An Evaluation of a New Mexico Department of Corrections Dental Treatment Program: Findings from Participant Intake Interviews

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Background

In March 2008, the New Mexico Department of Corrections (NMDOC) Education Bureau, in collaboration with the NMDOC Probation and Parole Division, implemented a pilot dental repair program for parolees currently under NMDOC supervision. The intent of the program is to provide services for parolees with significant dental problems in hopes of reducing visible barriers to employment, thus increasing their chances of successful reentry. The program was funded by a grant from the U.S. Department of Justice under the Edward Byrne Memorial Grant Program. The NMDOC contracted the University of New Mexico Hospital Dentistry Department to perform dental treatments. The New Mexico Statistical Analysis Center (NMSAC) at the University of New Mexico's Institute for Social Research (ISR) was contracted to provide an evaluation of program implementation and outcomes.

There is a substantial body of research suggesting that dental health is a major problem for prisoners. Researchers have consistently found that prisoners report significantly more dental problems than the general population (Lund et al., 2002; Mixson et al., 1990, O'Brien and Lee, 2006, Salive, Corolla, & Brewer, 1989). While this clearly suggests a medical need for expanded dental treatment for prisoners, the prevalence of dental problems for prisoners may also have implications for reentry. Given the large prison population in United States today (Listwan et al., 2008) and that an estimated 67.5% of inmates are rearrested within three years of being released (Langan and Levin, 2002), the issue of prisoner reentry has been described as at "the forefront of domestic public policy" (Kubrin and Stewart, 2006: 166) and is currently receiving a large amount of attention from academics and practitioners. While a substantial body of research has investigated the individual factors associated with reentry success (Benedict & Huff-Cordine, 1997; Ulmer, 2001; Listwan et al., 2003), research on reentry has not yet examined the influence of dental health and dental treatment on recidivism.

This may be an important oversight, as previous research suggests two mechanisms through which dental health may be linked to reentry success. First, a small body of research suggests that physical appearance is correlated with perceived criminality, affecting the way a person is treated by both the general public and the criminal justice system and therefore indirectly influencing recidivism outcomes (Bull, 1982). In this sense, improving the dental appearance of ex-offenders may reduce their perceived criminality, which in turn may result in more legitimate opportunities. Research also suggests that dental health and appearance are related to self-esteem (Patzer, 1995), which in turn is thought to be linked to desistance. More specifically, research suggests that self-appraisals of dental appearance were more strongly related to self-esteem than general appraisals of appearance (Kanealy et al., 1991) and that missing teeth were especially problematic (Oosterhaven, Westert, & Schaub, 1989). As a whole, this research indicates that negatively perceived dental appearance and poor dental health are related to decreased levels of self-esteem. Self-esteem, which is related to other social psychological constructs like self-efficacy and sense of control (Skinner, 1996), is thought to be an important component in the desistance process. This is exemplified by Maruna (2001, 2006), who argues that desistance is only possible when offenders adopt a prosocial identity and empirically demonstrates that self-perceptions are related to post release success (2004).

Second, dental treatment may be related to employment success. Research has shown that dental and facial appearance is strongly correlated with evaluations of attractiveness and professionalism (Eli, Bar-Tal, & Kostovetzki, 2001) and that employer evaluations of attractiveness and professionalism are related to employability (Avrey & Campion, 1982; Rankin & Borah, 2003). Perhaps more importantly, research suggests that dental treatment is related to favorable occupational outcomes. While a host of other factors are likely to be more directly related to employment outcomes, early research on this topic revealed that five years after treatment, there was still a modest, yet significant, positive relationship between occupational rank and having received dental treatment (Rutzen, 1973). More recently, a study of dental intervention for welfare recipients found that individuals who participated in a dental treatment program and received all prescribed treatment were twice as likely to report a favorable or neutral employment outcome as individuals who did not complete the program (Hyde, Satariano, & Weintraub, 2006). The relationship between dental appearance and employability is important for evaluating the reentry process, as sociological and criminological research suggests that there may be a relationship between incarceration and unemployment (Freeman, 1992; Laub & Sampson, 1993), incarceration and earnings potential (Western, 2002; Western, Kling, & Weiman, 2001) and employment and recidivism (Uggen, 2000; Uggen & Staff, 2001). The issue of employability is of extra importance for ex-prisoners, as this population suffers from both a general lack of work-related skills (Graffam, Shinkfield, & Hardcastle, 2008) and from the stigma associated with being an ex-convict (Uggen, Manza, & Behrens, 2003).

Program Administration, Data Collection, and Evaluation Objectives

Probation and parole officers identified potential dental program participants. Potential participants then submitted an application to the NMDOC Education Bureau, who selected participants for the program. The Education Bureau established the following criteria for the selection of participants:

- Dental work is only made available to parolees;
- Parolees should have been out of prison for three (3) months and must have at least six (6) months left of parole supervision;
- The service is available to parolees in the Albuquerque area only. Travel expenses are not covered;
- Priority is given first to parolees who participated in Project SOAR while incarcerated. Second priority is given to parolees involved in an education program while incarcerated. Third priority is given to other parolees;
- Priority is also given only to parolees determined by their Probation and Parole Officer (PPO) as being likely to succeed on supervision;
- Parolees must be in compliance with conditions of supervision and orders of the PPO;
- Parolees and PPOs must affirm that the current appearance of the parolee's teeth seem to present a barrier to gainful employment for the parolee (both unemployment and under employment);

- Parolees who receive the dental work services must be willing to: 1) sign a release of information, 2) participate in a pre- and post-treatment face-to-face interview, 3) participate in pre- and post-treatment photography, 4) provide personal testimony as to the impact of dental work, and 5) complete a program survey.

NMDOC began taking applications for the dental program in May of 2008. The initial group of program participants began receiving dental treatment in November of 2008. Enrollment continued through March 2009, and all treatment was completed by June 30, 2009.

The dental treatment program took several months to complete. Once participants were selected for the program, they met with the evaluation team from the New Mexico SAC for a pre-interview. The interviews were conducted at the Monte Vista Probation and Parole office in Albuquerque. During the first interview, which on average lasted about one hour, we asked participants to discuss how the dental issues affected their employment prospects and experiences, as well as a variety of other life areas. In addition, we asked participants about their background including arrest and incarceration experiences and past education and employment experiences. We also asked participants about their relationships with others, their future goals, and questions about their self-image. Participant interviews were audio recorded and then transcribed verbatim for coding and analysis.

Following this interview, a "before" photograph was taken by NMDOC personnel and the participants were given instructions to set up an initial appointment with the dental provider. UNM Dentistry constructed an individualized treatment plan for each participant. The participants were responsible for setting up all necessary appointments with the dental provider. About 2 months after dental treatment was complete, we interviewed each participant a second time. This interview covered similar topics with an additional section on participant's dental treatment experiences. The post-interview generally took about one half hour and was conducted at the same location as the pre-interview. NMDOC personnel took an "after" photograph.

In addition to the interview data, we collected data from the dentist about each participant's dental health and the dental treatment they received. We also received additional data from the NMDOC, which documents each participant's criminal history, corrections supervision history, and their participation in education programming during their incarceration.

Objectives of the Evaluation

The overall goal of the dental treatment program is to eliminate visible barriers to employment among parolees and thereby increase their chances for successful reentry. Using data from pre-treatment interviews, this initial report details the treatment population, their dental needs, their current life circumstances and related goals and expectations, their expectations of the dental treatment program, and their assessments of how the dental treatment will affect them in various life domains (work, education, family). Given the short amount of time between program completion and this report, we are unable to assess post-treatment outcomes at this time. Here, we lay the groundwork for assessing outcomes by addressing three objectives:

Objective 1: To describe the participant population in terms of demographic characteristics, education, employment, criminal history, and corrections history. Prior research has connected these characteristics to successful reentry. Clarke et al. (1988), Ulmer (2001), and Kubrin and Stewart (2006) demonstrated that males are more likely to recidivate than females probationers. Clarke et al.'s research also suggested that younger felons are more likely to recidivate than felons in other age groups, although Kubrin and Stewart describe this relationship as curvilinear, which might suggest that the recidivism-age curve is conceptually similar to the age-crime curve. Ulmer's (2001) analysis of offenders from Indiana indicated that both education and offense history are related to recidivism, with more educated offenders and felons with less serious offense histories being less likely to reoffend. And finally, Seiter and Kadela's (2003) review of a reentry program suggested that reentry programs that promote social support, employment, and education are likely to reduce recidivism. Given that this body of research has demonstrated a relationship between individual characteristics, prison programming, and reentry success, it is reasonable to infer that these characteristics may also impact program participation and program outcomes. A description of the actual participating population will be compared to that articulated as the target population. Additionally, this information will allow for an assessment of how goals and expectations addressed in objectives 2 and 3 differ by individual characteristics.

Objective 2: To describe participant goals and expectations for the future including thoughts on successful reentry, education and career aspirations, and their perceptions of the barriers they face and the resources they need to achieve their goals. This objective may help us to identify other areas where probationers and parolees need assistance to facilitate successful reentry.

Objective 3: To describe how participants articulate the impact of dental problems on education, employment, and personal relationships and the expected benefits of the dental treatment. The purpose of this objective is to set the stage for an assessment of whether the treatment meets their expectations on these same dimensions in the post-interview.

Objective 1: Program Participants

In total, 37 applicants were admitted to the dental treatment program; however, some applicants withdrew from the program before being interviewed. In total, pre-interviews were completed for 33 applicants. In the following sections, we describe the participant population in terms of their individual demographics, education, and employment characteristics. We also give some background on their criminal and corrections histories. At the end of this section, we summarize the congruency of the characteristics of the actual program population to those articulated in the criteria for selection.

