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Criminal Justice Drug Abuse Treatment Studies (CJDATS): Inmate Pre-Release Assessment (IPASS), 2001 [United States]

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Study Data Manual

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Criminal Justice
Drug Abuse Treatment Studies

Inmate Pre-Release Assessment (IPASS):
Study Data Manual

Study Summary

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Summary:

One of the CJ-DATS research priorities is therefore to develop and test a protocol for the *Inmate Pre-Release Assessment* (IPASS) that will have documented effectiveness as an aftercare placement tool (Farabee & Knight, 2001). More specifically, it will be a pre-release risk measure specifically designed for prison-based substance abuse treatment graduates that takes into account the inmates' historical drug use and criminal activity, as well as performance in prison-based treatment. The aims of this study are to test the ability of the IPASS to predict relapse and recidivism using a prospective design, and assess its use in matching offenders to a particular level of aftercare.

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Study Protocol:

Developing the Inmate Pre-Release Assessment (IPASS)

Summary: The UCLA Integrated Substance Abuse Programs (ISAP), in conjunction with Texas Christian University, the University of Kentucky, and Brown University, proposes to develop and test the Inmate Pre-Release Assessment (IPASS) as a method of (1) prioritizing aftercare treatment need among graduates of prison-based substance abuse treatment programs, and (2) specifying an appropriate level of care (residential, outpatient, or self-help groups).

A. Specific Aims

Although at least two valid assessments currently exist to inform decisions regarding level of supervision for paroling offenders (e.g., Level of Services Inventory) or modality of treatment for substance abusers in the community (e.g., ASAM criteria), neither of these assessments was developed specifically for substance-abusing parolees who are encouraged or required to participate in treatment after they are released from prison. The Offender Profile Index developed in the early 1990s was designed to yield a numerical score to recommend placement in one of four types of interventions: long-term residential treatment, short-term residential treatment, outpatient treatment, and urine monitoring only. However, the OPI did not appear to improve the assessment process relative to existing practices (McBride & Inciardi, 1993).

The IPASS was developed specifically as a post-release risk measure for prison-based substance abuse treatment graduates by taking into account the inmates' historical drug use and criminal activity as well as his or her performance during the prison-based treatment program.[1] It is completed by the inmate and his or her primary counselor. While the IPASS has demonstrated sound psychometric properties as a continuous measure of post-release risk and general treatment need for substance-abusing parolees (Farabee & Knight, 2001; see attachment), its ability to predict relapse and recidivism risk has not been tested using a prospective design.

The primary purpose of this study will be to refine the IPASS based on practitioner input, test the ability of the IPASS to predict relapse and recidivism using a prospective design, and assess its use in matching offenders to a particular level of aftercare.

This study will seek to test the following hypotheses:

1. Continued care participation and attendance will be higher among parolees who received a referral to a level of care that was consistent with the IPASS priority score.
2. IPASS-concordant referrals will show lower return to custody rates than discordant referrals.
3. The improved post-release performance among IPASS-concordant referrals will be the indirect result of receiving an appropriate aftercare placement.

[1] The IPASS is intended to be used with prison inmates who have received substance abuse treatment while incarcerated.

B. Background and Significance

In 1971, William Hunt and colleagues from Loyola University of Chicago published a simple but groundbreaking analysis in which they compared relapse curves of patients treated for heroin, tobacco, and alcohol dependence (Hunt, Barnett, & Branch, 1971). To their surprise, the relapse curves for these three substances were virtually identical. That something as pernicious as heroin dependence actually showed the same patterns of relapse as tobacco and alcohol dependence was in itself a significant contribution to the field of substance abuse treatment. But there was another important finding in their brief report that was more disconcerting: the percentage of abstainers fell from 100% at the time of treatment discharge to approximately 40% *within three months*. Moreover, the percent of patients who remained abstinent continued to decline during the next three months, finally approaching an asymptotic level for the remainder of the 12-month follow-up period. While these data did not bode well for the general effectiveness of treatment at that time (the curves were based on 84 studies), Hunt et al. made a critical observation: "Obviously, the majority of 'patients' need some further supportive or booster treatment during the first 6 months after successful completion of therapy." (Hunt, Barnett, & Branch, 1971; p. 455)

In the field of addiction treatment, the presumed need for some form of continued care following an initial intervention is generally driven by two assumptions. The first is that most patients leave programs to return to social networks or communities rich in cues that encourage the resumption of drug use (Brown et al., 2001; Catalano & Hawkins, 1985). The second assumption is that many treated substance abusers lack the requisite skills and knowledge to access the community services that are available to assist them in maintaining sobriety (Ashery et al., 1995).

