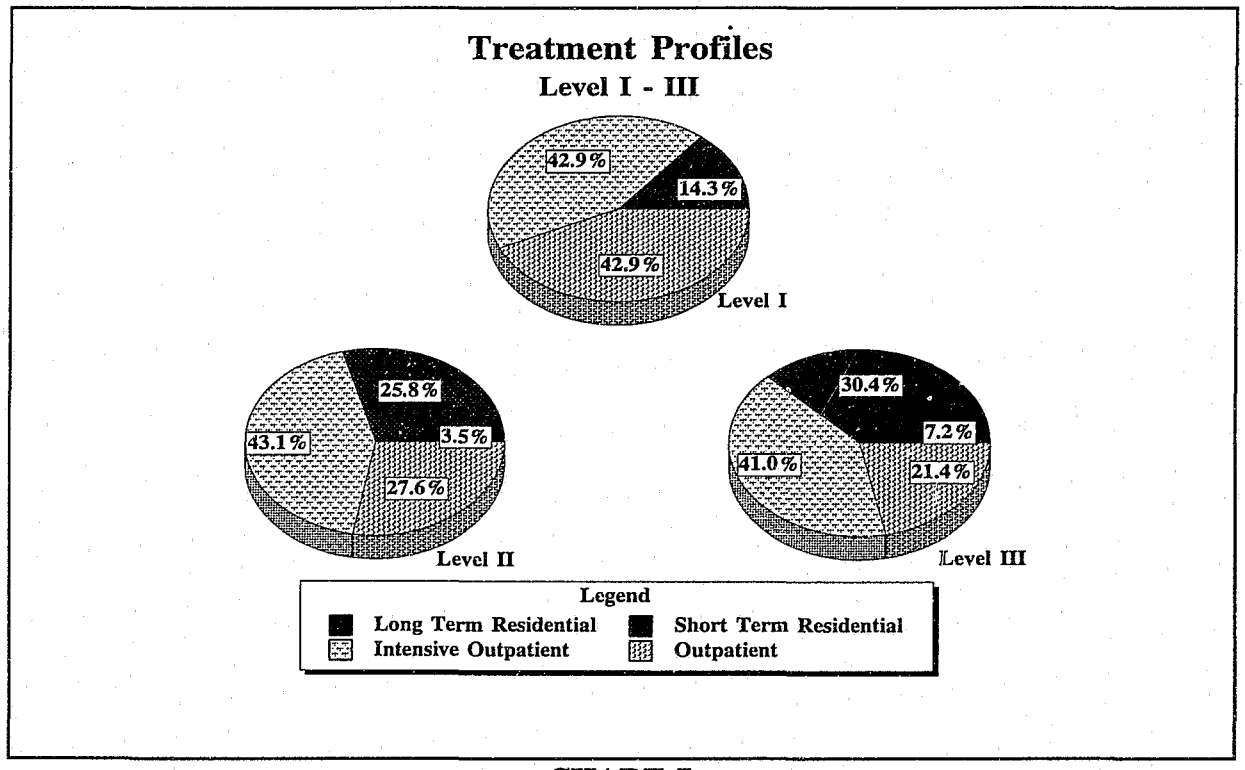


CHART 7

LEVEL I - V
SELF-REPORTED
DRUG USE AND URINALYSIS RESULTS

Table 2 depicts self-reported drug-use of offenders by type of drug. Interviewers asked about the frequency with which respondents had used specific drugs and families of drugs during the last 90 days; incarcerated offenders were asked about their drug use the 90 days prior to their incarceration.

Many offenders use more than one drug, and change the drugs they use because of availability or other factors. This chart should therefore be interpreted as an indication of the kinds of drugs that are most prevalently used and available in Delaware. In addition, it is commonly reported that many drugs are adulterated; drug users may not be fully aware of the drugs they are actually using.

TABLE 2
SELF-REPORTED FREQUENCY OF DRUG USE LAST 90 DAYS

DRUG BY FREQUENCY OF USE LAST 90 DAYS	LEVEL I PROBATION	LEVEL II PROBATION	LEVEL III PROBATION	LEVEL IV HH,TX,HC*	LEVEL V PRISON	TOTAL
Alcohol						
No use	8 (19.5%)	56 (23.7%)	69 (31.4%)	131 (64.2%)	62 (21.0%)	326 (32.7%)
< 1 Week	14 (34.1%)	67 (28.4%)	64 (29.1%)	40 (19.6%)	40 (13.5%)	225 (22.6%)
> 1 Week	15 (36.6%)	93 (39.4%)	70 (31.8%)	23 (11.3%)	85 (28.8%)	286 (28.7%)
Daily	4 (9.8%)	20 (8.5%)	17 (7.7%)	10 (4.9%)	108 (36.6%)	159 (16.0%)
Marijuana						
No use	28 (68.3%)	156 (66.1%)	156 (70.9%)	177 (86.6%)	150 (50.8%)	667 (67.0%)
< 1 Week	5 (12.2%)	46 (19.5%)	40 (18.2%)	13 (6.4%)	39 (13.2%)	143 (14.4%)
> 1 Week	6 (14.6%)	27 (11.4%)	21 (9.5%)	12 (5.9%)	53 (18.0%)	119 (12.0%)
Daily	2 (4.9%)	7 (3.0%)	3 (1.4%)	2 (1.0%)	53 (18.0%)	67 (6.7%)
Cocaine						
No use	39 (95.1%)	209 (29.8%)	192 (87.3%)	186 (91.2%)	183 (62.0%)	809 (81.2%)
< 1 Week	2 (4.9%)	6 (6.8%)	17 (7.7%)	8 (3.9%)	15 (5.1%)	32 (3.2%)
> 1 Week	---	9 (3.8%)	9 (4.1%)	3 (1.5%)	34 (11.5%)	18 (1.8%)
Daily	---	2 (.8%)	2 (.9%)	7 (3.4%)	63 (21.4%)	86 (8.6%)
Crack						
No use	40 (97.6%)	221 (93.6%)	203 (92.3%)	191 (93.6%)	205 (69.5%)	860 (86.3%)
< 1 Week	1 (2.4%)	10 (4.2%)	5 (2.3%)	5 (2.5%)	11 (3.5%)	32 (3.2%)
> 1 Week	---	4 (1.7%)	10 (4.5%)	1 (.5%)	3 (1.0%)	18 (1.8%)
Daily	---	1 (.4%)	2 (.9%)	7 (3.4%)	76 (25.8%)	86 (8.6%)

DRUG BY FREQUENCY OF USE LAST 90 DAYS	LEVEL I PROBATION	LEVEL II PROBATION	LEVEL III PROBATION	LEVEL IV HH,TX,HC*	LEVEL V PRISON	TOTAL
Heroin-Non IV						
No use	41 (100.0%)	236 (100.0%)	220 (100.0%)	204 (100.0%)	287 (97.3%)	988 (99.2%)
< 1 Week	---	---	---	---	3 (1.0%)	3 (.3%)
> 1 Week	---	---	---	---	1 (.3%)	1 (.1%)
Daily	---	---	---	---	4 (1.4%)	4 (.4%)
Heroin-IV						
No use	41 (100.0%)	235 (94.6%)	218 (99.1%)	201 (98.5%)	280 (94.3%)	975 (97.9%)
< 1 Week	---	---	---	2 (1.0%)	3 (1.0%)	5 (.5%)
> 1 Week	---	---	---	---	2 (.7%)	2 (.2%)
Daily	---	1 (.4%)	2 (.9%)	1 (.5%)	10 (3.4%)	14 (1.4%)
Coke - IV						
No use	41 (100.0%)	235 (100.0%)	217 (98.6%)	198 (97.1%)	260 (88.1%)	951 (95.5%)
< 1 Week	---	---	1 (.4%)	1 (.5%)	7 (2.4%)	11 (1.1%)
> 1 Week	---	---	---	1 (.5%)	5 (1.7%)	7 (.7%)
Daily	---	---	---	4 (2.0%)	23 (7.8%)	27 (2.7%)

* HH = Halfway House, TX = Inpatient Treatment, HC = Home Confinement

Alcohol is by far the most frequently used drug in the offender population, with a significant portion of offenders, particularly incarcerated offenders, reporting daily use. Marijuana is also used with significant frequency. Cocaine and crack cocaine represent the drug of current usage for many offenders; 20.9% of incarcerated women and 21.4% of incarcerated men report using cocaine on a *daily* basis. In addition, 30.2% of incarcerated women and 25% of incarcerated men report using crack cocaine on a *daily* basis. About 12% of incarcerated men reported light or heavy intravenous (IV) use of heroin or cocaine, and almost 25% of the incarcerated women in our sample reported *daily* IV drug use during the 90 days prior to their incarceration.

Urine tests were conducted in the probation population to increase the accuracy of self-reported information as well as to provide an additional, verifiable measure of drug use. Table 3 shows urine results for offenders in Levels I through III. Again, when comparing urine results that were also collected at the time of interview, resulting treatment profiles may underrepresent the need for treatment in this population by as much as one half.

A copy of the full table depicting self-reported frequency of drug use in the last 90 days is included in Appendix B.

TABLE 3
POSITIVE URINE TEST FOR PROBATION POPULATIONS

DRUG	LEVEL I PROBATION	LEVEL II PROBATION	LEVEL III PROBATION
Positive for at least one drug at time of interview	45.7%	39.4%	44.3%
Marijuana	28.6%	23.1%	22.4%
Cocaine	8.6%	16.7%	21.9%
Benzodiazepines	5.7%	4.1%	3.3%
Barbiturates	2.9%	2.3%	1.6%
Amphetamines	2.9%	.9%	2.2%
PCP	---	1.8%	.5%
Opiates	8.6%	4.1%	7.1%

Differences in self-reported drug use and urine testing results are consistent with experience from the Drug Use Forecasting (DUF) project (Stephens and Feucht, 1993). DUF is a project initiated by the National Institute of Justice to estimate the extent of drug use primarily among arrestee populations in 24 cities. For our analysis, probationers were interviewed and drug tested in the probation office, and although they were assured of confidentiality, there is good reason to expect some reluctance to be truthful about illegal behavior. Unlike incarcerated individuals, probationers face the threat of incarceration if their probation stipulations are violated.

In addition to the expected underreporting of drug use in this population, we also may have inadvertently examined a fairly low-risk cohort of probationers. We only interviewed probationers who *reported* for their scheduled appointments. On some interview days, there were significant numbers of probationers who did not report for appointments. These probationers, likely to be violated for failure to comply with supervision, are probably typical of the incarcerated violation population -- heavily involved abusers.