Demographic Characteristics

Table 1 presents the distribution of program participants by basic demographic characteristics. Program participants ranged in age from 23 to 55 years, with the mean age of 39.7 years. The majority of participants were female (N = 20, 60.6%). Participants self-identified in three

racial/ethnic categories[1]: 58 % of participants identified as Hispanic, 39% as White, and one participant reported as bi-racial. Fifteen percent of respondents were married; and 67% had minor children, although some had neither custody nor visitation at the time of the interview. Just under half of the respondents were in some form of transitional housing at the time of the interview.

Table 1. Participant Demographics (N = 33)

	N	**%**
Sex		
Male	13	39
Female	20	61
Race/Ethnicity		
Hispanic	19	58
White	13	39
Bi-Racial	1	3
Family and Residential Statuses		
Married	5	15
Minor Children	22	67
Transitional Housing Program	15	45
Restricted Movement	7	21

Education

At the time of the intake interview, 73% of participants had at least a GED or high school diploma. Table 2 presents the frequency of participant highest level of educational attainment. A little more than half of the participants have had some type of post-secondary education that included either current or previous enrollment in general education college courses or trade school courses. Of these, 5 participants reported that they were currently enrolled in post-secondary education programs. Three were in college working on general education requirements, one was enrolled at a local barber college, and another participant was in a trade apprenticeship program. Some participants, both those yet to receive a GED and those with GEDs, reported that they planned to pursue post-secondary education in the future.[2]

[1] We collapsed the following identifications into the Hispanic category: Hispanic, Latino/a, and Spanish.
[2] We discuss plans for future education in the section addressing Objective 2 on goals and goal attainment.

Table 2. Participant Highest Level of Educational Attainment (N = 33)

	N	%
Less than High School	9	27
High School Diploma/GED	7	21
Some Post-Secondary	17	52

Employment

Nearly 40% of participants were employed at the time of the initial interview. The majority of employed participants worked in some aspect of the service industry. Five respondents reported that they worked in food service, five were engaged in retail or customer service, and the remaining three were employed in skilled labor occupations. Most were satisfied with their current employment situation, although some indicated that they would like to find a better job. A few of these individuals indicated that they would like to advance in the current job or job field.

Table 3. Participant Employment Status (N = 33)

	N	%
Currently Employed	13	39
Looking for Employment	6	18
Not Actively Seeking Employment	14	42

Eighteen percent of participants indicated that they were looking for work (N = 6). These participants expressed interest in a wide variety of jobs. Participants who were seeking employment indicated a desire to be employed and suggested that they would accept any job for which they could be hired. Some had extensive employment backgrounds, from waitressing to bookkeeping to construction. Most stated that they had not been selective about where they applied and that they were simultaneously seeking work at multiple places. When asked why they thought they were unable to find work, some suggested that their status as a felon put them at risk to be passed over by potential employers. For example, one individual said, "I may be able to get in there, but I'm put to the bottom of the stack I think."

Forty-two percent of respondents were not seeking employment at the time of the intake interview. Participation in a residential treatment facility was the most common reason given for not seeking employment (N = 8). For the most part, these participants were eager to look for jobs but were not able to have a job until the final stage of their treatment. Two participants in this group were enrolled full time in post secondary education programs. Finally, some participants were not actively seeking employment for personal reasons. Four participants had physical issues that severely restricted their employment options and were instead pursuing Social Security Disability or other financial support.

Offense Types

Table 4 shows respondent reported type of offense leading to the most recent incarceration and/or current probation and parole supervision. (These frequencies do not sum to the total number of participants, as some reported more than one offense). Drug related crimes were the most commonly reported. Thirty-nine percent of participants had either a drug possession or trafficking charge. The second most commonly reported offense was property crime (36%); this category includes non-violent property crimes like auto theft, burglary and check fraud. Fifteen percent of participants were charged with DWI and 18% were charged with a violent person offense. Person offenses include violent crimes such as aggravated burglary, armed robbery or battery with a deadly weapon.

Table 4. Offense Types Reported for Current Supervision Sentence

	Frequency	%
Drug	13	39
DWI	5	15
Property Offenses (non-violent)	12	36
Person Offenses (violent)	6	18

In discussing the offenses that led to corrections supervision, some participants indicated they were not fully responsible for the crimes for which they were charged. Eight respondents deflected responsibility for their current charges. Two kinds of deflection were observed. First, some respondents claimed that they did not commit the crime and either they were "set-up" by or they "took charges" for someone else (N = 5). The second type of deflection involved blaming someone else for their involvement in the crime (N = 3). In two cases, participants were charged with drug trafficking, but both claimed they were with someone who was carrying drugs and ended up being charged. In another instance, a respondent charged with DWI claimed he was set-up by romantic partner. He was to meet her at a particular location and when he arrived, the police were waiting for him. This is telling as there is some literature to suggest that offenders who seek to justify their criminal involvement or deflect responsibility for their behavior are more likely to recidivate (Maruna, 2004).

Corrections Supervision

The majority of participants indicated that they had at least one arrest prior to that leading to their current term of corrections supervision; only 18% percent of participants (N = 6) reported that their most recent charge was their first arrest. All but two participants reported having served at least some time in prison and/or jail in the past and 82% were incarcerated for their most recent offense(s). Table 5 shows the distribution of participants by self-reported incarceration history and corrections supervision status.

All program participants reported being under NMDOC supervision at the time they were admitted to the dental treatment program. Fifty-two percent were on probation only, 21% were

on parole only, and 27% were under both probation and parole supervision. In addition to interview data, the Education Bureau provided us with pertinent information from the automated probation/parole records of program participants. From these data we gathered information on supervision status and violations of supervision conditions. The data indicated that program participants were at various stages of the reentry process at the time of the intake interview. Almost 40% had been on community supervision for over a year (N = 13), with a few nearing the fourth year of supervision. Another 40% had been on supervision more than 3 months but less than one year (N = 13). Some were in the early stages of supervision. Twenty-one percent of participants had been on supervision for less than 3 months (N = 7), the most recent parolee was out for 7 days at the time of the intake interview.

Table 5. Incarceration History and Corrections Supervision Status

	N	%
Incarceration History		
Served any prison/jail time (lifetime)	31	94
Served prison/jail time for most recent offense	27	82
Has served no prison/jail time	2	6
Supervision Status		
Probation	17	52
Parole	7	21
Both Probation and Parole	9	27
Time on Community Supervision		
Less than 3 months	7	21
More than 3 months but less than 1 year	13	39
More than 1 year	13	39
Violations		
Pre-intake violations	11	33

Automated records indicated that thirty-three percent of program participants had at least one probation and/or parole violation between their community supervision start date and the program intake interview (N = 11). Most violations, as recorded by the PPO, involved more than one type of infraction. The most commonly reported infractions were technical violations (e.g. association with prohibited persons, failure to report change of address or employment, failure to participate in assigned programs, failure to pay fees or restitution, failure to abide by other conditions of the probation and/or parole agreement, etc…). The second most common infraction was failure to report for a meeting with the PPO. The third most frequently reported infraction was substance related; this category included cases where the participant received a violation due to a failed drug test, self-reported drug use, failure and/or refusal to take a drug test, or was cited for alcohol use or possession. A few participants had been violated for failure to obtain and/or maintain employment and a couple received violations due to new arrests or other acts of a criminal nature. For three participants the most recent violation occurred over a year prior to being selected for program participation, six had violated within the past year but had no

violations within 3 months prior to the intake interview. Two participants had a violation within the 3 months before the intake interview. The number of pre-intake violations ranged from 1 to 4. While most of these participants had only one or two violations (N = 8), the remaining three had 3 or more violations. One participant received her fourth violation since her release to community supervision, testing positive for "meth, heroine, and cocaine," just 45 days before the intake interview.

Corrections and Other Program Participation

Sixty-seven percent of respondents reported that they participated in some type of voluntary programming while incarcerated (N = 22). Of the 11 reporting no participation in prison programming, two served no time for the most recent offense and two have never been in prison/jail. The most frequently reported types of programs were those related to substance abuse recovery. Forty-six percent of participants reported that they took part in one or more 12-step programs and/or a substance abuse related therapeutic community while incarcerated. Almost 40% of respondents reported at least partial participation in education programs (e.g. GED preparation, college classes, and/or vocational classes). Thirty percent of participants were involved in career preparation programs (e.g. SOAR, Career Pathways, or some components of these programs). Cognitive programs, including classes on parenting skills, anger management, corrective thinking, and coping skills, were reported by 30% of participants. Finally, a small portion of participants (12%) took part in faith-based programming. Many participants reported multiple types of program participation, with two reporting at least one program in all five categories. When only one type of program was reported, respondents most frequently reported involvement in substance abuse programming. Those involved in career and education programs typically reported multiple types.

Table 6. Participation in Prison Programs

	Frequency	%
Prison Programming		
Any Programming	22	67
Substance Abuse	15	46
Education	13	39
Career	10	30
Cognitive	10	30
Faith Based	4	12

Generally, participants reported that they found these programs to be helpful in a variety of ways. One individual stated that she felt the substance abuse programming was helpful "because they help you realize your problems and how to cope with them and to help yourself." Others indicated that substance abuse and cognitive programs helped them to understand personal issues, including how past events have impacted them and that these programs provided them with the tools they needed to "get clean." Those commenting on the efficacy of career and

education programming noted that the availability of these programs in prison provided them with an opportunity to access information and education they had difficulty obtaining before incarceration.

Some participants, however, did not feel that the programs they participated in while incarcerated were helpful. A few said that these programs did not provide enough one-on-one attention, which prevented them from getting as much out of the classes as they would have liked. Others stated that they were not open to what the programming had to offer them, so they did not absorb the information. For instance, one participant stated, "I didn't take it seriously." A number of participants indicated that they believed the programs were only what they made them, so the usefulness of the programs depended on the investment of the participant.

In addition to views on the utility of prison programming, some participants commented on obstacles that impacted their participation. The most frequently listed obstacle was that of sentence length. Participants reported that they were not allowed to enroll in certain programs unless they had a required amount of time left in prison. Some reported that their sentences were too short for program participation altogether. One individual mentioned that he was transferred more than once and thus could not enroll in the GED program at any of the facilities. Other obstacles mentioned were related to the participants' attitudes, such as not being ready for treatment or not being open to change.

