



Reducing Barriers to Re-Entry: Assessing the Implementation and Impact of a Pilot Dental Repair Program for Parolees

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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 was 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 with the University of New Mexico Hospital Dentistry Department to perform dental treatments. The New Mexico Statistical Analysis Center (SAC) at the University of New Mexico's Institute for Social Research (ISR) was contracted to provide an evaluation of program implementation and outcomes. The NMSAC issued a report in December, 2009, detailing program implementation. The current report focuses on program outcomes.

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. From the initial enrollment to the final post-treatment interview, program execution took 17 months. Once participants were selected for the program, they met with the evaluation team from the New Mexico SAC for a pre-treatment 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. Intake interviews were conducted in two phases. The first period began in July 2008 and ended in November 2008; 28 participants were enrolled. Once it became clear that funds would not be depleted at the close of treatment for the first round of participants, a second phase of the program began in February 2009 and ended in March 2009. An additional 9 participants were enrolled in this second wave, and in sum, 33 participants (for both phases) were enrolled. The second period began February 2009 and ended in March 2009; 9 additional participants were enrolled.

Following the pre-treatment 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. Dental treatment began on July 29, 2008 and ended July 8, 2009. Of the 33 participants enrolled, 28 made at least one visit to the dentist, 24 completed the dental treatment and 19 completed all program requirements including a post-treatment interview.

About 2 months after each individual’s 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 experience. The post-interview generally took about one half hour and was conducted at the same location as the pre-treatment interview. The first post-treatment interview was conducted on March 2, 2009 and the last post-treatment interview took place on September 9, 2009. At the post interview appointment, a NMDOC employee took an “after” photograph for their records. In total, 20 participants completed a post-treatment interview, though one of these participants did not complete dental treatment.

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—including all violations for the current supervision term—and their participation in education programming during their incarceration. Criminal history and incarceration information were provided at the time of enrollment. Violation data were extracted on October 30, 2009, allowing for approximately three months of post-treatment information.

Objectives of the Evaluation

Summary of Pre-treatment interview data

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. In the first installment of the evaluation report we used data from pre-treatment interviews to describe 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 would affect them in various life domains (work, education, family). This initial report laid 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.
- **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.
- **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.

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 (Ulmer, 2001; 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 (Pager, 2003). Further, while younger offenders are generally more likely to recidivate, older offenders with an extensive criminal history are also at increased odds of recidivism (Gendreau et al., 1996; Ulmer, 2001). Despite demographic risk factors, reentry programs can reduce the likelihood of recidivism, particularly those that promote social support, employment, and education (Petersilia, 2003).

Overall, participants were generally confident that they would not re-offend. In part, this reflects the selection criteria for the program. Individuals who participated in this research were only approved if they received a recommendation from their probation and parole officer and were making success towards re-entry. Moreover, there is general evidence that most prisoners and parolees overestimate their chances of post-release success (Dhami et al., 2006). 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. These barriers included 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.

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 the ways in which participants perceived their dental problems to affect these areas and in how the dental problems influenced these domains. Most of the participants reported that their dental problems affected employment and relationships in some way; just over half reported that their education has been affected in some way. The ways in which the dental problems affected participants fall into two broad categories: self-esteem and functioning. Employment was largely influenced 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, dental problems affect the perceptions others have of them, and also affect their confidence and interactions with others. On the other hand, few reported that pain/functioning affected their interpersonal relationships. Participants expected that their confidence and interactions with others would improve as a result of the dental treatment. They expected that this, in turn, would have a positive effect on one or more of the major life areas or their lives more globally.