Drug use data, both self-reported and through urinalysis, collectively point to a high degree of unchecked drug involvement in this population. Ultimately, more violations of probation will likely result.

SELECTED STAKES IN CONFORMITY

Selected stakes in conformity have been included in this report to give policy-makers a sense of other information that is available upon request as a result of this needs assessment, as well as to begin to describe issues such as offender employment and other factors that impact on the management of drug-involved offenders.

As seen in Table 4, about two-thirds of offenders at all levels (except incarcerated offenders) were employed at the time of interview. It is significant to note that a large proportion of these offenders did not work full-time during the past year, and that employment instability seems to increase as the sanction level increases. This stake also underscores the importance of addressing employment issues as a part of treatment.

TABLE 4
SELECTED STAKES IN CONFORMITY

VARIABLES	LEVEL I	LEVEL II	LEVEL III	LEVEL IV	LEVEL V
Currently Employed	63.4%	68.5%	57.7%	66.7%	---
*Weeks worked in last 12 mos.					
Less than 20	27.5%	23.8%	41.6%	50.0%	38.6%
20 - 34	12.5%	22.1%	21.5%	30.0%	22.1%
35+	60.0%	54.0%	37.0%	19.6%	39.4%
# of residences in last 12 mos.	2.3	3.6	3.2	3.2	2.9
No prior tx w/in last 5 yrs.					
Male	76.7%	70.8%	62.1%	53.4%	68.4%
Female	90.9%	72.7%	58.6%	39.3%	81.4%
At risk for HIV/AIDS	26.8%	40.4%	43.2%	54.2%	67.4%
Attempted suicide	9.8%	12.3%	16.4%	10.8%	14.4%

* For inmates 12 mos. prior to incarceration

The number of residences during the last 12 months has been displayed as an indicator of the instability of this population. In addition, having a stable residence is often a critical factor in whether short-term residential treatment versus intensive outpatient treatment is sufficient. Some offenders with treatment profiles for residential treatment may be successful with less expensive outpatient services if their residence stabilizes.

Although we know that the level of drug involvement in all levels is high, significant numbers of offenders at all levels have had no prior treatment experience.

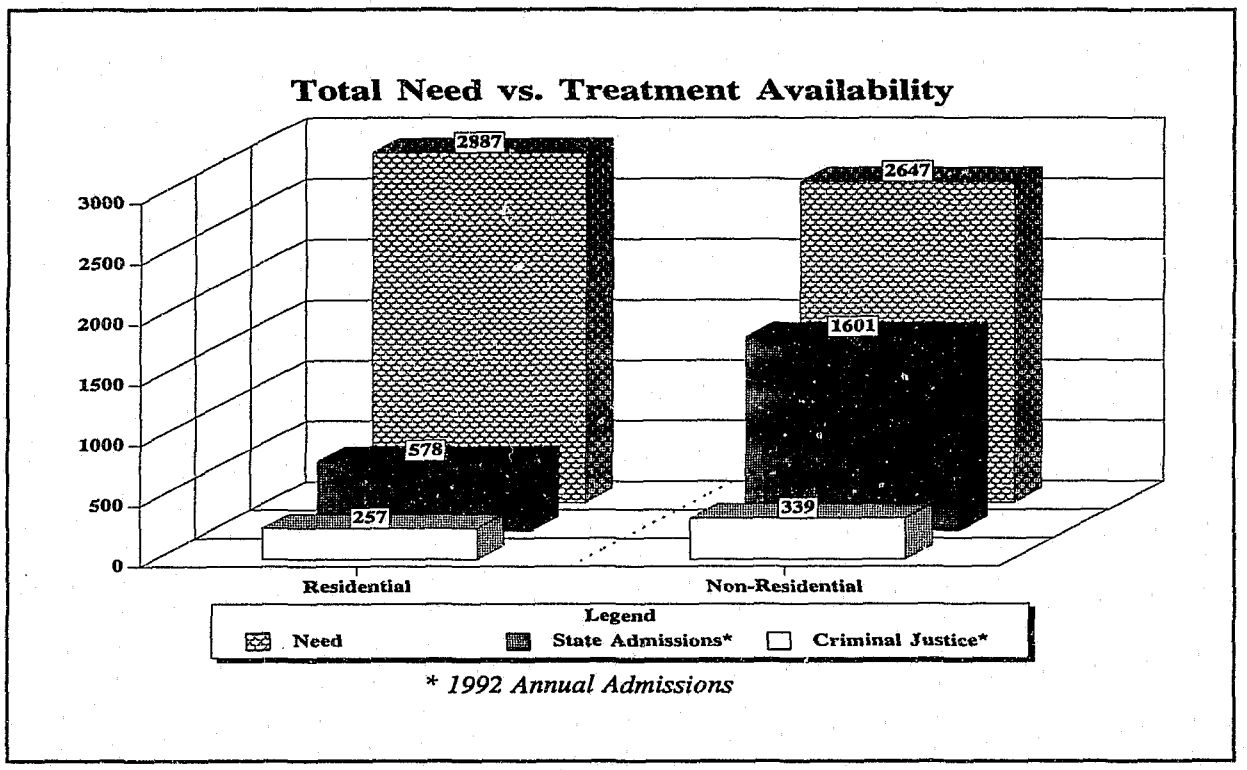
Large numbers of offenders in all levels are at risk for HIV/AIDS, because of a

combination of their drug use and their sexual behavior. The implications for providing medical care for this population must be underscored.

Finally, we have included the frequency of attempted suicide in this population as an indicator of mental health problems. Although not in this chart, we also looked at this variable by treatment profile. We found that 25% of offenders in need of long-term residential treatment have attempted suicide.

TREATMENT NEED VERSUS TREATMENT AVAILABILITY

Chart 8 compares the identified residential and non-residential services needed for the offender population with the 1992 statewide admissions to residential and non-residential treatment programs, as reported in Delaware Drug Indicators (Delaware Statistical Analysis Center, September 1993). It is clear that the services available statewide for all Delawareans are inadequate to meet the demands of just the criminal justice population.



** 1992 Annual Admissions*

CHART 8

DISCUSSION

The findings of this study should not be surprising, as they are reflective of other research nationwide, both self-reported by offenders and through urine screening of arrestees. Nonetheless, the extent of the drug problem in Delaware's offender population is startling and daunting.

There is indisputably a high level of illicit drug abuse in the offender population in Delaware. There is also a large gap between treatment services needed and services available for this population. Over 70 percent of the incarcerated population has a drug use problem serious enough to warrant at least outpatient treatment, and a substantial proportion of incarcerated and non-incarcerated offenders need residential treatment.

The Treatment Access Committee has concluded that the picture presented in this report reflects the consequences of neglect. We have a high number of offenders who require long-term residential treatment; this treatment profile is reflective of long-term drug use -- the culmination of a life of drug use. The number of drug-involved offenders who have never been exposed to the drug treatment system is noteworthy, as is the expense of incarcerating drug involved offenders who commit crimes at least in part due to their drug use.

The criminal justice system has failed in its responsibility to identify drug-involved offenders and take effective corrective action. The treatment system has failed to respond by providing both enough services and services that can respond effectively to drug addicts with legal problems. Offenders are the responsibility of the criminal justice system; drug treatment is the responsibility of the social services delivery system. Although well over half of offenders are drug-involved, and although over half of all people in drug treatment are offenders, until the Treatment Access Committee was created, no one was fully responsible for drug-involved offenders. Programs get started and then die or stumble along -- failing to get the attention and support of either system. It's not that a systematic approach for managing drug-involved offenders has been tried and failed, it has simply not been tried.

Delaware's prisons are overcrowded. There are currently over 200 sentenced offenders waiting in prison for placement in a Level IV sanction -- substantial numbers are waiting for placement in residential treatment. Many will be released without ever receiving the treatment ordered by the Courts.

It is clear from this study that high numbers of offenders -- at least a prison full -- are incarcerated for violating probation. The astonishing level of drug use in this population is compelling evidence that inability to comply with conditions of supervision and continued criminal activity in this population is integrally related to that unchecked drug use.

If the State of Delaware were to provide the treatment indicated for all offenders by this study, it would cost $50 Million -- *excluding* capital costs. We have estimated the cost

of providing treatment as indicated for the offender population using an average basic per diem rate currently paid by the State. For estimating purposes, we have assumed that long term residential treatment (LTR) is one year, short-term residential treatment (STR) is 4 months, intensive outpatient (IOP) and outpatient (OP) treatment is for 4 months. (Lengths of stay for all modalities actually vary considerably, depending on the individual and the program.) Residential costs are based on $75.00 per day, Intensive Outpatient costs are based at $4840 per course of treatment, outpatient is based on $1650 per course of treatment.

TABLE 5
COSTS OF TREATMENT
LEVEL I - V POPULATIONS

TYPE OF TREATMENT	BEDS/SLOTS	AMOUNT
Long Term Residential	637	$17,500,000
Short Term Residential	2250	20,250,000
Intensive Outpatient	1392	9,200,000
Outpatient	1282	2,100,000
TOTAL	**5561**	**$49,050,000**

Costs for providing services for just the incarcerated Probation Violation population, using the same cost estimates, are in the following chart.

TABLE 6
COSTS OF TREATMENT
LEVEL V PROBATION VIOLATORS

TYPE OF TREATMENT	BEDS/SLOTS	AMOUNT
Long Term Residential	219	$ 6,000,000
Short Term Residential	655	5,900,000
Intensive Outpatient	22	100,000
Outpatient	175	300,000
TOTAL	**1071**	**$12,300,000**

We do not recommend building a treatment system in this fashion. In the first place, many offenders in this survey are incarcerated and need to remain incarcerated. It would be foolish to invest in such a large system of residential services -- at least without further study

and development. We want to start slowly and thoughtfully to build a comprehensive system of care and case management for specific offender populations, expanding to include other offender groups as our technical ability and knowledge increase and as our success is demonstrated.

We have concluded a continuum of treatment services is essential for two reasons. First, offenders must be placed in the initial level of treatment warranted by their drug severity and life skills. Second, protracted involvement in the treatment system results in better treatment outcomes, including prosocial behaviors like employment. Finally, if outpatient services are well-developed, the use of expensive residential services can be minimized for certain clients and enhanced for others.

Treatment services must also be available inside the prisons -- for those persons who belong in prison. These programs need to be linked with programs in the community to ensure continued benefits upon release and thereby improve public safety. A network of residential and non-residential programming also needs to be in place to provide comprehensive services for offenders who can remain in the community *if* their substance abuse is curtailed. We must not develop a system that must send people to prison *just* so they can obtain treatment services.