The majority of participants reported that since being released to community supervision they had participated in some type of treatment programming. Over half (64%) reported that they were, at some point, enrolled in a transitional housing program, such as the New Mexico Women's Recovery Academy or a similar residential program. In most cases, the transitional housing program was substance abuse treatment oriented, but for some the programs were more general reentry initiatives. One-third of program participants indicated that they were involved in a 12-step substance abuse program. Five participants (15%) stated they were currently receiving mental health counseling. Four participants (12%) reported that they were involved in a faith-based program. While 30% participated in career programming in prison, only two (6%) reported involvement in a career readiness program post-release.

Table 7. Participation in Outside Programming

	Frequency	%
Outside Programming		
Any programming	27	82
Transitional Housing	21	64
12 Step Substance Abuse	11	33
Mental Health Counseling	5	15
Faith Based	4	12
Career	2	6

Participant Selection

All of the participants interviewed were in need of dental care but reported significant barriers to accessing dental treatment. Individuals often said that paying for care was difficult and they usually chose to postpone treatment, even if they knew it was badly needed, in order to pay for other basic necessities. Some also mentioned that both prison care and community care were available, but in both cases there was a long waiting list for treatment. We will provide details of participant dental problems and discuss how they believe these problems impact their lives in Objective 3. Outside of the need for dental care, the participant population diverges somewhat from the stated program participation criteria. In this section, we discuss how well participants met the program selection criteria and make note of characteristics that were not included that may impact program participation.

Education and Employment

Neither education nor employment status are included in the stated criteria for participant selection into the dental treatment program. However, based on the interview data a few observations are warranted. Most participants have (at least) a high school diploma or GED, which eliminates at least one obstacle to achieving and maintaining employment. This is consistent with the objective of recruiting probationers and parolees who are best situated to be successful with community supervision. Conversely, less than half of the participants in this study are looking or planning to look for work in the near future. Some are already employed and others are simply not seeking employment. Among those already employed, some have occupational advancement ambitions that dental treatment may facilitate. Among those not seeking work, some plan to seek work in the future (e.g., once released from transitional housing). However, some participants have no plans for future employment at all. These dynamics make it difficult to define and evaluate employment as the program outcome.

Offense History and Corrections Supervision Status

As originally designed, the program population was restricted to individuals on parole. However, only about half of the interviewees were parolees at the time of intake and two participants had never served any prison/jail time. Given that dental care is needed across both populations, the extension of the program to probationers is likely not a problematic diversion from the original program design. The participant selection criteria also contained preferences for individuals likely to be successful on community supervision, as determined by their PPO, and applicants were expected to be in "compliance with conditions of supervision." These criteria also specified that the applicant have 3 months time on community supervision, presumably enough time to make an assessment of their adherence to supervision requirements. An assessment of participant community supervision histories shows that most appear to meet these criteria. However, more than 20% of program participants had been under supervision for less than 3 months and one-third had a history of violations during the current term of community supervision (a few had extensive violation histories). We do not know the extent to

which basing the selection of participants on PPO beliefs about whether or not one is likely to succeed is important to program success. However, it appears that those persons recommending participants for the program interpreted these criteria differently from one another.

Corrections Program Participation

Since the criteria for program selection gave priority to those who took part in the Success for Offenders After Release (SOAR) program, we checked to see how many reported participating in this program. Eight participants (less than 25%) reported that they took part in the SOAR program while incarcerated. The criteria listed the second priority as parolees who participated in education programming while incarcerated. When we combine general education programs (e.g. GED, college enrollment) with the career oriented programs (e.g. SOAR, Career Pathways), 15 participants (46%) reported program participation while incarcerated. Overall, many participants did not meet the initial corrections education program selection criteria.

Objective 2: Goals and Expectations for Success

The second objective of this report is to detail participant reported goals and expectations for the future. Specifically, we report on participant responses to questions about their thoughts on successful reentry, education and career aspirations, general life goals, and their perceptions of the barriers they face and the resources they need to achieve their goals.

Likelihood of Staying Out of Prison

We asked respondents to assess their likelihood of staying out of prison in the future. Specifically, we asked each participant to comment on this question and then select a number on a scale of 1 to 10, where 1 is "probably going back" and 10 is "never going back." All but three participants (N = 30) ranked their likelihood of staying out of prison at an 8 or above. Of the remaining three, two did not answer the question and the other was unwilling to speculate about the future, replying: "you know, you can't, I can't predict what's going to happen tomorrow." Due to the concentration of responses at the high end of the scale, we divided the respondents into two groups: those who were certain they would not return to prison (N = 14) and those who were confident they would not return but expressed some caution about being overconfident (N = 16).

Participants expressed a number of reasons for their confidence with regard to not returning to prison. Some reported that they have acquired new tools for living (e.g. religious conversion, sobriety). Others indicated that they were motivated by family commitments to stay out of prison. Some made generic statements on change in their life situation. Reporting, for example, that they had "learned from past mistakes," "grew up," or were simply "in a better place." A few suggested that corrections supervision was a reason for confidence; either because their probation/parole officer was very supportive or they viewed the threat of prison time as so undesirable that they would not offend again.

We asked participants who were cautious about their chances of staying out of prison to comment on their lack of certainty. Some suggested that they were certain, but did not want to be overconfident. A few noted that due to a history of either substance abuse and/or mental illness, it was not possible to be sure. One respondent feared being returned to prison for a parole violation because he could not find a job. However, the most common explanation pointed to a belief in a lack of control over life circumstances. One-third of the respondents expressing caution suggested that someone else might get them into trouble—either by association or as the result of a "set-up." It is notable here that Maruna (2004) finds that offenders who view the bad things that happen to them as outside their control are more likely to recidivate.

Goals

We asked respondents to discuss employment and education goals specifically. We also inquired about other types of short and long-term life goals more generally. Table 8 provides a summary of the participant self-reported goals by type. It is important to note that general goals were completely self-reported (no interviewer prompting as to the range of goals that might be appropriate here) and that each participant may have interpreted the term "goal" differently. Therefore, that some participants mentioned one area, for example, "staying out of trouble," and some did not, may be indicative of their interpretation of what constitutes a goal and the goals that are most salient for them rather than an absence of desire to be successful in any particular area.

Table 8. Participant Self-Reported Goals by Type

	N	%
Education	27	82
Employment (current)	11	33
Meeting Basic Needs	24	73
Family Relationships	25	76
Personal Improvement	25	76
Staying Out of Trouble	11	33

Education

Twenty-seven participants reported having education related goals. For some, the goal was to get a GED (N = 6). Among those who wanted to get a GED, all but one stated that the acquisition of the diploma was a first step in a plan to pursue post-secondary education. Sixteen participants reported a desire to pursue post-secondary education (college or trade school). The remaining participants with education goals were already enrolled in post-secondary education and reported that completing the current course of study was an important goal. This distribution of responses is not surprising given that many of our respondents had already received a high school diploma or GED.

Employment

We solicited information on employment goals in two ways. First, we asked participants to talk about their current employment situation. When the respondent was unemployed, we inquired about their immediate plans to pursue employment. About one third of the interviewees reported goals related to current employment (N = 11). About half of these respondents reported they wanted "to get job." The other half indicated that they hoped to keep and/or advance in their current job. One participant stated that she would like to leave her current employment for "a better job." In addition to those articulating plans for current employment, four reported SSI as their goal for generating income.

Second, we asked participants to identify and discuss their "ideal" job. Because the question on future career goals was asked in this manner, almost all participants speculated on future careers. The three most frequently mentioned ideal jobs were those involving human services, trades, and business ownership. The types of human service occupations participants expressed interest in included: juvenile counselor/probation officer, law enforcement, drug/alcohol counselor, social worker, and church minister. Desired trade occupations included: welder, electrician, construction, veterinarian assistant, barber/hairstylist or cosmetologist, and message therapist. Those expressing interest in owning their own businesses reported interest in landscaping, arts and crafts, beauty salon or barbershop, construction, and property leasing. Generally, entrepreneurial interests were an extension of occupations mentioned as "ideal jobs." Others reported their ideal job as something in the medical field: laboratory technician, dental assistant, pediatrician, EMT, nurse or nursing assistant. Another commonly mentioned occupation was accounting (either accountant or book keeper). A few respondents expressed interests in the fields of education (teacher or teacher's aide) and business administration.

We compared speculative career goals to each participant's current employment goals, job experiences, and their current educational activities and goals to get a sense of what proportion of participants were actively pursuing their ideal job. In some cases, participants were already qualified for or actively working toward qualifications relevant to their career goals (N = 7). For example, one participant reported that her career goal was to work in an office environment and she was currently learning to type and was taking computer classes. Another was interested in being a barber, and was enrolled in a barber college. In addition, three participants were actively pursuing entry into educational programs congruent with their desired occupations. On the other hand, twenty-three participants reported that they were not actively pursuing their ideal job. Most indicated that they would like to get started (go to school, acquire business resources, etc…) but had to meet other needs first. For some, the ideal job was interpreted as more of a dream job rather than something that the participant would ever actually pursue. For example, one respondent stated that it was her dream to be a cosmetologist and open a "beauty salon/laundry mat/arcade/roller skating rink." While she indicated that her boyfriend was willing to help her build the salon, she was pursuing social security as a means of income and had no plans to attend cosmetology school.

For many participants, it may be difficult to obtain their desired career. A number of the occupations desired by program participants may be prohibited for individuals with felony convictions. Some expressed awareness of the possibility of this type of limitation. For

example, one program participant, who is currently a full-time college student working on a degree in a human services field, described her ideal job as "a social worker" or "teacher." However, she recognizes the consequences of the felony conviction when she says:

> "my stated degree right now is human services, but as a felon it's gonna be extremely unlikely that I'll be able to get a degree. I mean, I can get a degree, but to be able to use it…it's possible I'll change my major to just business administration."