Although there is widespread agreement concerning the need for continued care for substance abusers who receive treatment in prison, determining aftercare priorities and level of care based on risk has remained a largely subjective process.

A full appreciation of the need for aftercare and the practical issues affecting its provision requires an understanding of the existing research literature concerning continued care for prison-based treatment graduates. A few of these studies are summarized below.

Effectiveness of Continued Care for Parolees

Arguably the most developed literature on continued care participation appears in the criminal justice treatment literature. The majority of these studies show that, without continued care, in-prison treatment appears to have little effect (Griffith, Hiller, Knight, & Simpson, 1999; Hiller, Knight & Simpson, 1999). There is increased evidence that the prison-based component of treatment may serve primarily as an orientation or transitional phase for the community-based component. In fact, one recent evaluation revealed that inmates participating in prison treatment only (i.e., without continued care) had similar long-term post-treatment outcomes to those receiving no treatment at all (Lowe, Wexler, & Peters, 1998).

But of greater interest than these observed correlations between continued care participation and subsequent drug use and criminal activity are the reported percentages of prison treatment graduates who opt to enter community-based treatment. In a recent evaluation of a large, prison-based therapeutic community (TC) program in California, Anglin et al. (2002) found that only 11.2% remained in a residential or sober living program for 3 months or longer, or received an equivalent of outpatient service units (i.e., 36 units, assuming 3 weekly sessions for 3 months). This threshold was applied based on previous research indicating that a minimum of 3 months of treatment is typically required to produce meaningful changes in behavior (Simpson, Joe, & Brown, 1997). The evaluation of the prison-based Amity TC conducted by Wexler and colleagues (1999) found that 40% of the prison-based treatment completers (21% of the full intent-to-treat sample) also completed community-based continued care.

Motivation has been identified as a predictor of continued care attendance. Using a path analysis to examine the relationship between initial treatment motivation, treatment progress, and post-release outcomes among prison TC participants, De Leon et al. (2000) found an indirect relationship between motivation and 12-month recidivism. Specifically, inmates with higher treatment motivation were more likely to enter and complete continued care, which, in turn, was associated with a reduced likelihood of being returned to custody. Still, it should be noted that admission to this program was voluntary and that the mean motivation score of these inmates was 75% of the maximum possible score.

However, individual-level reasons for not participating in treatment account for only part of the problem. In a community-based study of 2,613 out-of-treatment and criminally active injection drug users in 21 U.S. cities designed to examine their drug treatment participation during the previous year, Farabee et al. (1998) found that 20% of the subjects cited individual-based reasons for not accessing drug treatment, whereas program-based reasons (e.g., no room, too costly, stringent admission criteria) were the most commonly given barriers to entering drug treatment (72 percent). Another commonly identified program, or systemic, barrier involves the lack of continuity and cohesion between primary treatment providers and the continued care programs to which their graduates are referred. According to Goldbart (1982), the ability of the primary and continued care providers to work together to facilitate the patients' transition from one level of treatment to the next and to share responsibility in monitoring the patients' progress are critical elements of the recovery process but, unfortunately, is rare in most treatment systems.

Based on these studies taken from the research on treatment within the criminal justice system, we can see that continued care attendance tends to be low among many primary treatment completers. Further, it appears that these low attendance rates stem from a diverse array of patient factors and program factors. Thus, by improving the process by which parolees are referred to aftercare it may be possible to sustain gains made over the course of the prison-based treatment phase.

C. Preliminary Studies

On August 10-12, 2000, a symposium of approximately 30 researchers and practitioners was convened in San Diego to take initial steps toward developing an assessment instrument to improve the re-entry process for prisoners with substance abuse problems. The symposium, hosted by Dr. David Deitch and colleagues at the University of California, San Diego, built upon findings from an earlier conference on Continuity of Offender Treatment from Institution to Community held in San Diego on June 14-15, 2000.