Building systems of services around specific offender populations will enable us to have a cost effective framework that can be responsive to as well as create other enhancements. This approach can be built into, and can facilitate, program approaches such as Boot Camps and Drug Courts. It can be tied into any number of intermediate sanctions or other kinds of corrections options. It is an approach that can fit into new federal initiatives, and will help ensure that these initiatives are well implemented to meet the needs of Delaware.

National research as well as studies of Delaware populations show that effective and accountable drug treatment substantially reduces the drug use and related criminal activity of drug-involved offenders. Providing comprehensive drug treatment in lieu of or as an augmentation to criminal sanctions is an effective element in a strategy to reduce drug use and crime. It is an approach that is consistent with, and dependent upon, effective law enforcement strategies. It is also consistent with community and public safety.

Research establishes that drug use *focuses and intensifies* criminal behavior in addicted offenders. Effective treatment, coordinated with sanctions and oversight by the criminal justice system, can reduce the drug use and criminality of addicted offenders -- at less cost than a prison sentence.

This substance abuse assessment has also demonstrated that we have the technical skills to identify drug-involved offenders, and to match them to appropriate treatment modalities. SENTAC gives us the ability to combine this treatment with appropriate criminal sanctions

in a continuum from prison through community placement. The Treatment Access Committee is building a range of comprehensive, continuous services, linked to the criminal justice system and some specifically tied to the Courts, through the Treatment AccesS Center.

The creation of the Treatment Access Committee and the Treatment AccesS Center by the General Assembly has given us the structure to focus our resources in a concerted fashion to coordinate our criminal justice and treatment resources, and to hold offenders accountable.

Our objectives are part of a good crime control strategy. We believe that we cannot afford to continue to spend precious resources on lackluster outcomes. The Delaware public has indicated strong support for this kind of approach -- even indicating they would tolerate increased taxes to provide drug treatment for offenders. According to a public opinion survey conducted by the Public Agenda Foundation in 1991, when asked "Do you think that there should be enough room in Delaware's drug treatment centers for every drug addict who wants help, even if that means a modest tax increase or a cutback in other state services", 67% of the survey respondents answered "yes" (Doble, Immerwahr and Richardson, 1991). We believe that this support stems from the magnitude of the substance abuse problem and the recognition by the public that the *problem* must be addressed, not just its symptoms.

We ask for your ongoing support and commitment to enable us to move forward.

RECOMMENDATIONS

The Treatment Access Committee is committed to building a comprehensive system of treatment, ancillary services and case management over the course of the next three to five years by tying a full continuum of services to expanding offender populations. It is safe to say that we have a three percent solution to a seventy percent problem -- our goal is to reach a ten percent solution by the year 2000. We intend to demonstrate that an investment of this magnitude will enable us to impact a sizeable proportion of the drug-involved offender population and will result in documented cost savings and reductions in both relapse and criminal recidivism.

We know we have an uphill battle to fight. First of all, we have a culture in all our treatment and criminal justice systems that we're not very serious. Offenders don't think they have to go to treatment -- in fact, most don't have much success accessing treatment if they want it. Judges consistently impose treatment as a condition of sentencing in all levels; their assumption, correctly so, is that most people won't ever get to treatment. Beyond that, even when people "go to treatment", no one is doing much to ensure they remain in treatment, or to support the effects of a successful primary treatment experience.

We are working with a treatment system whose primary client population -- at least its primary intended population -- are not criminal justice involved. We need to work with existing providers to improve treatment techniques and develop new providers who can work effectively and zealously with an often difficult population.

The system must include prison-based residential services as well as treatment engagement to move offenders into community-based treatment. It must include a full range of community-based services to transition prisoners into the community, as well as to treat the large numbers of offenders on community supervision or waiting in prison for community-based treatment and sanctions. Case management and urine monitoring are important elements to capitalize upon and improve the effectiveness of treatment, as well as to identify people who can't maintain abstinence without additional treatment and/or sanctions. We need Therapeutic Community models, 12-step models, relapse prevention models and everything in-between. Nothing less will do.

We need to examine our existing service delivery system and reconfigure it to maximize resources, reduce waiting lists (an anathema to treatment effectiveness), and expand services. We need to ensure that offenders receive medical services, educational remediation, job training and placement and other life skills as part of their treatment. We need to engage communities and volunteers (including AA and NA) in this process so that needed support is available after the criminal justice system ceases its involvement in a given case.

Our initial focus will be on the probation violation population, as they move through the Drug Court, regardless of whether they end up in prison or in strict community-based

sanctions. Movement through both systems, retention in treatment, and accountability to the criminal justice system will be facilitated and maintained by TASC.

Achieving this goal will require the commitment, talent and energy of each agency and individual that is represented on the Treatment Access Committee. It will require the commitment and support of the Governor and the General Assembly -- a commitment that must extend over election cycles and beyond terms of office. It will require the commitment and flexibility of budget writers and implementers as we weave opportunities for federal dollars into this initiative.

Specific recommendations and assurances:

1. This year, we request an additional $600,000 over and above the SENTAC Initiatives funding to fully implement TASC and treatment tied to the New Castle County Drug Court, and to the Kent/Sussex treatment initiative. The bulk of this funding will supplement residential treatment dollars available in last year's SENTAC Initiatives allocation. Remaining funds will be used to ensure effective case management services, pre-treatment engagement groups and tracking and data systems.

2. The Treatment Access Committee will actively seek federal funds, currently being developed, for Drug Courts, drug treatment, and evaluation this year. Efforts for doing this are already underway, and Delaware is positioned well for receiving them. The expectation is that these funds will be substantially in excess of those committed by the state.

3. The Treatment Access Committee staff will work with Health and Social Services, the Department of Correction, the University of Delaware, and with treatment providers to develop a plan to redesign existing community-based offender dedicated services for no-cost or low-cost implementation during this calendar year. The goals of this plan will be to better utilize existing physical space, improve intake, improve quality of services to offenders, and reduce waiting for admission.

4. Next year the Treatment Access Committee will present a report describing the utilization and impact of all services under our purview, and will begin the process of presenting an annual estimated budget to expand services to impact 10% of the statewide offender population by the year 2000. This translates to a basic doubling, over time, of treatment services currently available in the State, at an estimated cost of $12 to $15 Million.

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APPENDICES

The Offender Profile Index:

A User's Guide

NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS
444 North Capitol Street, N.W., Suite 642
Washington, D.C. 20001

Suggested citation: James A. Inciardi, Duane C. McBride, and Beth A. Weinman, The Offender Profile Index: A User's Guide (Washington, DC: National Association of State Alcohol and Drug Abuse Directors, 1993).

THE OFFENDER PROFILE INDEX:
A User's Guide

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BACKGROUND

As drug abuse escalated during the 1980s, fueling already rising rates of crime across the United States, increasing numbers of drug-involved offenders began coming to the attention of all segments of the criminal justice system. The Drug Use Forecasting (DUF) program, for example, since its inception in 1986, has repeatedly demonstrated that the majority of arrestees in most major cities are drug-involved.[1] By the close of the decade, it had become readily apparent that the criminal justice process had become "drug-driven" in almost every respect. In the legislative sector, new laws were passed to deter drug use and to augment penalties for drug-related crime. In the police sector, increased federal, state, and local funding served to expand street-level drug enforcement initiatives. In the judicial sector, the larger flow of drug cases resulted in overcrowded dockets and court rooms, as well as the creation of new drug courts, special dispositional alternatives for drug offenders, and higher conviction and incarceration rates. In the correctional sector, there was further crowding of already overpopulated jails and penitentiaries, the establishment of liberal release policies, and experimentation with new prison-based drug treatment programs.[2]

As an outgrowth of these phenomena, combined with the research evidence that coerced treatment for drug dependence seems to yield higher retention and lower relapse rates than voluntary treatment,[3] criminal justice systems throughout the United States have expanded the number and variety of diversion programs that offer drug abuse treatment services in lieu of or as a supplement to traditional court sanctions. Most notable in this behalf are the Treatment Alternatives to Street Crime (TASC) programs, approaches designed to serve as liaisons between the local criminal justice systems and community treatment programs. In existence since 1972, TASC programs are operational in more than 100 jurisdictions in 28 states.[4] Because of the documented treatment needs of so many arrestees combined with jail and prison overcrowding, the judiciary has come to be supportive of treatment as an alternative to incarceration.

A related issue is the development of drug testing technologies--primarily urinalysis testing--with pre-trial arrestees. Studies of arrestees in Washington, D.C. and New York City found that persons who

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[1] The Drug Use Forecasting program (DUF) was established by the National Institute of Justice to measure the prevalence of drug use among those arrested for serious crimes. Since 1986, the DUF program has used urinalysis to test a sample of arrestees in selected major cities across the United States to determine recent drug use. Urine specimens are collected from arrestees anonymously and voluntarily, and tested so as to detect the use of ten different drugs, including cocaine, marijuana, PCP, methamphetamine, and heroin. See Leading Drug Indicators, ONDCP White Paper (Washington, DC: Office of National Drug Control Policy, 1990); Eric D. Wish, "Drug Testing and the Identification of Drug-Abusing Criminals," pp. 230-244 in James A. Inciardi (ed.), Handbook of Drug Control in the United States (Westport, CT: Greenwood Press, 1990).

[2] James A. Inciardi, Criminal Justice (Fort Worth: Harcourt Bracè Jovanovich, 1993).

[3] Carl G. Leukefeld and Frank M. Tims (eds.), Compulsory Treatment of Drug Abuse: Research and Clinical Practice (Rockville, MD: National Institute on Drug Abuse, 1988).

[4] James A. Inciardi and Duane C. McBride, Treatment Alternatives to Street Crime: History, Experiences and Issues (Rockville, MD: National Institute on Drug Abuse, 1991).

tested positive by urinalysis at arrest for one or more "hard" drugs (usually heroin, cocaine, or PCP) had a greater number of rearrests than arrestees with a negative test result.[5] Importantly, these and related studies emphasized that extremely high proportions of arrestees were drug-involved, and that urinalysis appeared to be an effective technology for identifying the drug-using arrestee population. Furthermore, the expanded use of urinalysis in the District of Columbia and elsewhere to test and monitor pre-trial arrestees found that urinalysis surveillance reduced the rate of pre-trial misconduct, including rearrest.[6] These studies generated widespread support for drug testing as an adjunct to treatment for some offenders, and as an alternative to treatment for others. And it was within the context of these developments and findings that the Offender Profile Index evolved.