Others were uncertain about which occupations may be prohibited. Another participant currently enrolled in college expressed a desire to work with troubled youth, but was unsure whether or not this would be possible, she states:

> "Well, I started out, and you probably hear this quite often cause I know I used to say it when I first went to prison, I could be a good, good counselor. I started out in, going in that direction, um, really, really what I would really like to do, and I don't know if it's possible, I'd like to be a probation officer, for juveniles. I want to work with the juveniles, I don't know if it's possible, if not, I know could still get in the door somewhere as long as I can work with them."

Moreover, some who expressed awareness of these limitations named back-up careers, which also may be prohibited occupations. In one such case, the participant identified "something in law enforcement" as an ideal career, but recognizing that this would not be possible with a felony record, identified accountant as a second choice. Of course, a felony record may also prohibit the participant from pursuing this career goal.

Other Goals

We asked each participant to identify two or three goals, other than education and employment, for both the immediate future (within the next year) and in the long-term (5 or 10 years). Specifying other types of goals was difficult for most interviewees. Further, short term and long term goals were mostly distinct as a matter of scope rather than type. In this section, we summarize the four primary themes appearing in respondent articulations of other types of goals (see Table 8 above).

Twenty-four participants identified goals concerned with meeting and maintaining ***basic needs for living***. We defined basic needs as issues related to shelter, transportation, and resources related to daily life maintenance, like "paying my bills on time" and settling past debts. One participant reported that it was his goal to "keep working" because he "started dropping behind on rent" and needed to keep "food on the table and stuff like that…make sure my transportation is okay." Goals related to finding and maintaining housing were particularly common among participants who were either living in or had recently left a transitional housing program; these were frequently connected to employment and/or income goals. Some hinted at basic needs goals without fully articulating them; for example one participant said she would like "just to be stable." One participant stated that her primary goal was to provide for her kids to "not have to

struggle so much with everything…to not have to depend on other people to help me out." A number of participants also indicated that they expected their basic needs to be met over time and articulated related luxury goals like owning a home, buying a home for a parent or child, making improvements to their existing home, having a nice car (boat, motorcycle), achieving long-term financial security, and saving money for retirement.

Twenty-five participants stated goals that were related to ***family relationships***. Among those articulating goals related to family life, the specific nature of these goals varied a great deal. Many participants reported strained relationships with family members due to their criminal and drug use histories. One common goal was to "be there" for family members, especially children and grandchildren, in the future and to make up for prior absences/failings. For some, this translated into specific goals aimed at reuniting and spending time with family members, especially for those who have lost custody of children. A few reported a desire to start a family.

Twenty-five respondents articulated goals related to ***personal improvement***. We categorized goals related to sobriety, spiritual/religious life, health, and appearance/self-image in this category. Among those reporting substance abuse problems, maintaining sobriety was frequently articulated as a top priority. Participants indicated that remaining clean and sober was crucial to achieving goals in general; some began their listing of future goals with statements such as "nothing else is going to happen if I don't stay clean." Spiritual/religious participation goals were often related to maintaining sobriety. Some reported that being "physically healthy" was an important goal. In a few cases, health related goals were specifically defined in terms of an existing illness or injury. These participants also expressed concerns about access to medical care and health insurance. The last set of goals included in this category dealt with respondent articulated aims toward improving their physical appearance and/or self-image. A number of respondents mentioned completing the dental treatment program. Some provided more generally stated objectives about looking better or being more attractive. In most cases, appearance goals were connected to making their appearance match the changes in their lives/lifestyles. However, some suggested that they were still hoping to achieve improvements to their self-image. One respondent explained that the dental treatment may help improve his self-esteem, "as a drug addict…I have low self-esteem…so I am working on that."

The last category involves goals related to legal issues and plans for ***staying out of trouble***. Eleven participants articulated at least one goal related to staying out of trouble. In some cases these goals were related to "finishing probation and parole." One reported a desire to have "no paper" hanging over his head and to complete his sentence "without violations." A couple of respondents hoped that once the current sentence has been served they could get the felony conviction expunged from their respective records. Others expressed general goals relating to staying out of trouble, like "staying away from the drugs and the people I knew while I was doing it." For some, the desire to avoid trouble was new. One respondent described this sentiment when he reported, "I never use to worry about staying out of trouble, but now I do." Similar to those with sobriety goals, participants suggested staying out of trouble was both a goal unto itself and a necessity for achieving other short and long-term goals.

Perceived Barriers and Resources for Goal Attainment

We asked respondents to discuss what they believed to be obstacles to goal attainment. We also asked them to report on things that may help them to achieve their goals. The responses to these two questions overlapped a great deal. As such, we categorized these responses into a set of barrier/resource types: social support, money, internal motivation, sobriety, criminal history, health, religion/spirituality, and education. In this section we focus on how each resource area is believed to affect goal attainment. The types of barriers/resources are discussed in order of frequency of appearance across interviews beginning with the most often mentioned barrier/resource and ending with those less frequently mentioned.

Table 9. Barriers to/Resources for Goal Attainment

Barriers/Resources	Frequency	%
Social Support	25	76
Money	18	55
Internal Motivation	18	55
Sobriety	16	48
Criminal History	11	33
Health	10	30
Other	12	36

Social Support

Social Support was the most frequently identified barrier/resource needed (N = 25). The types of support mentioned included that from family members (N = 14), friends (N = 6), and others (N = 14). Although most participants indicated that they desired more social support, few were able to articulate the ways in which this support could either facilitate or hinder goal attainment. This is especially true in the case of family support. Participants believed family members, particularly children, to be motivating influences and other family members to be potential resources for moral/emotional support. Only a few mentioned family members providing financial or other material resources. The role of friend relationships (non-familial) was most often described as potentially hazardous to success. Four of the six respondents discussing the relationship between friendships and goal attainment indicated that they had to avoid old friends (or new friends with bad habits). One respondent indicated that he did not have the skills to develop healthy friendships, as all of his previous relationships centered on drug use. Two participants reported that being around "good people" could enhance their chances for success. Respondents generally defined "good people" as those who were responsible, healthy, mutually helpful, who have similar interests and a positive outlook. However, neither participant was actively pursuing new friendships. Other identified sources of social support included: probation and parole officers, 12 step sponsors, clergy, counselors, etc… These persons were most clearly described as providing a service or material resource.

For some, the relationship between social support as both a resource and a barrier was complicated. Some mentioned having support in some areas, but lacking support in others. For example, one participant reported that the support of family, friends, and others were all important to her success. Being reunited with her children was a motivating factor and the support of her 12-step program sponsor was a great help; but she also suggested that historically she has lacked support from family and friends. She explained that the "lack of support, you know, from family and friends and stuff, because support is very important, and I have lack of that in my life and it has been a hindrance in my life." The majority (N = 23) of respondents indicated that they would like additional support now or in the future. That a significant majority of participants noted the importance of social support and the potential danger of deviant peer influences for successful re-entry is notable. A growing body of research on desistance highlights the importance of social bonds in the context of pro-social influences and networks for desistance among both males and females (Belknap, 2007; Heubner et al., 2009; Samspon and Laub, 1993).

Money, Housing, & Transportation

Financial resources were the second most frequently identified barrier to and/or resource needed for goal attainment (N = 18). The ways in which financial resources posed barriers to goal attainment varied among participants. For some, goals regarding "stability" in housing, transportation, and basic necessities were being hindered by unemployment or under-employment. Others indicated that a poor credit history and problems accessing credit may prevent them from reaching long-term financial goals, as well as goals regarding education and business ownership. Recent research indicates that access to material resources is important for promoting successful re-entry (Heubner et al., 2009, Reisig et al. 2002).

Internal motivation

The ability to be self-motivated was cited as a resource for some and a barrier for others (N = 18). Some participants indicated that they lacked motivation in the past, but have experienced a transformation of sorts. One respondent reported, "My whole life has been turned around." A number of respondents suggested that the need for self-motivation to achieve their goals could be a problem. One respondent stated, "The biggest thing that could hurt me is to quit." Others shared similar sentiments, citing a "history of not completing things," "giving up real easy," and a fear that he or she might "lose interest." One respondent expressed reservations about continuing to be goal oriented once her probation supervision ended. This too is highlighted in the literature as important for desistance (Giordano et al. 2002; Maruna, 2004)

Sobriety

Those with substance abuse problems cited relapse, if one should occur, as a barrier to goal attainment (N = 16). In discussing the likelihood of goal attainment, one respondent indicated,

"if I start hitting the bottle, I'm through." Some see substance addiction as their only obstacle. One participant concluded the questions on future goals by stating, "it will all fall into place if I can just stay clean." Participants suggested that substance use leads to poor decision-making, bad behaviors, and contributes to a lack of motivation. Ultimately, a drug and/or alcohol relapse would affect all types of goals, but participants placed emphasis on those related to education, work, family, and staying out of trouble. Literature supports respondents' perceptions of the link between drug use and recidivism (Dowden & Brown, 2002; Uggen & Kruttschnitt, 1998).

Criminal history

Both criminal history and corrections supervision were identified as potential barriers to goal attainment (N = 11). Concerns about criminal history were largely articulated as affecting career opportunities. Respondents expressed the belief that their criminal histories, specifically having a felony record, influenced their employment opportunities in two key ways. First, respondents indicated that employers were hesitant to give opportunities to felons. Second, some participants indicated that the field of occupations available to persons with felony convictions was limited. Thus, even when jobs were accessible, they were often either undesirable or paid too little. Incarceration history and subsequent corrections supervision were also believed to be obstacles to goal attainment. A few participants reported difficulty in readjusting to life after being in prison, especially in regards to scheduling and organizing activities. Others indicated that time commitments for and the scheduling of probation and parole requirements interfered with other pursuits. It should be noted that a number of participants also suggested that corrections supervision helped them acquire the resources necessary to meet their goals.