Introductory discussions at the symposium centered on the scope of pre-release assessment and the importance of tracking the progress of individuals who are screened for assignment to substance abuse treatment programs upon their entry into the prison system. The discussion led to the conclusion that two screenings should be under consideration—the first an in-custody, pre-treatment screening for mental health and substance abuse problems, and the second a similar screening to determine treatment progress, need for community services, and level of risk prior to release. The present section summarizes the findings regarding the latter.

Development and Technical Description of the IPASS

Prior to an offender leaving a correctional institution, decisions must be made regarding recommendations and provisions of post-release services. For those who have received drug treatment services while incarcerated, these decisions often include assessing the need for continued substance abuse treatment.

The IPASS begins with the "Background" section, collecting critical tracking information, such as the offender's name, date of birth, gender, ethnicity, date prison sentence began, date treatment program began, and expected parole date. Although this information may be available within a correctional database, collecting it as part of the IPASS form provides quick and easy access to it.

Two critical factors in determining the need for continued treatment services are an offender's drug use and criminal history. Research clearly has demonstrated that offenders with the most severe levels of drug use prior to incarceration who do not receive post-release treatment services continue to pose a serious threat to public safety once they are released (Weekes et al., 2001; Wexler et al., 1999; Knight et al., 1999). Furthermore, the greatest threat to public safety is most likely to occur with those who have the most severe criminal backgrounds. For example, a study of over 1,800 offenders found that 40% of those with the highest level of criminal risk were reincarcerated within 5 years, compared to only 9% of those with the lowest level of criminal risk (Hoffman & Beck, 1985).

Part 1 and Part 2 of the IPASS include "static" historical items and serve as a "Baseline" for determining the need for post-release treatment services, with the higher drug use and criminal risk scores corresponding with greater need. Part 1 of the IPASS is designed to provide a quick assessment of criminal risk based on pre-incarceration risk factors. Similar to the Salient Factor Score (Hoffman & Beck, 1974), this part of the IPASS focuses heavily on criminal history, with questions about arrest and incarceration history, revocation history, and age of first criminal activity. Part 1 of the IPASS also asks about education level achieved, marital status and happiness, and friends drug use. Based on preliminary analyses of in-prison treatment participants from California and Texas (see Knight & Farabee, 2000), each of these factors was found to be related to an offender's likelihood to return to custody after being released from prison.

Part 2 of the IPASS is designed to provide a quick screen for pre-incarceration drug use severity. It is based on the first 10 items of the TCU Drug Screen II (see www.ibr.tcu.edu for the TCU Drug Screen instrument), with the items corresponding to Diagnostic and Statistical Manual (DSM) classification criteria for Drug Dependence. Adopted by several correctional agencies as the primary screen for drug use problems, the TCU Drug Screen has demonstrated good basic psychometric properties, including high reliability across different gender and ethnic groups. In addition, disclosure rates for drug-related problems have been relatively high. For example, nearly half of all newly admitted inmates to the Texas Department of Criminal Justice disclose 3 or more drug-related problems.

Whereas Parts 1 and 2 provide a "Baseline" need for treatment based on "static" measures, Parts 3 and 4 center on "dynamic" factors that are used to determine if the "Baseline" need for treatment should be adjusted. In theory, those at the same "Baseline" level who do well in treatment and successfully meet treatment goals should not require as intensive post-release treatment as those who do not do well and fail to meet treatment goals.

Part 3 begins by asking inmates if they want to enter a drug treatment program after leaving prison; and if so, which treatment modality is preferred. When compared to those who do not want to continue receiving treatment services after leaving prison, those motivated to receive these services are more likely to benefit from post-release treatment and therefore should receive placement "Priority" (Hiller et al. 2002; Knight et al., 2000). Likewise, research has demonstrated that offenders who do well in treatment typically are the ones who report having established a good rapport with their treatment staff (Simpson et al., 1995; Simpson & Knight, in press). They also are the ones most likely to have favorable post-release outcomes and perhaps not require as intensive post-release treatment services as those who may not have done as well in treatment. Therefore, subsequent items ask inmates to indicate how much they disagree or agree with 9 items pertaining to their interactions with the treatment staff. These items include the treatment staff being easy to talk to, easy to understand, listening to you, organized and prepared, treating you with respect, helping you solve problems, supportive of your progress, helping you with your recovery, and happy with your progress.