DEVELOPING THE OFFENDER PROFILE INDEX

As urinalysis became increasingly reliable, easy to use, and attractive to judges and policy makers, and as research documenting the effectiveness of drug abuse treatment accumulated, alternative sentences to treatment or drug testing were often considered. However, the judiciary struggled with questions of sorting and referral. How were judges to best determine the most appropriate course of intervention for any given arrestee? For which offenders was urine surveillance most appropriate? How intensive should treatment be for one drug-involved offender versus another?

The issues associated with the appropriate use of urinalysis testing and treatment for drug-involved arrestees resulted in the structuring of the Drug Testing Technology/Focused Offender Disposition Program (DTT/FOD). In 1987, the Bureau of Justice Assistance (BJA) approached the National Association of State Alcohol and Drug Abuse Directors (NASADAD) to:

1. develop and test the utility and reliability of an assessment instrument that would sort drug-using offenders in a way that would enable the courts to make appropriate referrals for drug treatment, drug testing or other human services; and,

2. develop a program methodology that would demonstrate if there existed a drug-abusing offender population that might benefit from a course of drug testing only.

From the outset, the Offender Profile Index (OPI) was not intended to be a complex clinical assessment instrument that yielded a specific treatment plan. Rather, the purpose was to structure a broad "sorting" instrument that would suggest general treatment/intervention alternatives. In developing the instrument, NASADAD worked within "social control" and "stakes in conformity" perspectives found

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[5] Eric D. Wish and Bernard A. Gropper, "Drug Testing by the Criminal Justice System: Methods, Research, and Applications," pp. 321-391 in Michael Tonry and James Q. Wilson (eds.), Drugs and Crime (Chicago: University of Chicago Press, 1990).

[6] Eric D. Wish, Mary Cuadrado, and J.A. Martorana, "Estimates of Drug Use in Intensive Supervision Probationers: Results from a Pilot Study," Federal Probation, 50 (1986), pp. 10-13; C.A. Visher, Assessment of Pretrial Urine Testing in the District of Columbia: A Reanalysis (Washington, DC: National Institute of Justice, 1988); J.A. Carver, Drugs and Crime: Controlling Use and Reducing Risk Through Testing (Washington, DC: National Institute of Justice, September/October 1986).

in studies of prediction in criminology and substance abuse treatment outcome.[7] NASADAD utilized its workgroup, an expert panel of clinicians and researchers in the fields of drug abuse and criminology, to operationalize "stakes in conformity" into specific content areas and to develop specific measurement questions. The content areas included family support, education, school, employment, home/residential stability, criminal justice involvement, psychological functioning, and drug treatment history. In addition, a short "drug severity index" was developed that yielded a numerical score based on the types and frequency of drugs used.

Decisions about categorical cutting points were made by members of the NASADAD expert panel and were based on their experience with the drug using criminal justice population. The summed scores yielded by the OPI recommended alternative treatment options--long term residential, short term residential, intensive or regular out-patient treatment, and urine monitoring only. In addition, but not a part of the scoring, was a brief HIV risk assessment.

TESTING THE OFFENDER PROFILE INDEX

In 1988, NASADAD solicited proposals to test the OPI. Fifteen cites submitted proposals, and the final participants were Phoenix (Arizona), Birmingham (Alabama), and Chicago (Illinois). In all three sites, the local Treatment Alternatives to Street Crime program was the participating organization. In all, more than 1,500 drug offenders referred to the project by the local courts were assessed with the OPI and directed to the designated intervention alternative.[8] Cutting points for scoring were recelebrated on several occasions during the project for the sake of refining the scoring and referral purposes of the instrument.

To determine the utility of the Offender Profile Index, extensive face-to-face interviews were conducted by NASADAD staff and consultants with virtually everyone associated with the DTT/FOD project--judges, probation officers, TASC administrators and case managers, and treatment program representatives. In addition, interviews were conducted samples of participating treatment program clients. Overall, the reviews were highly positive. Judges favored the OPI because its quantitative scoring mechanism provided an objective numerical assessment of treatment need upon which probation and diversion decisions could be made. It also supplied judges with information that was typically

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[7] See David P. Farrington and Roger Tarling, Prediction in Criminology (Albany: State University of New York Press, 1985); Don C. Gibbons, Changing the Lawbreaker: The Treatment of Delinquents and Criminals (Englewood Cliffs: Prentice-Hall, 1965); Travis Hirschi, Causes of Delinquency (Berkeley: University of California Press, 1969); James A. Inciardi and Dean V. Babst, "Predicting the Post-Release Adjustment of Institutionalized Narcotics Addicts," Bulletin on Narcotics, 23 (1971), pp. 33-39; L.C. Sobell and E. Ward (eds.), Evaluating Alcohol and Drug Abuse Treatment Effectiveness: Recent Advances (New York: Pergamon Press, 1980); Jackson Toby, "Social Disorganization and Stake in Conformity: Complementary Behaviors in the Predatory Behavior of Hoodlums," Journal of Criminal Law, Criminology, and Police Science, 46 (1957), pp. 12-17; Delbert S. Elliott, David Huizinga, and Suzanne S. Ageton, Explaining Delinquency and Drug Use (Beverly Hills: Sage Publications, 1985).

[8] For a full description of the full DTT/FOD experience, see Duane C. McBride, James A. Inciardi, and Beth A. Weinman, The Drug Testing Technology/Focused Offender Disposition Program (Washington, DC: National Association of State Alcohol and Drug Abuse Directors, 1992).

unavailable to them at sentencing. Probation officers favored the OPI because it provided them with a comprehensive overview of a client's drug severity, as well as measurements of conformity domains that were easily verifiable from probation records and field visits. Officials at TASC sites, including several who were not part of the project but nevertheless has access to the instrument, preferred the OPI to their local assessment instrument because it yielded the same treatment referral recommendations in a less time consuming and efficient manner. In fact, the Birmingham TASC site modified their local assessment instrument by incorporating much of the OPI. Treatment program officials indicated that OPI-referred clients had been correctly referred.

By contrast, there were a few TASC case managers who disliked the OPI, for two reasons: 1) its numerical scoring precluded the use of clinical skills and insights in making treatment referral decisions; and, 2) the instrument failed to provide enough client data to construct a comprehensive treatment plan. These objections, however, were the result of a misunderstanding of the purpose of the OPI. It was never intended as a comprehensive appraisal of mental health and treatment planning. Rather, it was designed as a broad sorting instrument for general needs assessment.

As the project endured and the OPI became available to court and correctional practitioners across the country, it was generally viewed as an easily scored assessment instrument that provided general guidelines for treatment need. In 1992, furthermore, the State of Delaware adopted the OPI as the needs assessment tool for system-wide treatment planning.

USING THE OFFENDER PROFILE INDEX

To reiterate, the Offender Profile Index is <u>not</u> a clinically-oriented instrument designed to yield a comprehensive substance abuse treatment plan. Rather, it is a broad "sorting' or classification instrument appropriate for determining which <u>type</u> of drug abuse treatment intervention--long term residential, short-term residential, intensive outpatient, regular outpatient, or urine monitoring only. Diagnoses and assessments for comprehensive treatment planning are best accomplished at the particular program to which the client is directed.

The administering of the Offender Profile Index involves a face-to-face interview that can be completed in about 30 minutes. It can be administered by any trained professional with basic interviewing skills. The assessment is essentially self-scoring, and a numerical score corresponds with a specific referral recommendation. A complete copy of the instrument appears at the end of this document, and has been printed in a manner designed for easy reproduction.

As noted earlier, the Offender Profile Index and its associated service recommendations are based on "stakes in conformity." In this behalf, research findings have indicated that individuals with <u>high</u> stakes in conformity (as measured by educational attainment, employment history, living arrangements, and arrest history) are less likely to commit crimes than persons with low stakes in conformity. Data further indicate that persons with high stakes who do commit crimes are less likely to be recidivists than persons with low stakes, and therefore, require less supervision and fewer services.

The specific background data and stake in conformity indices that are included in the Offender Profile Index are:

1. Socio-demographic and Offense Characteristics
2. Drug Severity Index
3. Family/Support Sub-Index
4. Educational Stake Sub-Index
5. School Stake Sub-Index
6. Work Stake Sub-Index
7. Home Stake Sub-Index
8. Criminal Justice History Sub-Index
9. Psychological Stake Sub-Index
10. Treatment Stake Sub-Index
11. HIV Risk Behaviors Sub-Index

Each of the indices and their scoring are discussed in the pages that follow.

General Instructions

The OPI is basically self-explanatory. The interview should be conducted in as private an environment as possible to help ensure accurate answers. The interviewer should explain the basic purpose of the OPI to the subject, focusing on the need to determine the type and level of services required and the need for client cooperation. Answers to the specific questions are indicated by circling the appropriate response or writing it in.
Make sure ALL applicable items are answered and are legible.

Cover Page: Several items are to be entered on the cover page. The first is the client identification number. Since different institutions use different types of identifiers, an ID number arbitrarily consisting of 6 digits has been included here. this can be modified as necessary. The cover page also asks the interviewer to note whether or not verification of the client's criminal justice history has been conducted. This is done to help ensure accuracy in client self-report.

Finally, the cover page asks the results of a preliminary urinalysis test, to be taken before the client is interviewed. This urinalysis is another attempt to ensure client accuracy in self-report. Having the pre-OPI urinalysis report available at the time of the interview allows the interviewer to fully probe the extent of a client's drug use history.

Background Questions

The first series of questions in Part I of the OPI focuses on basic background and socio-demographic characteristics.

Jurisdiction: This item specifies the jurisdiction or court where the case is being handled.

Socio-Demographic Characteristics: The next few items include a variety of client identifiers–name, social security number, date of birth, age, sex, and ethnicity. These items provide basic information that will assist in describing the populations served.

Offenses: These refer to charges in the client's current case. If the client has more than four criminal charges, list only the four primary ones. Since exact terminology for offenses tends to vary from one jurisdiction to the next, these items are left for the interviewer to fill in.

Client Cooperation: This item asks about a client's general state of cooperation. Uncooperative clients are those who refuse to answer the questions posed during the interview process. A client is also deemed uncooperative if he or she refuses the intervention strategy recommended. However, denial of drug use should not be automatically considered as uncooperative behavior. Should the client have a "possession" charge, or exhibit "track marks" or the burns and sores about the mouth typical of chronic crack smokers, but denies drug use, perhaps urinalysis or a restatement of the purpose of the interview is in order. Mentally disoriented clients are those who exhibit extreme confusion, or bizarre behaviors that prohibit the conducting of a meaningful interview. Individual clients deemed uncooperative or mentally disoriented should be referred for psychiatric assessment, or returned to court for an alternate disposition.

Signature and Date of Interview: A signature is recommended for the sake of identifying who conducted the interview should some question rise at a later date. Signatures must be legible. The date of the interview should include month, day, and year.