Health

Just under one-third of respondents indicated that either the existence of or the potential for health problems could pose a barrier to goal attainment in general, and employment goals in particular (N = 10). Some participants reported physical injuries or chronic illnesses that affect their ability to work, limit the types of jobs they can do, or prevent employment all together. Others noted that they require constant medical care and an inability to access care could be a major barrier to future plans. Another way in which health was articulated as a potential barrier involved those who reported that they suffer from mental health issues. These respondents indicated that mental health problems put them at risk for re-offending or made working consistently difficult.

Other Barriers/Resources

Participants identified a number of other barriers/resources related to both their successful reentry and future goal attainment prospects. While less frequently reported, some respondents suggested that their future successes would be bolstered by their connection to religion/spirituality (N = 5). Whenever mentioned, religion/spirituality was cited as a resource

for goal attainment. A few participants reported that access to and completion of educational programs was a crucial resource for goal attainment (N = 5). Occupational goals often required the respondent to pursue some sort of educational program or certification.

Two participants suggested that discrimination could pose a problem for goal attainment. One respondent, who reported an occupational goal in a male dominated field, believed that sex discrimination may inhibit her chances of securing employment.

Expectations for the Future and Program Participation

The purpose of asking participants to discuss their expectations for the future is to ascertain whether participants have employment goals, whether they see themselves as candidates for successful reentry, and what they articulate as the barriers to goal attainment besides dental problems (addressed in next section). Only one-third of interviewees articulated goals related to their current employment situation. This is not surprising, given that almost 40% of participants were already employed and only six were currently looking for jobs. This finding may complicate assessing employment as an outcome of the dental treatment program. However, research has suggested that the impact of dental treatment on employment may be far reaching (Rutzen, 1973). When asked about long-term occupational goals, almost all of the interviews identified an "ideal job" they would like to pursue. For most, these long-term plans required pursuing additional education.

Participants were confident regarding their ability to be successful on probation and parole. However, many seemed uncomfortable answering questions about other types of goals. For some, this discomfort was explained as a reluctance to divide their focus between successful reentry and other issues. For others, goal setting was complicated by beliefs about the need for and accessibility of social and material resources. A number of participants suggested that familial relationships were motivating them to be successful. However, many participants noted not only a lack of support but also an inability to establish (especially outside of the family) and maintain healthy relationships. Internal motivation, financial resources, sobriety, and health were frequently articulated as necessary for personal stability. While criminal history was seen as a detriment to occupational goals, personal stability was more often cited as a necessity for other types of goal attainment. Next, we examine how participants believe their dental problems affect employment, education, and personal relationships.

Objective 3: Beliefs about Dental Problems

Respondents reported a variety of dental problems. While each participant was given a dental assessment post-interview, in this report we use their terminology to explain the problem(s). Participants articulated twelve distinct dental problems. These are listed in Table 10 below, along with the number of participants who identified each problem. Some participants reported multiple dental problems. The number of problems per participant ranged from 1 to 6, with the majority of participants (N = 25) reporting more than one problem.

Seventy-six percent of participants reported having one or more missing teeth (N = 25). The location of the missing teeth (front or back) varied across participants, as did the extent of the problem. Participants who were missing teeth most often reported missing more than one tooth. Only four of the 25 were missing only one tooth. One of these four reported: "this one just fell out. Broke off and fell right out." Five participants were missing either all or nearly all of their teeth. One participant described the extent of the problem, stating that she had "17 teeth missing and my front teeth are missing." A few participants reported having no teeth at all. The remaining participants are missing two or more teeth, but not all of them. Respondent explanations for missing teeth varied and included the teeth being pulled out (N = 13), fallen out (N = 4), or knocked out (N = 5). For a few participants, it was unclear why their teeth were missing.

Table 10. Reported Dental Problems (N = 33)

	Frequency	%
Dental Problem		
Missing teeth	25	76
Pain/sensitivity	13	39
Broken/cracked teeth	11	33
Rotting teeth	7	21
Gums (receding, swollen, deteriorating)	7	21
Cavities	5	15
Bad breath	4	12
Broken dental work	4	12
Crooked teeth	3	9
Discoloration	3	9
Enamel loss	3	9
Wisdom teeth	3	9
Dental problems not articulated	1	3

Pain was the next most commonly reported dental problem. The extent varied from what some described simply as "discomfort" to much more extensive pain. For example, one participant said:

> " if I get a tooth ache man, oh my gosh, it just doesn't have one, it sets them all off, and man, it'll put me in tears. Bad tears, and it'd be like, I'd have to take at least half a bottle of ibuprofen, you know what I mean? To get them to calm down and stuff."

Another participant described the pain as affecting not only the mouth area, but also her throat and ears. In addition to reports of missed workdays due to dental pain, participants also indicated that attempts to alleviate pain had jeopardized their probation/parole standing. For

example, one participant reported that she failed a breathalyzer because she was using Anbesol to relieve dental pain, although she was given and passed a retest.

Eleven participants reported broken teeth. Teeth were described not only as broken, but also cracked, chipped, "crushed," and as being "stubs." Twelve reported other structural problems with their teeth, including rotting teeth (N = 7), which were often described as being black having black spots, and cavities (N = 5). Seven participants said that they have problems with their gums. Problems described included receding gums, gingivitis, swelling, and bleeding gums. Four respondents explained that they had broken dental work. This included broken/missing caps and broken dentures/bridges. Numerous other problems were listed by a handful of individuals, including bad breath, crooked teeth, discoloration (yellowing), enamel loss, and problems with wisdom teeth (impacted and abscessed).

Sources and Length of Dental Problems

We also derived respondents' perceptions of the sources of their respective dental problems and the length of time they have experienced dental problems from the general description of their dental issues. Twenty-three participants commented on what they believed to be the source of their problem(s); for the remaining 10, the source of the dental problem was not addressed. All but one participant provided an assessment of the timing of the onset of their dental issues. Table 11 provides a list of reported sources of dental problems and the frequency of participants who reported each problem. It should be noted that some individuals listed multiple reasons for their dental issues.

Table 11. Source of Dental Problems (N = 23)

	Frequency	%
Lack of Care	12	52
Substance Abuse	11	48
Accident/Altercation	7	30
Bad Dental Work	1	4

The most frequently identified source of dental problems was a lack of consistent and routine dental care. For some, neglect was described as failing to see the dentist regularly, while others indicated that they just did not floss/brush enough. One person explained that her current dental problems were compounded by a predisposition to bad teeth; she notes she has "soft teeth" and an excess of acidity in her mouth. Another blamed her current dental problems on having eaten a lot of candy as a child.

The second most commonly identified source was having a history of substance use. Eleven individuals (33%) stated that their dental problems were caused, at least in part, by substance abuse. The types of substances identified as causing dental problems included methamphetamines, cocaine, alcohol and nicotine. For some, drug use and lack of dental hygiene were related. One participant explained that he had been taking care of his teeth, "But then drinking and drugging got in the way of doing any kind of, you didn't care if you went to the dentist or not."

Seven individuals discussed altercations or accidents that led to their dental problems. Two described having their teeth knocked out or crushed due to domestic violence. Two noted fights with others as resulting in missing teeth. One participant lost teeth during a traffic accident and one indicated that he was a bystander to a fight and got hit in the face with a glass of beer. Other individuals were less clear about the cause of their dental issues, and one individual stated that previous bad dental work had caused current problems.

As shown in Table 12, the majority of respondents had suffered with their dental problems for ten years or more. Most of these respondents said they have had dental problems all their lives or since childhood, although some reported that the dental problems began when they were adults. Thirteen participants indicated that their dental problems had been ongoing for less than ten years, with responses ranging from one to eight years, and most respondents falling between three to seven years. One participant did not report on the length of the dental problem.

Table 12. Length of Dental Problems (N = 32)

	Frequency	%
10 or more years	19	59
Less than 10 years	13	41

Beliefs about Dental Problems

In order to understand the perceived impact of the dental problems, we asked participants about how the dental problems affected their lives. We focused on three life areas: employment, education and relationships. All respondents indicated that at least one of these areas was influenced by dental problems, either as a problem area or as something they expected would improve once dental treatment was completed. Participants most often cited problems with or expected benefits to employment and relationships. Less than half cited problems or benefits with regard to education or educational experiences (see Table 13).

Table 13. Life Areas Affected by Dental Problems

	Dental affects this area		Expects improvement in this area		Affects and/or expects improvement	
Area	Frequency	%	Frequency	%	Frequency	%
Employment	31	94	8	24	32	97
Education	17	52	5	15	18	55
Relationships	28	85	7	25	28	85

Within these three areas, several themes emerged regarding how the dental problems specifically affected the respondents' lives. These themes can be broadly classified as representing either functioning or self esteem issues. *Functioning issues* were coded where statements were made regarding pain or interference with daily activities within or outside of the three major life areas. For example, several participants noted that they were limited in what they could eat (i.e., could not eat apples). One person noted that due to her limited diet, she lacks the energy to exercise. Others noted speech problems or bad breath.

The level of specificity with which participants related dental problems to self esteem allowed us to subdivide self esteem effects into four categories: perceptions of others, perceptions of self, self confidence and interactions with others. These categories, while not mutually exclusive, function as a heuristic device for organizing the discussion of the ways in which dental problems impact participants' lives. Below, we define these categories and discuss the frequency with which participants identified each as related to their dental issues.

- The *perceptions of physical appearance to others* category reflects instances in which respondents viewed others as having had or potentially having negative beliefs about them as a result of the physical appearance of their dental problems.[3] There is considerable variance in the degree to which respondents indicated that their dental issues affected the perceptions of others. For example, some noted that visible dental issues resulted in negative first impressions, but at the same time indicated that these impressions may be altered once the person gets to know them.

- The *perceptions of physical appearance to self* category documents cases where respondents explicitly expressed that their beliefs about their own physical attractiveness are affected by dental problems. This was evidenced by such statements as "my teeth are ugly", "I don't look pretty", etc.