Part 4 is to be completed by the inmate's primary counselor and begins by recording the number of "major" disciplinary acts an inmate committed prior to and during their time at the treatment program. Inmates who continue to commit infractions are likely to be the ones who need the most intensive levels of services and supervision once released from prison (Lattimore, Visher, & Linster, 1995). In addition to these 2 items, there are 9 items where the primary counselor is asked to indicate how much he/she disagrees or agrees with items pertaining to their interactions with the inmate toward the end of treatment.

These items include whether the inmate was easy to talk to, honest and sincere, cooperative, hostile or aggressive, manipulative, motivated to recovery, getting along with other inmates, liked by staff, and making acceptable progress.

IPASS Scoring

Although future research may need to determine the optimal way to score the IPASS, such as by using a weighted algorithm, simple unit scoring was used for this study. For example, "Yes" responses to selected items were counted as a score of "1" and "No" responses were counted as a score of "0." Continuous scores (such as number of "major disciplinary acts") were dichotomized based on prior research findings and on the distributional properties of the item responses collected during this study.

Scoring for Part 1 was based on findings from prior evaluations of prison-based drug treatment programs in California and Texas (see Knight & Farabee, 2000). For Question 1, a score of "1" was assigned if the inmate indicated having been arrested at least 4 times during the past 5 years and a score of "0" if he had not been arrested at least 4 times. For Question 2, a score of "1" was assigned if the inmate indicated having ever been in prison (not including this time) and a score of "0" for having no prior incarcerations. For Question 3, inmates who were younger than 16 the first time they committed a crime were scored "1" and those who were at least 16 were scored "0". A "Yes" response to Question 4 (having probation or parole revoked) was scored as "1" and "No" as "0", as were "Yes" and "No" responses to Question 5 (unemployed). Question 6a (years of school completed) was scored as "1" if the response was less than 12 and "0" if it was 12 or greater. Question 6b (graduated high school or completed GED) was scored as "1" if the response was "No" and "0" if "Yes". Although Question 7a (married or living with someone) was not scored, Question 7b was scored as "1" if the response was "No" and 7a (married) was "Yes", and scored "0" if 7a was "No" or if married was "Yes" and Question 7b was "Yes." If Question 7b was left blank, then Question 7b item was scored "0." Question 8 (friends use drugs) was scored as "1" if the response was "Yes" and "0" if it was "No." The dichotomized items were then summed with the scale score ranging from "0" to "9."

Scoring Part 2 included responses to Questions 1 through 9, with "Yes" responses being scored "1" and "No" responses being scored "0." However, Question 4 was scored "1" if 4a or 4b had a "Yes" response; Question 4 was scored "0" if there was a "No" response to both 4a and 4b. Likewise, responses to Questions 6a, 6b, or 6c were assigned a "Yes" response for Question 6; a "No" response to all 3 items resulted in a score of "0" for Question 6. Question 10 ("which drug caused you the most serious problems?") was not scored, but should be considered when making recommendations for post-release treatment services. The score for Part 2 was based on the responses to these 9 items and ranged from "0" to "9."

The "Baseline" Score" was then derived by adding the summed scores from Parts 1 and 2, resulting in a score ranging from "0" to "18," with higher numbers suggesting a "Baseline" need for more intensive treatment services.

Scoring for Part 3 included only Questions 2a-2i. A "Yes" response to Question 1 ("Do you want to enter a drug treatment program after you leave prison?") was not scored although it should be considered when making post-release treatment recommendations. For each of the ratings under Question 2, a score of "1" was assigned if the inmate indicated any agreement (ratings of 4, 5, or 6) to the question. A score of "0" was assigned if the inmate indicated being unsure or disagreed with the item. These scores were then summed and ranged from "0" to "9."

Part 4 was scored similarly. Although Questions 1a and 1b were not scored (due to missing data), the inmate's history of "major" disciplinary acts may need to be considered when making decision regarding post-release treatment services—particularly with respect to decisions about services that may or may not be available within the inmate's assigned level of post-release supervision. For each of the ratings under Question 2, a score of "1" was assigned if the counselor indicated any agreement (ratings of 5, 6, or 7) to

the item. A score of "0" was assigned if the counselor indicated being unsure or disagreed with the item. Questions 2d (hostile or aggressive) and 2e (manipulative), however, received a score of "1" if the inmate indicated any disagreement (scores 1, 2, or 3) to the item and a score of "0" if the inmate was "unsure" or "agreed" with the item. These scores were then summed and ranged from "0" to "9."