Drug Severity Index

The Drug Severity Index was developed after reviewing the many attempts to scale drug use patterns described in the research literature.[9] It examines types of drugs used and frequency of use to assign an index score. Drug severity should be based on a client's last 90 days on the street, whether that be prior to arrest or while on probation. Descriptive information on age of first use and first continued use, although not scored, is useful for better understanding the characteristics of the overall target population.

At first glance the drug severity index might appear quite complex since there are drugs, drug groups, frequency codes, and severity codes. Some explanation plus a little practice with the instrument will demystify it all rather quickly.

First, there are 17 drugs grouped into four major categories. Category A includes alcohol and marijuana. Category B includes inhalants, hallucinogens, and sedative pills. Category C includes stimulant pills, non-intravenous (IV) cocaine, amphetamines and ice, crack, oral opiates, and basuco (coca paste). Category D includes all forms of IV drug use, speedballing, and the use of street methadone. Categories A through D reflect a progression of involvement in drug abuse.

Second, there are four drug frequency codes, all of which are self-evident.

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[9] For example, see Robert M. Bray, William S. Schlenger, S. Gail Craddock, Robert L. Hubbard, and J. Valley Rachal, Approaches to the Assessment of Drug Use in the Treatment Outcome Prospective Study (Research Triangle Park, NC: Research Triangle Institute, 1982); Richard R. Clayton and Harwin L. Voss, Young Men and Drugs in Manhattan: A Causal Analysis (Rockville, MD: National Institute on Drug Abuse, 1981).

Third, there are seven possible drug severity scores, ranked from 6 to 0. Code 6 indicates minimal drug use, and hence, low drug severity. At the other end, code 0 indicates the intravenous (IV) use of heroin, and thus, extremely high drug severity. More specifically:

6 = code 0 in A through D
or
code 1 in A and B

A client receives a drug severity score of 6 if he or she does not use any of the drugs listed (a frequency code of 0) or uses any of the drugs in categories A or B less than once a week (a frequency code of 1). These individuals are considered light or non-users.

5 = code 2 in A
or
code 0 or 1 in B

A client receives a drug severity score of 5 if he or she uses alcohol or marijuana (category A) no more than once a week (a frequency code of 2), and uses any of the drugs in category B less than once a week or not at all (frequency code of 0 or 1). These individuals are considered moderate to heavy alcohol and/or marijuana users.

4 = code 3 in A
or
code 2 or 3 in only one drug in B

A client receives a drug severity score of 4 if he or she uses alcohol or marijuana daily (frequency code of 3 in category A), or uses no more than one drug in category B once a week or more (a frequency code of 2 or 3). These individuals are considered heavy alcohol and/or marijuana users, who may also use one other drug fairly regularly.

3 = code 2 or 3 in 2 or more drugs in B
or
code 1 in C

A client receives a drug severity score of 3 if he or she uses 2 or more drugs in category B at least weekly (frequency code of 2 or 3). A person may also receive a drug severity score of 3 if he or she uses any drug in category C less than once per week. These individuals are considered moderate to heavy poly-drug abusers.

2 = code 2 or 3 in C

A client receives a drug severity score of 2 if he or she uses speed, crank, or some other form of stimulant pills, snorts cocaine, and/or smokes crack, ice or basuco (category C) once a week or more (a frequency code of 2 or 3). These individuals are considered regular amphetamine or cocaine users, but do not use their drugs intravenously.

1 = code 1 in D

A client receives a drug severity score of 1 if he or she uses any drugs intravenously or illegal methadone (category D) less than once a week (a frequency code of 1). These individuals are considered light IV drug users.

0 = codes 2 or 3 in D

A client receives a drug severity score of 0 if he or she uses illegal methadone at least weekly or takes other drugs intravenously at least weekly (a frequency code of 2 or 3 in category D). These individuals are considered heavy IV users.

As noted earlier, although the drug severity index may appear confusing at first, its logic becomes readily apparent after it is administered a few times. Moreover, with most clients there are scoring short-cuts. For example, if the client's drug use is limited to alcohol or marijuana, then the drug severity score is either a 5 or a 6. If the client is an IV drug user, then the severity score is automatically a 0 or 1. Likewise, there are other patterns that will emerge after repeated use of the instrument. The appropriate drug severity score is to be entered in the space provided at the lower right corner of the page.

Family/Support Stake Sub-Index

The purpose of the family/support stake sub-index is to document the stability of the client's human relationships as well as the crime or substance use problems of those with whom he or she is close. This sub-index is based on 4 specific items: living arrangements; stability of living arrangements; proportion of friends who have been incarcerated 30 days or more; and the pro-portion of friends who have received or are receiving alcohol or other drug treatment.

Living arrangements: Question 1 asks the client to indicate with whom he or she is currently living. A score of 2 is recorded in the space provided to the right of the question if the client is living with a spouse, sex partner, or family. A score of 1 is recorded if the client is living alone or with friends, and a score of 0 is noted if he or she lives on the street or in some type of institution.

Stability of living arrangements: Question 2 asks about the length of time the client has been in his or her current living pattern. If it has been 1 year or more, a score of 2 is recorded; if it has been 6-12 months a score of 1 is recorded; and if it has been less then 6 months a score of 0 should be recorded.

Questions 3 and 4 focus on whether the client's spouse, sex partner, or whomever else he or she is living with has been treated for an alcohol or drug problem or has gone through detoxification. "Detox" is mentioned separately here since many street drug users don't consider it to be "treatment." Whether or not the client's spouse, sex partner, or whomever else he or she is living with has been incarcerated for 30 days or longer is also asked.

Question 5 asks the client about the number of his or her close friends, prior to his or her arrest. "Close friends" has not been operationally defined here because it is a subjective designation that will likely vary from one individual to the next. For one client it may be a crime partner or "running" partner. For another it may be a drinking or bowling friend. For still others it may include people in whom they can confide. In any case, most people consider "close" friends to be persons with whom they

have considerable contact, identify with, look up to, or in some other way have a significant relationship. (It should be noted here that the answers to Questions 3, 4, and 5 are not used to score the family/support stake sub-index. For analytical purposes, however, the information is important.)

Proportion of friends incarcerated 30 days or more: Question 6 focuses on how many of the client's close friends (the friends numbered in Question 5) have served time in jail or prison. If half or more have been incarcerated for 30 days or longer then a score of 0 is recorded; if it is none or almost none then a score of 2 is recorded.

Proportion of friends receiving treatment: Question 7 focuses on the number of close friends who have been treated (including detox.) for substance abuse. If half or more have been treated, a score of 0 should be recorded in the space provided; if it is less than half, a 1 should be recorded; and if it is none or almost none, then a score of 2 should be recorded.

Computing the Family/Support Sub-Index Score. As is indicated on the OPI, the Family/Support Sub-index score is computed by totaling the scores in questions 1, 2, 6, and 7. If that figure totals 6 to 8, circle the 2 in the Family/Support score line (the last line on the page). This score indicates that the client has a high degree of stable non-deviant relationships, and thus, a high family/support stake in conformity. If the summed score is 4 or 5, circle the 1 on the last line. This indicates a moderate stake. If the summed score is 3 or less, circle the 0. This indicates that the client has minimal or no stable relationships with non-drug users or non-criminals.

Educational Stake Sub-Index

The purpose of the Educational Stake Sub-Index is to document the educational attainment of the client. Those who have higher educational levels are assumed to have higher stakes in conventional behavior.

The four questions in this sub-index simply ask for the total number of years of normal education (question 1). If the client has less than 12 years of schooling (i.e., less than the completion of high school), questions 2 and 3 determine if he or she has a GED or has had any vocational or technical training. Question 4 asks for the specific vocational/technical courses completed.

In filling out this section, one needs first to record the number of grades completed in the space provided to the right of question 1. If this number is 12 or more, proceed directly to the scoring. If it is less than 12, ask questions 2, 3, and 4. Record the answers to 2 and 3 by circling the appropriate item. The answer to question 4 should be entered clearly and concisely in the space provided.

Computing the Educational Stake Sub-Index Score. A score of 2 is circled if the client has completed 12 or more years of education; or has earned a GED ("yes" in question 2); or has completed 9 or more years, plus vocational or technical training ("yes" in question 3). These individuals are seen as having a high educational stake. A score of 1 is circled if the client has completed 9-11 years of education but has not earned a GED, and has not had any vocational or technical training. These individuals are seen as having a moderate educational stake.

A score of 0 is circled if the client has completed 8 years of education or less. These individuals are seen as having a low educational stake.

School Stake Sub-Index

Because of the relatively young age of many offenders, it is possible that some might still be attending high school or a vocational training program at the time of processing, rather than having full or part-time employment. Thus, it is important to determine if they have a current school stake. The fact that someone makes the effort to attend classes suggests some level of stake in conformity.

Question 1 asks if the client is currently attending school. If the answer is no, item 2 on this page instructs you to circle 0 in the school stake score at the bottom of the page and proceed to the next sub-index (Employment). If the answer is yes, ask question 3. Question 3 attempts to determine if the client is currently a full- or part-time student. If he or she is full-time, circle 2 in the School Stake Score. If he or she is part-time then circle 1.

The enrollment verification is obtained by recording the specific name of the school, as well as its address and school telephone number. No less than a 10 percent random sample of cases should be verified. Please note at the bottom of the page if the information was verified and whether it was accurate.

Work Stake Sub-Index

The Work Stake Sub-Index is intended to document the client's current or recent employment activity. Question 1 asks how many weeks the client worked during the past year either outside the home or as a homemaker with responsibilities for others. In the space provided below and to the right of question 1, assign a weight of 2 for 35 weeks or more; a weight of 1 for 20-34 weeks; and a weight of 0 for less than 20 weeks.

Question 2 asks if the client is currently employed. Circle the appropriate answer. If yes, ask question 3; if no, ask question 4.

Question 3 asks the client to indicate how many hours he or she typically works outside the home or as a homemaker. In the space provided below and to the right of question 3, assign a weight of 2 if the client works 35 hours or more a week; a weight of 1 if the client works 14-34 hours a week, and a weight of 0 if the client works less than 15 hours a week.

Question 4 is asked of those who are not currently employed, focusing on their most recent job--inside or outside the home. Assign a weight of 2 in the space provided below and to the right of question 4 for those who worked 35 hours or more per week; a weight of 1 for those who worked 15-34 hours per week; and a weight of 0 for those who worked less than 15 hours per week at their last job.

Space is provided to record the client's current or last employer, address, telephone number, and supervisor's name. For a homemaker, the pre-sentence investigation report (if available) can be used to verify client information. No less than 10 percent of the clients should have their employment verified. Since a recent pay stub serves as adequate verification, all clients should be asked if they can provide one. At the bottom of the page indicate if there was verification and if the information was accurate.