- The *interactions with others* category designates responses where participants report alterations to their behavior based on these beliefs. This is represented by statements that indicate that the participant acts differently with others because of the dental problems. For example, some respondents report that when they speak with others, they cover their mouths, do not smile, are less interactive with others than they would be otherwise, etc. Additionally, this also reflects the idea that others treat them differently because of their dental issues. Included here are statements indicating that others tease them or in some other way another person has said or done something that is related to the dental problems.

- The *self confidence* category captures those responses where participants articulate how these beliefs and interactions make them feel. Lack of confidence is coded as such when the participant explicitly states that they feel embarrassed, that they are self conscious, etc.

Table 14 displays the frequency with which respondents identified each category in their description of how the dental problems affect their lives. Confidence is the most commonly described problem and the most frequently cited area in which participants expect improvement. While a number of participants identified negative self-perceptions of their appearance as a problem or an area of expected improvement, this was least frequent. In the next section, we discuss the ways in which participants expressed these problems in relation to employment, education, and their relationships with others.

[3] Since we specifically asked participants to describe how others see them, it is not surprising that this is a theme that emerged. However, these responses were not limited to this question. Indeed, the negative perception on the part of others based on the dental problems is mentioned throughout many interviews.

Table 14. Problems Identified as Barriers/Expectations Regarding Dental Treatment

	Dental affects this area		Expects improvement in this area		Affects and/or expects improvement	
	Frequency	%	Frequency	%	Frequency	%
Perceptions of others	27	82	9	27	28	85
Physical appearance to self	12	36	9	27	18	55
Confidence	30	91	24	73	30	91
Interactions with others	25	76	18	55	26	79
Pain/functioning	22	67	10	30	23	70

Effects of Dental Problems on Employment, Education, and Relationships

Employment

All but one participant indicated that employment was an area affected by the dental problems or an area they expected would improve due to the dental treatment. Participants reported a variety of ways in which they believed employment was affected. Primarily, participants expressed concerns about the perceptions of potential employers and current or potential customers. Some also mentioned interactions with coworkers as being affected by the dental problems. Utilizing the categories constructed above, we observed that most participants believed that employment was negatively impacted due to the perceptions of others, their own level of confidence, and in their interactions with others (see Table 15 below). Few reported that beliefs about their own physical appearance impacted their employment prospects or experiences.

Table 15. How Respondents Believe Dental Problems Affect Employment

	Affects Employment	
	Frequency	%
Perceptions of others	18	55
Physical appearance to self	4	12
Confidence	17	52
Interactions with others	17	52
Pain/functioning	14	42

Several participants felt that potential employers viewed them negatively due to the dental issues; that is, potential employers' first impressions of the participant were influenced by the dental problems. The degree of the perceived impact varied, with some participants indicating that while the dental problems might cause a negative first impression, it was not such a barrier that it would prohibit them from getting a job. Although, some felt that the dental problems prohibited them from getting jobs they wanted. For example, one participant felt that the dental problems would signify to potential employers that he is someone who "smokes crack," and that this had caused him to be "[excluded] from a couple of jobs." Another participant relayed that she had applied for a waitressing job, and had been told by the manager that he would not hire her because he did not want her in the restaurant "with your teeth like that." Another, hoping to

start his own business, felt the dental problems prohibited him from appearing trustworthy and would limit his pool of clients.

A number of participants noted that the dental problems affected them on the job, in particular, in their interactions with customers. Participants discussed their unwillingness or difficulty with smiling, engaging in prolonged conversations, or making eye contact due to missing or bad teeth. Other participants indicated that customers did not want to talk to with them or generally viewed them negatively. This was a prominent theme among those working in the service industry (restaurants, fast food, etc...) and more generally for those who wanted to work with the public in any fashion. Among those participants who were not currently employed, some stated that they would not apply for jobs that involve working with the public because they do not want to interact with customers due to their dental problems. Others felt they were not able to secure these types of jobs. One participant noted that she enjoys customer service related jobs, but would not be able to get the type of job she wants because of her teeth. She says:

> "Anybody can get a job, I don't care what you look like…But it's the quality of the job you can get… when you've got teeth this bad, people don't really want to talk to you and don't trust you."

Those employed in certain types of industries, e.g. construction, were less likely to indicate that their interactions were inhibited due to dental problems. However, a handful reported that they sometimes had to interact with customers on the job and this was adversely affected by visible dental problems. One participant working in construction also noted that the appearance of his teeth affected his interactions with co-workers, in that the fellow workers made fun of his teeth.

Fourteen participants noted that the functioning or pain associated with the dental problems adversely affected them on the job. Most who noted this as a problem indicated that they either missed work or did not perform their job as well as they could due to the dental problems. Two noted that their bad breath was noticeable and two felt that the dental problems impaired their ability to speak. Both of these problems created difficulties with respect to customer relations.

Finally, five participants explained that their own beliefs about their physical appearance affected their employment. Primarily, this effect derived from inhibited interactions with others, lack of self-confidence, or both. That is, because they felt they did not look good- for example, "I feel like my mouth is gross"- they would not interact with others and felt embarrassed.

Only one respondent felt that the dental problems did not impact her employment currently, in the past or in the future. She has not worked since her dental problems began and has no plans to secure employment in the future.

Education

Sixteen participants said that either their dental problems affect their educational experiences or expect that the dental treatment will help them in an education setting. For some, the educational setting was a post secondary environment; while for others the setting was inside a treatment

facility. Many participants focused on the ways they felt their confidence was impaired and/or the ways in which their own interactions with others were inhibited. Additionally, some participants noted that pain or dental treatment made them miss classes. Some participants also indicated that the perceptions of others impacted their education.

Table 16. How Respondents Believe Dental Problems Affect Educational Experiences

	Affects Education	
	Frequency	%
Perceptions of others	4	12
Physical appearance to self	2	6
Confidence	12	36
Interactions with others	11	33
Pain/functioning	6	18

Most of the participants who cited a relationship between their dental issues and educational experiences, currently or in the past, described the relationship as indirect. In particular, they suggested that a lack of confidence presented a challenge in the educational environment where interaction with others was a necessity. Participants who noted that their interactions with others were impaired in the educational arena were less likely to say that others treated them differently, instead noting that they acted differently due to the dental problems. There was one participant who indicated that she was teased at school due to her dental problems, but, the majority reported smiling less, limiting their time talking with others, hiding their mouth, etc. These actions were described as deriving from a lack of confidence, "esteem things," rooted in feelings of embarrassment about the dental problems.

In terms of the way others perceived them in the educational arena, most respondents simply noted that people notice their teeth and that they expected that once the dental treatment was completed, people would view them more positively. One participant also stated that a certain amount of professionalism was expected in the educational setting and the dental problems detract from her ability to appear professional.

There were nine participants who indicated that the dental problems did not influence their education either currently or in the past, and they did not anticipate that it would be a problem in the future. Among these, only one was currently enrolled in an educational program. Although this participant was missing teeth, he indicated that his educational experience was not affected because he does not have to "get up and do speeches or anything like that." This participant was enrolled in a trade apprenticeship, but his comment suggests that if his program of study was different, he may view the dental problems as problematic. The remaining participants were not currently enrolled in educational programs, but several had applied or indicated that they were thinking of apply to school. Given that they were already scheduled to have the dental treatment, they did not anticipate the dental problems affecting the education in the future.

Relationships

The majority of respondents felt that the dental problems either influenced their interpersonal relationships (outside of employment and education) or that the treatment would improve these

relationships. Table 17 provides frequencies for the categories for how respondents described the dental problems affecting their personal relationships.

Table 17. How Respondent Believes Dental Problems Affect Relationships

	Affects Relationships	
	Frequency	%
Perceptions of others	27	82
Physical appearance to self	8	24
Confidence	20	61
Interactions with others	18	55
Pain/functioning	5	15

Participants discussed three types of relationships that are affected by dental problems: intimate partnerships, friends/family relationships and all other interpersonal interactions, which included: meeting people for the first time, talking with apartment managers, strangers in line at the grocery store, etc. The only relationships that are not included here are those with employers or education related as these have already been discussed. Within each of these areas, the dental problems were described as affecting past, current, and/or potential relationships. Respondents tended to focus more on current or future relationships rather than past relationships.

Intimate Relationships

Ten participants reported that intimate relationships were currently or could in the future be affected by their dental problems. Participants currently in relationships most often reported that they felt embarrassed about their dental problems, which led to interaction problems with their significant others. One participant reported that she did not want to kiss or even talk to her partner. Another believed that his dental problems were so significant that he was afraid his girlfriend would "find someone else." One participant reported that her partner was embarrassed of her. Another respondent stated that her partner points out when she has bad breath, though she considered this to be supportive.

Five participants indicated that their dental problems may inhibit forming new intimate relationships. Some participants reported that they believe potential partners see them negatively due to the appearance of their dental problems. Specifically, they suggested that potential intimate partners would be turned off by the appearance of their teeth or view their dental problems as evidence of meth use or some other character flaw. For example, when talking about how potential partners see him, one participant said they think, "he don't care, he just has them like that…no self respect or motivation to fix them." Others felt the problem comes from within, emphasizing that it "gives me a complex" which made it difficult to meet someone new. One respondent reflected on past intimate relationships and noted that her self-consciousness about the dental problems ruined relationships because she was continually putting herself down, which she said was a "turnoff for them [partners]."

Familial Relationships

Five respondents reported that their dental problems affected their relationships with family members. Primarily, these respondents discussed the ways in which their family members reacted to their dental problems. In comparison to others with whom participants interact, family members were reported to be more overt about their reaction to the participants' dental problems. Some noted that family members comment on the state of their teeth; these comments were problematic for some respondents, but not for others. One female participant was dismayed by comments made by her son: "you have a meth mouth" and she said, "that like hurt my feelings so bad." Another respondent noted that his mother-in-law questions him about why he does not get his teeth fixed. Other respondents reported that while their family members mentioned the appearance of their teeth, they were generally more accepting than they believed others with whom they interacted to be. For one respondent, her dental problems made mealtime with family uncomfortable, because her "teeth are really awful" and she was deeply embarrassed for others to watch her eat.