The "Adjustment" Score" was then derived by adding the summed scores from Parts 3 and 4, resulting in a score ranging from "0" to "18."

The final "Priority" Score" was then calculated by subtracting the "Adjustment" Score" from the "Baseline" Score," with the possible range of "-18" to "+18," with higher scores indicating a greater need for post-release treatment services.

As noted earlier, decisions regarding need for post-release treatment should consider not only the final "Priority" Score," but also the type of drugs causing problems (e.g., opiate use may suggest the need for methadone maintenance), "major" infractions that occurred during prison treatment (e.g., may require a treatment setting that includes intensive supervision), and whether the inmate is requesting post-incarceration services (e.g., may be relatively "low risk" and have done well during treatment, but feels strongly that more treatment is needed).

Sample for Initial Pilot Study

Data were collected between May and July 2001, from 467 inmates who volunteered to participate in the study. They were from 4 different states (275 from California, 93 from Oregon, 58 from New Mexico, and 41 from Maryland). Although the sample was split fairly equally between males (n=55%) and females (n=45%), it was predominately Caucasian (44%) or African American (27%), with a median age of 36 years (ranging from 19 to 68). Half of the sample had been in treatment for nearly 8 months (223 days), and had been in prison for a little more than 13 months (415 days). Half of the sample also was within 2 months (55 days) of their expected parole date.

IPASS forms were administered to inmates housed in 14 institutions in four states: California, Maryland, New Mexico, and Oregon. An overview of these programs is provided below in Table 1.

Table 1: Description of Participating Programs (N=14)

Program (State)	Gender	No. Beds	Custody Level	Program Length (Mos.)
California				
CRCF	F	96	Min.	9-12
CRCFA	F	196	Min.	9-12
SATF	M	730	Min.	6-18
VSPWI	F	256	Min./Med.	6-24
VSPWD	F	250	Min./Med.	4-8
Maryland				
RSAT	M	300	Min.	6
New Mexico				
CMRU	M	36	Min.	12
LCCF	M	350	Med.	12
POU	M	45	Min.	12
RCC	M	24	Min.	12
Oregon				
Turning Point	M	50	Min.	7-12
Turning Point	F	50	Min.	7-12
Bridgepoint	M	60	Min.	7-12
In Focus	F	60	Min.	7-12

CRCF (CA): California Rehabilitation Center Program F
CRCFA (CA): California Rehabilitation Center Program FA
SATF (CA): California Substance Abuse Treatment Facility
VSPWI (CA): California Valley State Prison for Women "Integrity" Program
VSPWD (CA): California Valley State Prison for Women "Destiny" Programs
RSAT (MD): Maryland Residential Substance Abuse Treatment
CMRU (NM): Central Minimum Restrict Unit
LCCF (NM): Lee County Correctional Facility
POU (NM): Paul Oliver Unit
RCC (NM): Roswell Correctional Center

Results of Initial Pilot Study

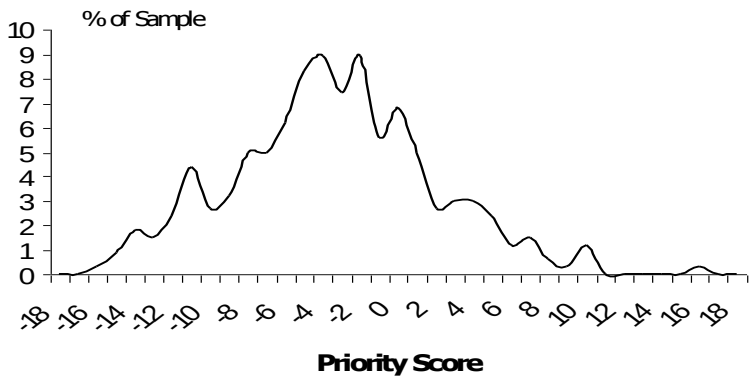
This section summarizes the results of the initial findings of the IPASS psychometric study. The primary objective of this study was to examine basic psychometric properties of the IPASS and make recommendations for possible revisions. Specifically, item responses and scoring, inter-item and scale correlations, scale reliability coefficients, and item-total correlations were examined.