Computing the Work Stake Sub-Index Score. The Work Stake Sub-index is scored by summing the weights derived from the answers in questions 1, and 3 or 4. At the bottom of the page,

circle 2 for when the sum of scores is equal to 4; circle 1 when the sum or scores is 2 or 3; and circle 0 for those with 0 or 1. Those with a score of 2 are considered to have a high work stake; those with a 1 have a moderate work stake, and those with a 0 are considered to have a low work stake.

Home Stake Sub-Index

The purpose of this sub-index is to document the type and stability of the client's residence during the past year. Question 1 asks for the client's current residence and telephone number. Please record the information clearly. This should be verified for all clients. A recent bill or postmarked letter with the client's name and address will suffice, and it should be the responsibility of the client to get this type of document to the interviewer.

Questions 2 and 3 solicit the length of time at the residence in question 1. If the client has lived at the current address at least 12 months, proceed to question 5. Question 5 asks if the client contributed to the payment of his or her lodging--whether it be rent or mortgage. Check the appropriate space indicating if the client contributes "all," "some," or "none" of the rent or mortgage money.

Space is provided for verification. As noted above, the most recent residence of all clients residences should be verified. In addition, the date of the residence check, the name of the checker, and the results of the check must be indicated in the space provided.

Computing the Home Stake Sub-Index Score. The Home Stake Sub-index score is computed on the basis of three items: contributions to rent or mortgage, number of residences, and validity of residence information.

A score of 2 is circled if the client pays all of the rent or mortgage (question 5), has had less than four residences in the last 12 months (questions 3 & 4), and the residence has been verified as correct. All three of these conditions must be met!
A score of 2 is considered to indicate a high home stake.

A score of 1 is circled if the client made some contribution to his or her housing costs (question 5), had less than 6 residences in the last 12 months (question 4), and provided correct residence information. All three of these conditions must be met! A score of 1 is considered to indicate a moderate home stake.

A score of 0 is circled if the client made no contribution to his or her housing costs (question 5), or had 6 or more residences in the last year (question 4), or if the residence information was found to be false. As such, if any of these three conditions are met the score becomes 0, and is considered to indicate a low home stake.

Should a client or a member of his or her household be unable to provide residence verification information, the score becomes 0. Different residence information yielded by the verification process should be recorded.

Criminal Justice History Sub-Index

The Criminal Justice History Sub-Index is designed to indicate the extent of client involvement with the criminal justice system. The questions are very straight forward. Question 1 asks the client to indicate the total number of arrests he or she has had in the last 5 years. Question 2 asks for the total number of convictions in the last 5 year. Question 3 asks for the total time served in detention, jail, or prison (in months) during the past 5 years. The client's self report should be comparable to the criminal justice verification of arrests done by the interviewer.

Computing the Criminal Justice History Sub-Index Score. A score of 2 is circled for the Criminal Justice History Sub-Index if the client has had 2 arrests or less and/or no more than 45 days incarcerated. A score of 2 is considered to indicate a relatively high stake in non-criminal behavior.

A score of 1 is circled if the client has had 3-10 arrests and/or 46 days to 6 months of incarceration in the last 5 years.
A score of 1 is considered to indicate a moderate stake in non-criminal behavior.

A score of 0 is circled if the client has had 11 or more arrests and/or has been incarcerated for more than 6 months in the last 5 years--reflecting a low stake in non-criminal behavior.

In scoring this sub-index, time incarcerated should weigh more heavily than the number of arrests, since time incarcerated usually indicates the severity of crimes committed.

Psychological Stake Sub-Index

The general focus of the various sub-indices thus far has been on objective behaviors and verifiable facts. However, it is also important to include one sub-index that focuses on emotional health. This is not a psychiatric diagnostic tool, but rather a simple attempt to give a rough indicator of emotional functioning.

Question 1 asks the respondent to indicate if he or she has ever acted out of control--even when not on drugs. A score of 2 is recorded on the line to the right and below question 1 if the client indicates there have been no such "out of control" episodes. A score of 1 is recorded if there was 1 such episode, and a score of 0 if there were 2 or more episodes.

Question 2 asks if the client ever attempted or seriously considered suicide. A score of 2 is recorded in the space to the right and below question 2 if the client answered "no" to both parts of question 2. A score of 1 is recorded if the client considered suicide but never attempted it. A score of 0 is recorded if the client attempted suicide.

Question 3 asks about treatment for nervous or mental problems. A score of 2 is recorded in the space to the right and below question 3 if the client has never been treated for nervous or mental problems. A score of 1 is recorded if the client has been treated once, and a score of 0 is recorded if the client has been treated more than once.

Computing the Psychological Stake Sub-Index Score. First sum the scores recorded for questions 1, 2, and 3. This is the total composite score for this sub-index, and should be recorded in the

space provided. A Psychological Stake Sub-Index Score of 0 is circled if the total composite score is 0 or 1. This score is considered to indicate potentially severe psychological problems. A score of 1 is circled if the total composite score is 2, 3, or 4. This score is considered to indicate a moderate level of psychological problems. A score is considered indicative of a high degree of stable emotional functioning.

Treatment Stake Sub-Index

This brief sub-index consists of only one question: "How many months have you spent in treatment during the past 5 years?" Circle 2 if the client has been in treatment 12 months or more in the last 5 years, and circle 0 if the client has been in treatment for less than 12 months.

Although the logic of this scoring may appear a bit peculiar at first, it is based on the research finding that individuals who have spent 12 months or more in drug abuse treatment are more likely to have positive treatment outcomes than those who have not. A treatment stake score of 2 is considered to indicate a high stake in successful treatment outcome. A score of 0 is considered to indicate a low stake in successful treatment outcome.

HIV Risk Behaviors Sub-Index

This section of the OPI is designed to provide information on the AIDS-related risk behaviors of the client population. The information obtained is not used in computing the final OPI score. Rather, it represents a step in documenting the distribution of risk behaviors of those coming to the attention of the local criminal justice system. The questions are straight-forward, self-explanatory, and require that the appropriate answer be circled in each instance. Five specific risk behaviors are focused on:

1. The number of sex partners
2. The use of condoms
3. Anal penetration
4. The sharing of needles
5. The cleaning of needles

There are separate questions for males, females, and IV drug users. Questions 1 and 2 are for everyone. Questions 3 through 6 are for males only; questions 7 and 8 are for females only; and questions 9 through 13 are for IV drug users of both sexes. At the bottom of page 12, the interviewer is asked to indicate if the client is at high risk for HIV infection. A client is considered to be at high risk for HIV infection if he or she:

1. had unprotected sex with multiple partners during the past year;
2. had any sexual contacts with IV drug users;
3. shared drug paraphernalia with IV drug users and did not properly clean them before use; and,
4. engaged in sex involving anal penetration.

Profile Summary

Part IV of the OPI involves the actual computation of the total score and the determination of recommended services. The drug use severity score and the stake in conformity scores for each of the 8 sub-indices can be obtained from the bottoms of the appropriate pages in the instrument. Sum the 8 sub-index scores and record as indicated adjacent to the line labeled "Total Stake in Conformity Score."

The higher stake in conformity scores combined with less serious and less frequent drug use results in a recommendation of less intensive services. At the other end of the continuum, low stake in conformity scores and/or IV drug use result in a recommendation of long term, residential treatment.

Services Recommended

1. Long-term Residential Treatment: Long-term residential treatment is recommended for any client who uses illegal methadone or any drugs intravenously–heroin, other narcotics, cocaine, or amphetamines.

   Intravenous (IV) drug use has been found to be the culmination of a drug-using career. Given the many psychological, behavioral, and physical consequences associated with IV drug use, the intense supervision and services of long-term residential care are required.

2. Short-term Residential Treatment: Short-term residential treatment is recommended for any client with a drug use severity score of 2, and a stake in conformity of less than 12. These individuals use non-IV stimulants or oral opiates on a weekly basis and require the services and supervision provided within the context of short-term residential care.

3. Intensive Outpatient Treatment: Intensive outpatient treatment is recommended in two situations.

   (1) The first involves persons with a Drug Use Severity score of 3 and a stake in conformity score of less than 12. While this person may be using several drugs regularly, he or she may not yet need the more rigid monitoring of a short-term facility; thus, he or she is placed in the most stringent of the non-residential categories.

   (2) The second involves persons with a Drug Use Severity score of 2 and a high stake in conformity (12 or higher). These persons are somehow able to maintain a job and stable living arrangements, while using non-IV cocaine, crack, amphetamines or oral opiates on a weekly basis. Therefore, these individuals require some level of intensive attention, but do not require residential treatment.

4. Outpatient Treatment: Outpatient treatment is recommended in two situations.

   (1) The first involves persons with a Drug Use Severity score of 4 and a total stake in conformity of less than 12. These individuals are daily users of alcohol and/or marijuana who also use one Category B drug and have low to moderate stakes in conformity. Because drug use has apparently progressed beyond experimental or social, recreational levels combined with less than optimal stakes in conformity, it is believed that the additional supervision and services of outpatient treatment are required.

(2) The second involves the client with a more serious drug problem, e.g., a Drug Use Severity of 3. Clients in this group are poly-drug users. Even with a high stake in conformity score (12 or better), outpatient treatment is recommended for these typically non-recreational users.

5. Urine only: Urine monitoring only is recommended in two situations.

(1) The first includes clients with a Drug Severity Score of 5 or 6. Individuals with this drug severity score only use alcohol and/or marijuana, or use other drugs (including sedatives, inhalants, and hallucinogens) less than once a week. Since they are non-users of other drugs, they qualify for urine only regardless of their stake in conformity score.

(2) The second includes clients who have a total stake in conformity score 12 or more (and thus a high stake), and have a Drug Severity Score of 4, (daily users of alcohol and/or marijuana plus one drug in category B) also qualify for urine only. Because of their minimal illegal drug use and/or their relatively high stakes in conformity, they are considered the best candidates for a urine monitoring program.

The Need For AIDS Education/Intervention

If the conclusion was reached that the client is at high risk for HIV infection, then "yes," should be circled at the end of the instrument, and HIV/AIDS prevention/intervention services should be provided. At a minimum, AIDS prevention literature should be made available to all clients.