Four participants noted that, despite a desire to do so, their dental problems affected their ability to form new friendships. Self-consciousness regarding physical appearance was the primary explanation for participant beliefs about the impact of dental problems on meeting new friends. One participant noted that she would like to form new friendships, but is embarrassed by the appearance of her teeth. Another echoed this response, indicating that she wanted to meet new people, but not until her dental problems were fixed. Generally, participants reported that they expect the improvement to their appearance after the dental work to make them more comfortable in social settings and better able to socialize with others. One participant explained that after the dental work, she expected that she would "be a part of society, instead of being closed in and behind doors."

Other Interpersonal Relationships

When discussing the effects of the dental problems on relationships, participants often described the relationships in general; that is, how the problems affected all types of interpersonal relationships rather than a particular relationship (e.g., family, friends, etc.). Twenty-two respondents mentioned that interpersonal relationships in general were affected by dental problems. The relatively high number of statements regarding interpersonal relationships is, in part, due to the questions we asked. In addition to asking respondents about their family and friends, we also asked them to discuss to describe what kind of first impression they make on others, and then to discuss how they think the dental problems affect that impression. We also asked participants to describe how they view themselves and whether or not the dental problems influence this view. Additionally, peppered throughout the interviews, participants would offer statements that reflect their beliefs about how the dental problems affect their interactions with others.

Themes that have been described up to this point are repeated here. For example, respondents discussed the ways in which their perceptions of themselves affected their interactions with others. Participants indicated that they believed the dental problems made them "ugly" and they

felt embarrassed when they interacted with others. Participants discussed how they believe the dental problems influenced others' perception of their character. Some descriptions included: a drug addict, criminal, homeless, and a trouble-maker. One participant noted that he can tell that others have a negative impression of him because people look at his teeth, not his eyes. Several noted that the first impressions people have of them are bad because of their dental problems; for some, they believe this will change once they get to know the participant, but getting to know people is problematic given the first impression. The third way the dental problems influence these relationships is in the way they interact with others. As explained previously, respondents indicated that they do not talk as much as they normally would, do not smile or hide their teeth, or act differently than they normally would by making self-deprecating jokes about their dental problems. One participant noted that the lack of teeth makes it difficult for him/her to express his/her feelings through facial movements. Additionally, for one participant, the physical act of speaking was impaired by the dental problems, making it difficult to verbally communicate with others.

Only one participant indicated that the dental problems had no affect on his interpersonal relationships. This participant said that he has always been somewhat self-conscious about his appearance, but that the dental problems did not exacerbate his feelings of self-consciousness within current relationships.

Expected Benefits as a Result of Dental Treatment

Most participants expected improved confidence and interactions with others as a result of the dental treatment. For many, these issues were interrelated; that is, they expected that as their confidence improved, interactions with others would also improve. Less frequently, participants noted they expected improvement to their physical appearance as seen either by themselves or others. For example, some said that the dental treatment would make them look "cuter" or "smarter." Again, this was often expected to result in improved interactions with others. For some, these improvements are expected to specifically impact one of three major life areas (employment, education and relationships). For others, this is expected to have a more global impact on the participant's life.

Participants described a variety of ways in which they believed the dental treatment would increase their confidence. For some, they indicated simply that their confidence would improve: "I'd feel more of a somebody" or they would feel better about themselves. For the majority of participants, this improved confidence was articulated as an outward action. Many participants noted that they would feel better, and in turn, would be able to smile, be more outgoing with others, would be able to kiss their partner or potential partner, etc. Some expected that the newfound confidence would make it easier to find employment because they would be more willing to talk with potential employers or interact with the public. Others noted that it would be easier to go to school if their confidence improved.

Several participants indicated that they expect that they would like the way they look better. Some participants also believed that the dental treatment would improve the way they looked to others. Others suggested that the dental work would influence the way they were treated by

others, expecting that they would be treated with more respect. This improvement was expected to translate into employment benefits for some. For example, one participant felt that the dental treatment would make him appear more trustworthy, thereby improving his ability to get customers. Another noted that once the dental treatment was done, potential employers would want to hire her.

While improvements in self esteem, perceptions of self and others and interactions with others were anticipated, some participants also expected health and functioning benefits. These health benefits included overall improvement in general health (due to dental induced toxins) and dental health specifically. Many expect improvement in functioning, such as the ability to eat foods that they cannot eat currently and improvements in breath odor.

Discussion & Conclusions

The New Mexico Department of Corrections began a pilot dental repair program for parolees in May 2008. The goal was to reduce visible barriers to employment among parolees in order to help them gain employment and thereby improve reentry success. The current report described the treatment population by focusing on three objectives. This work provides suggestions for future implementation of the program and lays the groundwork for assessing outcomes for subsequent reports.

Objective 1: To describe the participant population in terms of demographic characteristics, education, employment, criminal history, corrections history, and dental needs.

We included this objective for two reasons. First, the literature suggests that certain individuals are more likely to recidivate than others. Therefore, it is important to know who participated in the program. Second, the NMDOC specified criteria for program participation, including length of time on parole, compliance with conditions of parole, etc. Thus, we compared the participating population with the target population in order to assess whether there was fidelity to these criteria.

Description of Participants

Most program participants were female (61%), Hispanic (58%) or non-Hispanic White (39%), and had minor children (67%). The mean age was nearly 40 years old. Most had a high school education or above; 21% completed high school and 52% had participated in post-secondary education. Many participants were currently employed (N = 13); some were seeking employment (N = 6) and some were not actively seeking employment (N = 14) at the time of the interview. In part, those not actively seeking employment were not doing so because they were in a transitional housing program that prohibited employment at the time they were interviewed. Among those who were employed, most worked in service or construction industries. Just under half were in some sort of transitional housing program at the time of the interview. The most common types of offense participants reported being involved in leading to their current supervision were drug offenses (39%, N = 13) and property offenses (36%, N = 12).

Approximately 18% of participants had been involved in prior violent offenses and 15% had been charged with DWI. The types of dental problems participants described included broken, rotting and missing teeth. They most often described the source of the dental problems as lack of dental care and substance abuse. Over half had lived with their dental problems for ten years or more. Lack of dental care was sometimes due to cost and difficulty accessing dental care.

As a group, program participants exhibit both risk and protective factors with respect to their potential for desistance. The literature on recidivism suggests that males are more likely to recidivate than females (Uggen and Kruttschnitt, 2002). However, for both males and females, a substance abuse history increases the odds of recidivism (Heubner et al, 2009). Moreover, minorities may face more barriers to successful re-entry than whites. Further, while younger offenders are generally more likely to recidivate, older offenders with an extensive criminal history are also at increased odds of recidivism. Despite demographic risk factors, reentry programs can reduce the likelihood of recidivism, particularly those that promote social support, employment, and education (Petersilia, 2003).

Participant Population Compared to Criteria

We found that there was some incongruence between the participant population and the target population. Each criterion is described below with a description of the population.

The first criterion was that the dental work should be made available only to parolees. Over half of the participant population was on probation (52%) with the remainder either on parole or dual supervision. Thus, there was a mismatch between this criterion and the selected population.

The second criterion was that parolees should have been out of prison for three (3) months and must have at least six (6) months left of parole supervision. A little less than one-quarter of those participating in the program (21%, N = 7) had been under supervision for less than 3 months. We were not able to obtain projected supervision completion dates, so were not able to determine how much time was left on their supervision.

The third criterion was that the service was available to parolees in the Albuquerque area only; the program did not cover travel expenses. Some of the participants were living at the Women's Recovery Academy in Los Lunas at the time they were admitted into the dental program. Likely these participants were admitted because there is daily transportation between the Recovery Academy and Albuquerque; however, transportation did prove to be problematic for some participants when trying to schedule and keep dental appointments.

The fourth criterion states that priority is given first to parolees who participated in Project SOAR while incarcerated. Second priority is given to parolees involved in an education program while incarcerated. Third priority is given to (all other) parolees. Thirty percent of program participants had been enrolled in SOAR or a similar program, and 40% participated in an education program (but may not have completed it).

The fifth criterion was that priority is also given only to parolees determined by their Probation and Parole Officer (PPO) as being likely to succeed on supervision. We have no way of directly measuring this criterion as this was not documented. However, as noted below, some participants were not in compliance with the conditions of their probation/parole, which has implications for their long-term success under supervision.

The sixth criterion states that parolees must be in compliance with conditions of supervision and orders of the PPO. Upon examining the records of each of the participants, we found that eleven (33%) had one or more violations prior to intake into the program. Three of these had violated within three months of the intake interview- one of whom tested positive for meth, heroin and cocaine 45 days prior to the interview.

The seventh criterion states that parolees and PPOs must affirm that the current appearance of the parolee's teeth seem to present a barrier to gainful employment for the parolee (both unemployment and under employment). All participants had dental problems, most including rotten, missing or cracked teeth. The second part of this criterion has to do with barriers to employment. We found that approximately 40% of participants were employed at the time of the interview. Among those not employed (N = 20), most (N = 14) were not actively seeking employment at the time of the interview. Four of those not actively seeking employment were unlikely to seek employment in the future; the remaining were likely to seek employment at some point. Since the goal of the program is to improve employability, these four individuals are likely not appropriate candidates for this program.

Finally, parolees who receive the dental work services must be willing to: 1) sign a release of information, 2) participate in a pre- and post-treatment face-to-face interview, 3) participate in pre- and post-treatment photography, 4) provide personal testimony as to the impact of dental work, and 5) complete a program survey.