Item Responses and Scoring

Response distributions for all items in Part 1 and Part 2 were acceptable, with no apparent floor or ceiling effects. Likewise, item response distributions were good for Part 3 and Part 4. Specifically, in Part 3, "Agree" responses ranged from 57% agreeing that their treatment staff was organized and prepared (Question 2d) to 80% agreeing that treatment staff treated them with respect (Question 2e). Favorable responses for Part 4 ranged from 56% (Question 2e) agreeing that the inmate had not

been manipulative to 86% agreeing that the inmate was liked by staff (Question 2h). Figure 1 illustrates the normal distribution of the "Priority" Score.

Figure 1: Priority Score Distribution (N=339)



Scale Intercorrelations

Table 2 shows the Pearson Product Moment correlation coefficients between the four computed Parts (or scales). Part 1 and Part 2, which constitute the "Baseline" score, were significantly correlated, as were Part 3 and Part 4, which constitute the "Adjustment" score. Although significant, these correlations were modest. The correlation between the "Baseline" (Part 1 + Part 2) and "Adjustment" (Part 3 + Part 4) scores (r=.14) was not significant, suggesting that each captures information from unique dimensions. Thus, based on these findings, the four Parts comprising the IPASS appear to assess related but distinct constructs, and to account for only slight to moderate amounts of shared variance.

Table 2: Zero-Order Correlations between IPASS Parts

	Part 1	Part 2	Part 3	Part 4
Part 1	--			
Part 2	.36*	--		
	(N=382)			
Part 3	.04	.22*	--	
	(N=405)	(n=398)		
Part 4	.04	.02	.14*	--
	(N=383)	(N=380)	(N=402)	

*p<.05

Internal Consistencies

One of the primary goals of this study was to determine the appropriateness of individual items by examining how well items were related to the construct they were designed to measure. This is typically referred to as the "internal consistency" of the scale. A scale consisting of items that assess a

heterogeneous set of behaviors or attitudes is likely to produce a more ambiguous and less reliable score than one that consists of similar items that tend to "hang together." Parts 2, 3, and 4 are each designed to assess a single construct. That is, items within each of these scales are designed to be similar in nature and represent one "factor." For example, all of the items in Part 2 are explicitly related to drug use behavior and are designed to measure the severity of inmate drug use. Each of the items in Part 3 pertains to how the inmate feels about the treatment program. Similarly, each of the items in Part 4 relate specifically to how the counselor feels about the inmate's progress toward the end of treatment.

Within Parts 2, 3, and 4, dichotomously scored items used in constructing the scale score were examined. In general, higher coefficients are more desirable, with those with alpha coefficients greater than or equal to .60 considered to be internally consistent. As evidenced in Table 3, overall reliabilities for each of these scales were relatively high. In each scale, item-total correlations also were high, providing evidence that each of the items in these scales needed to be retained.

Table 3: Reliability Coefficients of IPASS Scales

Scale	Coefficient Alpha
Part 1	NA
Part 2	.91
Part 3	.92
Part 4	.85

A reliability coefficient was not computed for Part 1 because, although the items gather information about an inmate's criminal risk, they are not designed to be unidimensional. That is, a higher score on one item (e.g., "Have you ever been on probation or parole and had it revoked") is not necessarily expected to be related to a higher score on another item (e.g., "How many years of school have you completed?"). Principal Component analyses of dichotomized items support the scales multidimensionality by showing that items in Part 1 represent at least 3 different dimensions (eigenvalues greater than "1"). As noted earlier, comparable risk scales (such as the Salient Factor Score) have been found to be predictive of criminal risk after release from treatment.

Test-Retest Reliability

One of this study's goals was to assess the test-retest reliability of the instrument. To achieve this goal, one of the sites recruited an *additional* 16 inmates near the end of their stay in a treatment program to participate in the test-retest study. The first administration of the form was followed by a second administration 28 days later. Although a larger sample size was targeted, as well as a shorter test-retest window (1 week apart), logistical constraints prevented this from occurring. Although the longer test-retest window should not affect Parts 1 and 2 because the items are "static" and reflect a preincarceration period, Parts 3 and 4 are designed to assess change over time in treatment and are likely to be impacted by the 28-day window. Interpretations, therefore, of test-retest reliability findings should be interpreted with caution.

As illustrated in Table 4, test-retest correlations were significant for each Part of the IPASS as well as for the "Baseline," "Adjustment," and "Priority" scale scores.