OFFENDER PROFILE INDEX

CASE # _ _ _ _ _ _

CRIMINAL JUSTICE VERIFICATION

Arrests Verified: _____

Date of Verification: ____

Not Verified: _____

URINALYSIS RESULTS (PRELIMINARY):

Negative for All Drugs: ____

Positive for:

Cocaine	_____
Opiates	_____
Amphetamines	_____
THC	_____
Benzodiazepines	_____
Barbiturates	_____
Phencyclidine	_____

Date of Test: _____

Confirmed: Yes __ No __

PART I: Background Information

Jurisdiction: _____

Client's Name: _____
Last First Middle

Social Security Number: _ _ _ - _ _ - _ _ _ _

Date of Birth: _ _ / _ _ / _ _
Month Day Year

Age: ____

Please circle appropriate responses:

Sex: 1. Male 2. Female

Ethnicity:

1. White
2. Black American
3. Black/Haitian
4. Black/Other Caribbean
5. Native American
6. Asian or Pacific Islander
7. Hispanic/Mexican
8. Hispanic/Cuban
9. Hispanic/Puerto Rican
10. Hispanic/Other

Type of Client:

1. Pre-Sentencing
2. Sentencing
3. Post-Sentencing

Offenses:

1. _____
2. _____
3. _____
4. _____

UNCOOPERATIVE/DISORIENTED CLIENTS: If client refuses to cooperate or appears too disoriented to provide the information requested, the interview should be terminated and the appropriate indicator circled.

Client was:

1. Mentally Disoriented
2. Uncooperative
3. Cooperative, continue interview

_____
Interviewer's Signature

_____
Date of Interview

PART II: DRUG SEVERITY INDEX

Illegal Drugs and/or Non-Medical Use of Prescription Drugs	Age of 1st Use	Age of 1st Continued Use	CODING FREQUENCY: 3=daily 2=1/wk or more 1=less than 1/wk
A.			
1. ALCOHOL	____	____	____
2. MARIJUANA, kif hashish, etc.	____	____	____
B.			
3. INHALANTS, glue solvents, etc.	____	____	____
4. HALLUCINOGENS lsd, pcp, etc.	____	____	____
5. PILLS, downers, prescribed sedatives, tranquilizers	____	____	____
C.			
6. PILLS, uppers, speed, crank	____	____	____
7. AMPHETAMINES, Ice, crystals	____	____	____
8. OPIATES, pills, Dilaudid, codeine, T's and Blues	____	____	____
9. COCAINE, non-IV, inhalation,snorting	____	____	____
10. CRACK, freebase	____	____	____
11. BASUCO, coca paste	____	____	____

D.

12. HEROIN, (IV)	____	____	____
13. COCAINE, (IV)	____	____	____
14. SPEED, (IV)	____	____	____
15. OTHER IV NARCOTICS	____	____	____
16. COCAINE/HEROIN (IV) speedball	____	____	____
17. ILLEGAL METHADONE	____	____	____

SCORING:

6 = 0 in A - D OR 1 in A
5 - 2 in A OR 1 in B
4 = 3 in A OR 2 or 3 in only 1 drug in B
3 = 2 or 3 in TWO or more drugs in B OR 1 in C
2 = 2 or 3 in C
1 = 1 in D
0 = 2 or 3 in D

DRUG SEVERITY SCORE _____

PART III: STAKE IN CONFORMITY INDEX

A. Family/Support Stake Sub-Index

1. With whom are your currently living? ___

a. spouse/sex partner	= 2
b. parents/family	= 2
c. alone/friends	= 1
d. street/institution	= 0

2. If (a) or (b) above, how long have you been living in that arrangement? ___

1 year or longer	= 2
6 to 12 months	= 1
less than 6 months	= 0

3. Has your spouse/sex partner or any of the people with whom you are currently living EVER been incarcerated for 30 days or longer? (1) Yes (2) No ___

4. Has your spouse/sex partner or any of the people with whom you are living ever been treated for a drug or alcohol problem or gone through detox?
(1) Yes (2) No ___

5. How many close friends do or did you have prior to your arrest? ___ (not scored)

6. How many of these friends have EVER been incarcerated for 30 days or longer? ___

half or more	= 0
less than half	= 1
none or almost none	= 2

7. How many of these friends have ever been treated for a drug or alcohol problem, or have gone through detox? ___

half or more	= 0
less than half	= 1
none or almost none	= 2

TOTAL COMPOSITE SCORE for questions 1, 2, 6, 7 above: ___

Family/Support Stake Sub-Index Scoring

Assign a weight of 0 for a composite score of 0 - 3
Assign a weight of 1 for a composite score of 4 - 5
Assign a weight of 2 for a composite score of 6 or greater

FAMILY/SUPPORT STAKE SCORE (circle the appropriate score): 0 1 2

B. Educational Stake Sub-Index

1. What is the highest grade in school that you completed? (If 12 years or more, proceed to scoring below) ___

2. If less than 12, did you receive a GED? 2) Yes 1) No (If client received GED, proceed to scoring below)

3. Have you attended any vocational/technical courses? (If no, proceed to scoring 2) Yes 1) No below)

4. If yes, what courses or training programs did you complete?

_____

_____

Educational Stake Sub-Index Scoring

Assign a weight of 2 for: 12 or more years of schooling, or GED, or 9 or more years + completed skills training

Assign a weight of 1 for: 9 - 11 years without completed skills training

Assign a weight of 0 for: 8 years or less

EDUCATIONAL STAKE SCORE (circle the appropriate score): 0 1 2

C. **School Stake Sub-Index**

1. Are you currently attending school? 2) Yes 1) No

2. If **No**, score 0 below and go to Work Stake Sub-Index

3. If **Yes**, is schooling full- or part-time?

   If Full-time, score 2 below

   If Part-time, score 1 below

Interviewer: Obtain enrollment verification information below:

1) Not Verified 2) Inaccurate 3) Accurate

Enrollment Verification Information

Name of School: _____

Address: _____

_____

Telephone Number: _____

SCHOOL STAKE SCORE (circle the appropriate score): 0 1 2

D. Work Stake Sub-Index

1. How many weeks have you worked outside the home and/or as a homemaker (with responsibility for others) during the past 12 months? ___

   Assign a weight of 2 for 35 weeks or more
   Assign a weight of 1 for 20 - 34 weeks
   Assign a weight of 0 for less than 20 weeks ___

2. Are you currently employed outside the home and/or as a homemaker (with responsibility for others)? 2) Yes 1) No

3. If YES, how many hours a week do you typically work? ___

   Assign a weight of 2 for 35 or more hours/week
   Assign a weight of 1 for 15 - 34 hours/week
   Assign a weight of 0 for less than 15 hours/week ___

4. If NO, how many hours a week did you work on your last job? ___

   Assign a weight of 2 for 35 hours or more/week
   Assign a weight of 1 for 15 - 34 hours/week
   Assign a weight of 0 for less than 15 hours/week ___

INTERVIEWER: Obtain employment verification information below

Employment Verification Number

Name of Employer: _____

Address: _____

Telephone Number: _____

Supervisor's Name: _____

1) Not Verified 2) Inaccurate 3) Accurate

Work Stake Sub-Index Scoring

Sum of Scores (from questions 1 and 3 or 4) = ___

Assign a weight of 2 for a composite score of 4
Assign a weight of 1 for a composite score of 2 - 3
Assign a weight of 0 for a composite score of 0 - 1

WORK STAKE SCORE (circle the appropriate score): 0 1 2

E. Home Stake Sub-Index

1. What is your most recent residence:

_____
Street

_____
City State Zip Code
Telephone: _____

2. Dates you resided there: From _____ to _____

3. Number of months at that residence: _____
(If 12 months or more, proceed to question #5)

4. How many residences have you had during the past 12 months? ___

5. During the past 12 months, how much were you contributing to the rent or mortgage of the place(s) you were living?
1) ___ none 2) ___ some 3) ___ all

VERIFICATION

___ place of last residence verified as correct
___ dates of last residence verified as correct
___ place of last residence verified as incorrect
___ dates of last residence verified as incorrect
___ residence not verified

Date of residence check: _____

Name of checker: _____

Home Stake Sub-Index Scoring

Assign a weight of 0 if the client: made no contribution to the rent of mortgage during the past 12 months or had 6 or more residences, or if most recent residence was false.

Assign a weight of 1 if the client: made some contribution to the rent or mortgage during the past 12 months or had 4 - 5 residences, and most recent residence was verified as correct.

Assign a weight of 2 if the client: made the total contribution to the rent or mortgage, and had less than 4 residences, and the residence was verified as correct.

HOME STAKE SCORE (circle the appropriate score): 0 1 2

F. Criminal Justice History Sub-Index

1. Total arrests in last 5 years: ___

2. Total convictions in last 5 years: ___

3. Total time served (months) in last 5 years: ___

Criminal Justice History Scoring

Assign a weight of 2 if client:	no more than 2 arrests and/or 45 days incarcerated in the last 5 years
Assign a weight of 1 if client:	3 to 10 arrests and/or 6 months incarcerated in the last 5 years
Assign a weight of 0 if client:	11 or more arrests and/or more than 6 months incarcerated in the last 5 years

NOTE: In scoring, time incarcerated should weigh more heavily than # of arrests.

CRIMINAL JUSTICE SCORE (circle the appropriate score): 0 1 2

G. Psychological Stake Sub-Index

1. Have you ever felt if you had acted out of control, or have others told you that you had acted out of control, at any time when you were NOT under the influence of alcohol or drugs? 1) Yes 2)No

   If "YES," how many times in the last year? ___

   Score 2 if none
   Score 1 if only 1 time
   Score 0 if 2 or more times ___

2. Have you ever attempted suicide? 1) Yes 2) No

   If "NO," have you ever seriously considered suicide?
   1) Yes 2) No

   Score 2 if no to both questions
   Score 1 if yes to considered
   Score O if yes to attempted ___

3. Have you ever been treated for nervous or mental problems? 1) Yes 2) No

   If "YES," how many times did you receive treatment? ___
   Score 2 if never treated
   Score 1 if treated once
   Score 0 if treated 2 or more times ___

TOTAL COMPOSITE SCORE FOR QUESTIONS 1 - 3 ABOVE: ___

Psychological Stake Sub-Index Scoring

Assign a weight of 2 for a composite score of 5 - 6
Assign a weight of 1 for a composite score of 2 - 4
Assign a weight of 0 for a composite score of 0 - 1

PSYCHOLOGICAL STAKE SCORE (circle appropriate score): 0 1 2

H. Treatment Stake Sub-Index

1. How many months have you spent in drug abuse treatment during the past 5 years? ____

Assign a weight of 2 for 12 months or more
Assign a weight of 0 for less than 12 months

TREATMENT STAKE SCORE (circle the appropriate score): 0 1 2

I. HIV Risk Behaviors Sub-Index

1. How many sex partners have you had in the last year? ___

2. What proportion of the time were condoms used?
   1. None
   2. About a quarter
   3. About half
   4. About three-quarters
   5. Almost all