Based on this review, we find there is a lack of fidelity between the criteria and participant population. Certainly, there are numerous reasons for this lack of fidelity. It may suggest that future program implementation should revise the criteria to include a broader pool of participants or more rigid screening mechanisms should be employed to ensure fidelity. Alternatively, there may need to be some combination of revision and rigid screening. These revisions should take into account the key program goals and the population that would most benefit from a program designed to address these goals. If occupational success remains the key program goal, at a minimum, applicants should be screened to assess current employment status, barriers and goals.

Objective 2: To describe participant goals and expectations for the future including thoughts on successful reentry, education and career aspirations, and their perceptions of the barriers they face and the resources they need to achieve their goals.

The purpose of this objective is to ascertain whether participants have employment goals, whether they see themselves as candidates for successful reentry, and what they articulate as the barriers to goal attainment besides dental problems (addressed in next section). These factors should influence the likelihood of successful employment and reentry.

Overall, participants were generally confident that they would not re-offend. Among those who thought recidivism was possible, most noted a lack of control over life circumstances. Most participants (82%) had some type of education goal. Only 33% had a current employment goal (to secure employment). Nearly all articulated an ideal job that they would like to pursue, though interviewers prompted this. The degree to which participants had actual plans to pursue their dream job varied, with ten making steps towards this job and the remaining 23 not actively pursuing their dream job. Additional goals included meeting and maintaining basic needs, enhancing family relationships, personal improvement (including both internal and external changes), and plans to stay out of trouble. Participants also articulated barriers to goal attainment. Barriers include lack of financial resources, concerns about sobriety, criminal history, and health- particularly in terms of impacting employment goals. Social support and internal motivation were discussed as both a barrier and a support. It is notable that participants' insights into the barriers they face are consistent with the literature on barriers to successful re-entry. Though we do not know whether participants will successfully navigate past these barriers, that they recognize them and are also able to articulate the kinds of social and material capital they need to access to facilitate their success is a notable first step.

Objective 3: To describe how participants articulate the impact of dental problems on education, employment, and personal relationships and the expected benefits of the dental treatment.

We asked participants to explain how the dental problems affected each of these life areas (education, employment and personal relationships). This allowed us to understand more completely how many participants feel their dental problems affect these areas and in what way the dental problems influenced these domains. Most of the participants reported that their dental problems affect employment and relationships in some way; just over half believe that education has been affected in some way. The ways in which the dental problems affected participants fell into two broad categories: self-esteem and functioning. Employment was largely impacted by self-esteem issues. Participants expressed concerns about the perceptions of others (such as potential employers), as well as noting that their confidence and interactions with others were negatively impacted by dental problems. A little less than half noted that dental pain or functioning interfered with employment. Among those who felt their education was affected by their dental problems, confidence and interactions with others were most frequently cited as problematic. The third most common area was pain/functioning. Respondents were most likely to relay that in terms of their relationships, they believe the dental problems affect the perceptions of others, followed by impacting confidence and interactions with others. They were least likely to see pain/functioning as an influence on interpersonal relationships. Participants expected that their confidence and interactions with others would improve as a result of the dental treatment. This would in turn have a positive effect on one or more of the major life areas or their lives more globally.

Suggestions for Future Program Implementation

Since this was a pilot program, it is expected that some refinement of the program would need to occur. The suggestions offered here reflect our observations regarding discrepancies between

program specifications and implementation. Our intent is to provide feedback that will help strengthen program implementation in the future. We focus on areas that are important in process evaluation.

We noted a discrepancy between the stated target population and the participating population as describe above. There are a number of possible reasons for this difference. First, in reviewing the criteria, we find that some are vaguely defined. For example, "compliance" is not specific. We noted that one participant had tested positive for drugs 45 days prior to intake into the program. For some, this may be construed as non-compliant, for others, no subsequent violations may signal a shift towards compliance. Thus, we recommend that the NMDOC specifically define the admission criteria. For example, the NMDOC may decide that the candidate must have clean UAs for at least three months prior to admission. They may decide that certain technical violations are acceptable, but other violations are not. These definitions need to be standardized so there is no confusion about program eligibility.

Ultimately, it is up to those reviewing applications to decide whether the criteria have been met. Our second recommendation, then, is for the applicant review committee to ensure that the program criteria have been met prior to accepting potential participants into the program. One way to facilitate this would be to construct a checklist that clearly specifies each criterion and its components.

Through conversations with staff involved in selecting participants, we know that to some extent they purposefully relaxed the criteria for admission. This may have been done in part because those referring potential participants were not adhering to the criteria. This in turn may have been partially due to unclear specifications. However, it is clear that the target group was parolees, though many probationers were admitted into the program. It may be that there were not enough parolees available who met the other criteria eligible for the program. This suggests that it may be beneficial to complete a programmatic needs assessment. It is not clear how the NMDOC established the need for a dental treatment program for parolees. As we note in the introduction, there is literature to support the utility of such a program for offenders, it is not clear how acute the need is among New Mexico parolees. A needs assessment could help to refine the target population and pinpoint problem areas including the depth and scope of the existing problem. For example, it may be that dental needs are more important among those seeking particular types of employment, such as service industry jobs regardless of probation or parole status. Moreover, it may be that tattoos, for example, are a greater barrier to employment. A program needs assessment would help identify problems and prioritize interventions.

We also suggest constructing a logic model to determine the goals and objectives of the program, incorporating the results of the needs assessment. This will also help determine short and long-term expected outcomes, and identify the appropriate tools for evaluation of those outcomes. The stated goal of the program as it stands is to promote successful reentry by improving employment opportunities. However, a number of the participants were gainfully employed at the time of the interview and at least four of the interviewees had no plans for future employment. A logic model may help to solidify the objectives of the program as well as to provide a way to promote a common understanding of the program. Further, this will help to define the criteria for participation more fully. For example, there is no criterion that specifically

states that the potential participant must intend to seek employment (and within what time frame). This is an important omission that should be addressed in the future.

Future reports will focus on outcomes. Building on our findings here, program completion and overall positive reentry will be the focus of the outcomes study. Clearly, other mechanisms are at play in success in these areas besides the dental treatment itself. We have laid the foundation for assessing these factors. There were 37 potential participants for the program. Four of these were scheduled to complete an interview, but did not do so. These were dropped from the program. Thirty-three participants completed the first interview; 24 of these completed the dental treatment. Of those who did not complete the dental treatment, three received partial dental treatment; six never went to the dentist. Twenty of the twenty-four participants who completed treatment participated in a post treatment interview. Our next report will focus on those who did complete treatment and describe their reentry success to date. Additionally, we will explore the reasons participants failed to complete treatment. While employment is a stated goal for the program, assessing employment as an outcome is complicated given the short study period and the fact that the few participants were actually seeking employment. However, we can examine the perceived influence of treatment on employment experiences and opportunities.

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Appendix: Participant Interview Schedule

I am going to start by asking a few questions about you and your background.

1. Sex (interviewer circle—though if an all-male sample—this is not necessary):

   Male Female

2. Date of Birth?

3. What is your race/ethnicity?

Dental Repair Program

4. Why did you apply to the dental repair program?
   - *Do not probe for details at this point.*

5. How long have your teeth been a problem for you?
   - *Do not probe for details at this point.*

I would like to know a little bit about your offending and incarceration history.

6. Why are you currently on parole (what was the offense for which you were most recently incarcerated)?
   - *Tell me a little bit about the incident that landed you in prison*

7. How long ago were you released to parole?

8. Before being paroled, how long did you spend in prison?

9. Was this your first incarceration? If not, how many *other* times have you been incarcerated?

10. What kind of training and/or treatment did you receive in prison?
    - *Did you participate in any education programs? If so, which ones?*
    - *Did you participate in any job training programs? If so, which ones?*
    - *Other programs?*
    - *Were you mandated to programs or did you choose to participate?*

11. Do you think the training and/or treatment you received in prison was helpful for you? Why/why not?

12. How likely are you to stay out of prison in the future (1 to 10)? Why do you say this?

These next questions will help me get a sense of your educational experiences.

13. Did you complete high school or receive your GED? (interviewer circle response)

    Yes (go to 14) No (skip to 16)—why not? Plans to?

14. Since completing high school or getting your GED have you taken any college courses or enrolled in any technical schools or other technical training programs (or do you have any immediate plans to do so)?

    Yes No

15. Tell me about your college or technical school training since graduating high school or completing your GED.

16. How have your dental problems affected your educational experiences?

I am also interested in your employment experiences.

17. Are you currently employed?

    Yes No—looking for job probes

18. What kind of job do you currently have?
    - *Tell me a little about your current job*

19. Ideally, what kind of job would you like to have?

20. Have you ever been fired from a job? If so, why?

21. What are some of the difficulties that you encounter when searching for jobs?
    - *Do employers seem concerned with your background (criminal record)?*
    - *Do employers seem concerned with your appearance/presentation skills?*

22. Have your dental problems been an issue for you on the job or when looking for jobs?

This next set of questions asks about your future plans and goals.

23. I know you have probably talked with your probation officer and some of the prison staff about your future goals. What are some of the goals you have set for yourself *(other than those already discussed)*? Aim for 2 to 3 goals.

24. Probe dental problems here

Now I am going to ask you a little bit about the people you spend time with.

25. Who do you spend most of your time with? Probe relationship, activities and influence

26. Who else (family, friends) do you spend time with? Probe relationships, activities and influence.

27. Of the people you spend time with, who is the best and worst influence on you? Why?

28. Probe kids if not yet mentioned.

29. probe dental problems—how do they affect your relationship with those you hang out with.

This next set of questions is designed to help me get a sense of how you see yourself and how you think others see you.

30. When you meet people for the first time, what do you think their first impression of you is? (If this is hard for them to answer, rephrase: how might someone who just met you describe you to someone else?)

31. How about people you know, how do they see you? (rephrase: how might your friends/family/significant other describe you to someone else?)

32. How would you describe yourself?

33. Probe dental problems here.

Thank you very much for your time today. I enjoyed talking with you and look forward to meeting with you again after you complete your dental work. Good luck with everything.