Table 4: Test-Retest Correlations of IPASS Scales

Scale	Test-Rest Correlation
Part 1 (n=16)	.62
Part 2 (n=13)	.86
BASELINE (n=13)	.79
Part 3 (n=16)	.59
Part 4 (n=16)	.90
ADJUSTMENT (n=16)	.82
PRIORITY (n=13)	.84

Test-retest correlations of specific items indicated that problematic items were found only within Parts 1 and 3. All item correlations were significant for Part 2 (ranging from r=.58 to r=1.0) and for Part 4 (ranging from r=.45 to 1.0). Of the items in Part 1, items 5 (unemployed most of the year) and 8 (friends use drugs) had correlations of .38 and .43, respectively. Ambiguity may have resulted from the use of the word "most" in item 5 and needs to be changed to be more concrete. It is unclear why item 8 did not have a higher correlation. Item 1 (times arrested or taken into custody) faired the worse, with a correlation of .10. This may be the result of asking for a response with an unrestricted range and setting the "cutoff" score to 4 or more times. Part 3 had 5 items with non-significant correlations (Question 2b r=.30, 2c r=.46, 2d r=.30, 2h r=.15, and 2i r=.31). As indicated above, changes in these scores may reflect actual changes in an inmate's rating of the program over the 28-day period and not necessarily reflect poor test-retest results. Even with these non-significant correlations, the overall test-retest correlation for Part 4 was .59 and .84 for the "Adjustment" score.

D. Research Design and Methods

Overview of Study Design

The IPASS will be administered to inmates within 90 days of their release, along with a trailer form on which the prerelease counselors will indicate how important it is for that inmate to receive aftercare and what level of care (i.e., residential, outpatient, or self-help) is indicated. Although the transitional counselor will oversee the administration of the IPASS, aftercare placements will be based on his or her existing practices. Using a "passive matching" procedure comparing IPASS-concordant and IPASS-discordant referrals, parolees will be compared with regard to aftercare show up rates and retention (based on clinic records), and 12-month re-arrest (based on official records).

Validation of the IPASS Using Passive Matching

RC staff will administer the revised IPASS to small groups of inmates who are within 90 days of release from a prison-based treatment program. They will also be responsible for administering the counselor section of the IPASS to each inmate's primary counselor. It is important to note that the IPASS will not be scored by the

transitional counselor; rather referrals will be made according to existing practices and the IPASS forms will be mailed to the Lead Center for entry and analysis. In addition to the IPASS, the transitional counselor will complete a locator form, and a placement form indicating whether the inmate was referred to aftercare, what level of care was recommended, and how important it was for the inmate to receive continued care. The baseline administration of the Addiction Severity Index also will take place at this time.

In order to minimize "contamination" that could occur as a result of transitional counselors inadvertently making continuing care referrals based on inmates' responses to the IPASS, each participating prison will be provided a data "lock box" in which inmates can place their completed IPASS forms. The local project coordinators will remove the contents from these lock boxes upon completing a data collection visit and bring the forms back to the RC.

The target sample for this study will be 600 subjects. Melnick et al.'s (2001) study found that 29% of the subjects were placed in a program that was discordant with a referral based on their standardized assessment. Using program completion as the primary outcome, these investigators found an effect size of approximately .30. Based on these data, the current study would require a sample size of 360 (n=180 in the mismatched group and n=180 in the matched group) in order to detect a similar effect size where power=.80 and alpha (one-tailed)=.05 (Lipsey, 1990). To achieve this target sample size in the mismatched group would require a total sample size of 600 (.30 x 600=180). For both phases, only inmates who are expected to participate in some form of aftercare (either because they volunteer or are mandated to do so) will be recruited for participation in the study.[2] At each of the selected in-prison treatment sites, subjects will be recruited at the time when the aftercare planning process normally begins.

Project Timeline

The proposed study will take place over two years, although virtually all of the data will be collected by the end of Year 1. The exception will be the 12-month recidivism data that will need to be collected during the third quarter of Year 2.

Table 1: Project Timeline

	YR 1				YR 2			
Tasks	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Prepare IRB applications	X							
Prepare DSM plan	X							
Develop trailer form	X							
Administer IPASS		X	X					
Collect proximal outcome data			X	X				
Collect recidivism data							X	
Analyze results & prepare reports					X	X	X	X

Assessments

Study measures will be administered according to the data collection schedule in Table 2.

[2] Voluntary and mandated aftercare participation status will be taken into account as a covariate.