FOR MALES ONLY

3. What proportion of your sex partners were prostitutes?
   1. Almost all
   2. About three-quarters
   3. About half
   4. About a quarter
   5. None

4. What proportion of these sex partners were IV drug users?
   1. Almost all
   2. About three-quarters
   3. About half
   4. About a quarter
   5. None

5. What proportion of these sex partners were males?
   1. Almost all
   2. About three-quarters
   3. About half
   4. About a quarter
   f. None

6. If any were males, what proportion of the time did sexual contact involve anal penetration?
   1. Almost all
   2. About three-quarters
   3. About half
   4. About a quarter
   5. None

FOR FEMALES ONLY

7. What proportion of your sexual partners were IV drug users?
   1. Almost all
   2. About three-quarters
   3. About half

4. About a quarter
5. None

8. What proportion of the time did sexual intercourse involve anal penetration?
   1. Almost all
   2. About three-quarters
   3. About half
   4. About a quarter
   5. None

ASK BOTH MALES AND FEMALES (IV DRUG USERS ONLY)

9. When you had your own works, how often did you share them with others?
   1. More than half the time
   2. About half the time
   3. About a quarter of the time
   4. Almost never

10. After sharing your works, how often did you clean them before using them yourself?
   1. Almost never
   2. About a quarter of the time
   3. About half the time
   4. More than half the time
   5. Never shared

11. What do you usually use to clean your works?
   1. Never clean them
   2. Other (specify) _____
   3. Water
   4. Alcohol
   5. Bleach

12. When you did not have your own works, how often did you clean the works you borrowed?
   1. Almost never
   2. About a quarter of the time
   3. About half the time
   4. More than half the time

13. On these occasions, how did you clean these works?
   1. Never clean them
   2. Other (specify) _____
   3. Water
   4. Alcohol
   5. Bleach

INTERVIEWER: Is client at high risk for HIV infection? Yes No

PART IV: PROFILE SUMMARY

1. Drug Use Severity (from page 3) ___

2. Stake in Conformity
   - A. Family/Support Score (from page 5) ___
   - B. Educational Stake Score (from page 6) ___
   - C. School Stake Score (from page 7) ___
   - D. Work Stake Score (from page 8) ___
   - E. Home Stake Score (from page 9) ___
   - F. Criminal Justice Stake Score (from page 10) ___
   - G. Psychological Stake Score (from page 11) ___
   - H. Treatment Stake Score (from page 12) ___

TOTAL STAKE IN CONFORMITY SCORE ___

Profiles (circle one)

1.	**Long-term Residential Treatment**	0 or 1 drug severity
2.	**Short-term Residential Treatment**	2 in drug severity plus conformity stake of less than 12
3.	**Intensive Outpatient Treatment** (must have contact with client in a therapeutic session of at least one hours duration, 3 times/week or more)	a) 3 in drug severity plus conformity stake of less than 12 OR b) 2 in drug severity plus conformity stake of at least 12
4.	**Outpatient Treatment** (must have contact with client in a therapeutic session of at least one hours duration, no less than one time/week	a) 4 in drug severity plus conformity stake of less then 12 OR b) 3 in drug severity plus conformity stake of at least 12
5.	**Urine Only**	a) 5 or 6 drug severity OR b) 4 drug severity plus conformity stake of at least 12

Is AIDS prevention/intervention indicated? Yes No

In completing the interview it has been determined that the client experiences overriding mental health problems and is not suitable for drug intervention. *(Circle) Yes No*

APPENDIX B

Self-Reported Frequency of Drug Use last 90 days for Delaware Department of Correction Populations: Levels 1 - 5

LEVEL OF CUSTODY

DRUG by Frequency of Use last 90 days	Level 1 Probation		Level 2 Probation		Level 3 Probation		Level 4 WR, TX, HC*		Level 5 Prison		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Alcohol												
no use	8	(19.5%)	56	(23.7%)	69	(31.4%)	131	(64.2%)	62	(21.0%)	326	(32.7%)
<1 week	14	(34.1%)	67	(28.4%)	64	(29.1%)	40	(19.6%)	40	(13.6%)	225	(22.6%)
>1 week	15	(36.6%)	93	(39.4%)	70	(31.8%)	23	(11.3%)	85	(28.8%)	286	(28.7%)
daily	4	(9.8%)	20	(8.5%)	17	(7.7%)	10	(4.9%)	108	(36.6%)	159	(16.0%)
Marijuana												
no use	28	(68.3%)	156	(66.1%)	156	(70.9%)	177	(86.8%)	150	(50.8%)	667	(67.0%)
<1 week	5	(12.2%)	46	(19.5%)	40	(18.2%)	13	(6.4%)	39	(13.2%)	143	(14.4%)
>1 week	6	(14.6%)	27	(11.4%)	21	(9.5%)	12	(5.9%)	53	(18.0%)	119	(12.0%)
daily	2	(4.9%)	7	(3.0%)	3	(1.4%)	2	(1.0%)	53	(18.0%)	67	(6.7%)
Inhalants												
no use	41	(100.0%)	235	(99.6%)	220	(100.0%)	204	(100.0%)	294	(99.7%)	994	(99.8%)
<1 week	--	--	--	--	--	--	--	--	1	(.3%)	1	(.1%)
>1 week	--	--	1	(.4%)	--	--	--	--	--	--	1	(.1%)
daily	--	--	--	--	--	--	--	--	--	--	--	--
Hallucinogins												
no use	39	(95.1%)	233	(98.7%)	217	(98.6%)	203	(99.5%)	280	(94.9%)	972	(97.6%)
<1 week	2	(4.9%)	3	(1.3%)	3	(1.4%)	--	--	10	(3.4%)	18	(1.8%)
>1 week	--	--	--	--	--	--	--	--	2	(.7%)	2	(.2%)
daily	--	--	--	--	--	--	1	(.5%)	3	(1.0%)	4	(.4%)
Downers												
no use	40	(97.6%)	232	(98.3%)	216	(98.2%)	200	(98.0%)	279	(94.6%)	967	(97.1%)
<1 week	1	(2.4%)	2	(.8%)	2	(.9%)	--	--	7	(2.4%)	12	(1.2%)
>1 week	--	--	1	(.4%)	2	(.9%)	1	(.5%)	6	(2.0%)	10	(1.0%)
daily	--	--	1	(.4%)	--	--	3	(1.5%)	3	(1.0%)	7	(.7%)
Uppers												
no use	39	(95.1%)	234	(99.2%)	218	(99.1%)	203	(99.5%)	284	(96.3%)	978	(98.2%)
<1 week	1	(2.4%)	2	(.8%)	2	(.9%)	--	--	4	(1.4%)	9	(.9%)
>1 week	--	--	--	--	--	--	1	(.5%)	4	(1.4%)	5	(.5%)
daily	1	(2.4%)	--	--	--	--	--	--	3	(1.0%)	4	(.4%)

DRUG by Frequency of Use last 90 days	Level 1 Probation		Level 2 Probation		Level 3 Probation		Level 4 WR, TX, HC*		Level 5 Prison		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Amphetamines												
no use	41	(100.0%)	234	(99.2%)	220	(100.0%)	204	(100.0%)	288	(97.6%)	987	(99.1%)
<1 week	--	--	--	--	--	--	--	--	1	(.3%)	1	(.1%)
>1 week	--	--	2	(.8%)	--	--	--	--	4	(1.4%)	6	(.6%)
daily	--	--	--	--	--	--	--	--	2	(.8%)	2	(.2%)
Cocaine												
no use	39	(95.1%)	209	(29.8%)	192	(87.3%)	186	(91.2%)	183	(62.0%)	809	(81.2%)
<1 week	2	(4.9%)	6	(6.8%)	17	(7.7%)	8	(3.9%)	15	(5.1%)	58	(5.8%)
>1 week	--	--	9	(3.8%)	9	(4.1%)	3	(14.7%)	34	(11.5%)	55	(5.5%)
daily	--	--	2	(.8%)	2	(.9%)	7	(3.4%)	63	(21.4%)	74	(7.4%)
Crack												
no use	40	(97.6%)	221	(93.6%)	203	(92.3%)	191	(93.6%)	205	(69.5%)	860	(86.3%)
<1 week	1	(2.4%)	10	(4.2%)	5	(2.3%)	5	(2.5%)	11	(3.7%)	32	(3.2%)
>1 week	--	--	4	(1.7%)	10	(4.5%)	1	(.5%)	3	(1.0%)	18	(1.8%)
daily	--	--	1	(.4%)	2	(.9%)	7	(3.4%)	76	(25.8%)	86	(8.6%)
Heroin - NonIV												
no use	41	(100.0%)	236	(100.0%)	220	(100.0%)	204	(100.0%)	287	(97.3%)	988	(99.2%)
<1 week	--	--	--	--	--	--	--	--	3	(1.0%)	3	(.3%)
>1 week	--	--	--	--	--	--	--	--	1	(.3%)	1	(.1%)
daily	--	--	--	--	--	--	--	--	4	(1.4%)	4	(.4%)
Heroin - IV												
no use	41	(100.0%)	235	(94.6%)	218	(99.1%)	201	(98.5%)	280	(94.3%)	975	(97.9%)
<1 week	--	--	--	--	--	--	2	(1.0%)	3	(1.0%)	5	(.5%)
>1 week	--	--	--	--	--	--	--	--	2	(.7%)	2	(.2%)
daily	--	--	1	(.4%)	2	(.9%)	1	(.5%)	10	(3.4%)	14	(1.4%)
Coke - IV												
no use	41	(100.0%)	235	(99.6%)	217	(98.6%)	198	(97.1%)	260	(88.1%)	951	(95.5%)
<1 week	--	--	1	(.4%)	2	(.9%)	1	(.5%)	7	(2.4%)	11	(1.1%)
>1 week	--	--	--	--	1	(.5%)	1	(.5%)	5	(1.7%)	7	(.7%)
daily	--	--	--	--	--	--	4	(2.0%)	23	(7.8%)	27	(2.7%)
Speed - IV												
no use	41	(100.0%)	236	(100.0%)	220	(100.0%)	202	(99.0%)	290	(98.3%)	989	(99.3%)
<1 week	--	--	--	--	--	--	--	--	3	(1.0%)	3	(.3%)
>1 week	--	--	--	--	--	--	--	--	--	--	--	--
daily	--	--	--	--	--	--	2	(1.0%)	3	(1.0%)	5	(.5%)

*WR=Work Release; TX=In-patient Treatment; HC=Home Confinement