Baseline Measures

1. Inmate Pre-Release Assessment (IPASS) – The revised version of the IPASS will be administered by the transitional case managers to study participants and their primary counselors at their institution.
2. Transitional Counselor Trailer Form. This form will be developed in Phase I and will include the transitional case managers' ratings of each inmate's need for continued treatment, type and location of program to which the inmate was referred, whether the inmate accepted the referral, and the main factor(s) that determined how the aftercare referral was made. In addition, the transitional counselor will record the duration, type, and dose of the prison treatment received.

Primary Efficacy Measurements

1. Proximal Outcomes

    a. Amount of Treatment Activities - Total number of continued care sessions attended will be extracted from aftercare clinic records and the percentages of attendance of total sessions scheduled will be tabulated. A data abstraction form will be developed to standardize the types of information collected across program sites.

    b. Length of Treatment Episode - Calculated by the number of weeks in which subjects are actively participating in continued care.

2. Long-Term Efficacy Measures

    a. Recidivism. Return to custody data will be extracted from each state's Department of Corrections database and will include type of offense and time until first return.

Training

Although administration of the IPASS is relatively straightforward, some training will be required. As part of the earlier pilot study described above, Farabee and Knight (2001) developed a brief administration and scoring manual. However, this will need to be revised in conjunction with the refinements made to the IPASS. To reduce costs, we propose scheduling a half-day training with a representative from each of the RCs (in conjunction with a Steering Committee meeting). These representatives would then provide the training to the transitional counselors at each of the participating institutions in their state.

Analysis Plan

Summaries of the characteristics of the study participants will be prepared to investigate group equality at baseline as well as to provide information necessary for decisions about covariates in post-hoc analyses. A summary will be prepared to show program and study attrition over time in both concordant and discordant groups.

The primary and supplementary outcome measures will be analyzed for the evaluable participant population. While there is every intent to be complete in describing the analyses to be performed, it is not possible to anticipate every contingency and some adjustments may be required to meet constraints posed by the structure of the data.

Equality of groups at baseline will be evaluated by comparing demographic and drug-use information collected on the IPASS. Baseline demographic values, where they potentially affect the responses on primary dependent measures or where they are found to be unevenly distributed between groups at baseline, may be investigated post-hoc. Likewise, it will also be necessary to control the parolees' voluntary status regarding aftercare participation, as well as whether they paroled to an urban or rural county. In particular, if indicated in preliminary analyses, HLM will be used to control for variation between research sites, thus allowing us to retain the power of the aggregate sample.

All statistical tests will be one-tailed, since the IPASS-based referral is hypothesized to result in improved outcomes. Alpha will be set at the 5% level for all tests.

The four primary hypotheses of the study will be tested as follows:

1. Continued care participation and attendance will be higher among parolees who received a referral to a level of care that was consistent with the IPASS priority score. This outcome will be evaluated using an appropriate test of means (a Student's t-test or ANOVA, depending on the structure and nature of the distributions) applied to the total number of continued care sessions attended (including 0).
2. IPASS-concordant referrals will show lower return to custody rates than discordant referrals. The binary outcome of any recidivism will be tested using logistic regression, with the selection of covariates determined by a comparison of IPASS-concordant and discordant groups at baseline. The time to recidivism will be measured using survival analysis.
3. The improved post-release performance among IPASS-concordant referrals will be the indirect result of receiving an appropriate aftercare placement. For this analysis, path modeling will be used to assess direct and indirect relationships between referral (IPASS concordant or discordant), aftercare participation, and long-term outcomes. The specific technique used will be dependent upon the nature of the distributions of both the continued care attendance variable and the substance use variable.

Data Collection

All data collected for this project will be sent to the UCLA Data Management Center for entry and cleaning. Data will be collected at the study site on paper Case Report Forms (CRFs). The DMC will provide paper CRFs to the study site, which are completed by the RAs and faxed in to the central data repository at the DMC using a Cardiff Teleforms system. These forms are to be completed on an ongoing basis during the study. Forms will be completed according to the instructions provided during training. The local project coordinators will review all CRFs before faxing them to the DMC, and during the study, she will monitor the CRFs for completeness, accuracy, and legibility. When data are received at the DMC, they will be reviewed and if incomplete or inaccurate data are found a data clarification request will be forwarded to the site for a response. The local project coordinators will resolve the identified inconsistencies and errors and return the forms to the DMC within 2 weeks.

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