The dental treatment program was a pilot project aimed at assessing the feasibility and potential for success of the intervention. Our initial report assessed program design issues related to participant selection and intake procedures. The current report focuses on short term intervention outcomes. However, some key findings from the initial report are relevant to our

current outcomes assessment because our initial report identified some issues with program fidelity that may have some bearing on program outcomes. Specifically, we found incongruence between the characteristics of the participant population and those articulated as criteria for program selection. To begin, a substantial number of participants did not fit the stated selection criteria for participant supervision status, time on supervision, residential location, or prison program participation. In addition, three items in the selection criteria were at the discretion of the Probation and Parole Officer (PPO): likelihood of succeeding on supervision, compliance with terms of supervision, and an assessment of dental appearance. While it may be that all participants met these criteria, we were unable to assess this, as the officers used their own subjective assessments to identify participants meeting these criteria. Moreover, we did not have any data that might confirm. Furthermore, though the program was geared towards parolees seeking new or improved employment opportunities, participant employment status and goals were not considered prior to enrollment. These issues are detailed in the first report and will be further discussed in the final sections of this report. At the same time, our initial report notes that each of the participants did have significant, visible dental problems and each perceived these problems to be a detriment to their long term success in one or more key life domains.

Post-treatment Evaluation Data

In the current outcomes report, we combine pre-treatment data with details of each participant's dental treatment plan and data from a post-treatment interview. The primary objectives for this report (continuing from the initial report) include:

- **Objective 4:** To examine the effect of population characteristics (demographic, education, employment, criminal history, and corrections history) on three outcomes-- completion of the dental treatment, completion of the program, and probation/parole performance.
- **Objective 5:** To describe how participants articulate the impact of dental treatment on education, employment, and personal relationships. We will also compare participant reported effects to those anticipated prior to receiving the dental treatment.
- **Objective 6:** To assess how participants experienced the dental treatment program from intake to completion. Here we focus on participant perceptions of the organization and delivery of the dental treatment program.
- **Objective 7:** To assess the fidelity of program delivery with program goals and objectives.

Description of Dental Treatment Provided

The provision of dental treatment differed for each participant. The number of visits and the types of services provided were based on each participant's specific dental problems. The program provided both medical and cosmetic dental services. However, cosmetic services were limited. Partial dentures were provided for participants with missing teeth. Procedures such as teeth whitening and/or straightening with braces were beyond the limit of program

resources. In this section, we describe the time, cost, and types of dental services provided. The data available for this section apply only to the 28 participants who made at least one dental visit.

Treatment

At the initial visit, all participants received a cleaning and an exam, which included x-rays. Following the exam, the dental team developed a personalized treatment plan for each participant. The dental team provided intensive cleaning when necessary and attended to basic medical needs by filling cavities and extracting wisdom teeth. Twenty-two participants had at least one tooth extracted. For some, this meant the removal of all remaining teeth. The number of teeth extracted ranged from 0 to 24, with an average of 4.7.

In total, 19 participants were fitted with a dental prosthetic. Nine participants received a full denture (upper, lower, or both) and 12 participants received a partial or multiple partials to replace missing teeth.¹ Six of these participants received at least one adjustment after receiving the denture and/or partial.

The remaining 9 participants did not receive any type of denture or partial. Four participants did not receive a denture and/or partial even though one was specified in the original treatment plan. Each had teeth extracted but failed to complete their respective treatment plans. One of the participants in this group had all of her remaining teeth removed and then absconded from supervision. The reasons for attrition in the other three cases are unknown.

Five participants did not present with dental problems necessitating a denture/partial. These participants were all enrolled during the first phase of participant selection. They reported a variety of dental problems, including: cavities, broken dental work, discoloration, gum deterioration, pain/sensitivity issues, etc... It would be overly simplistic to suggest that these dental problems did not present a visible barrier to employment. For example, one of these participants presented with blackened plaque build-up, which was visible when she spoke. She also reported having chronic bad breath. She indicated that her primary opportunity for employment was as a restaurant server and believed her teeth affected her both the likelihood of getting a job and the confidence to interact with the public in the workplace. The types of dental work provided to these participants included: filling cavities, multiple intensive cleanings, and repairing dental work—including the replacement of discolored fillings.

Treatment Cost

The program spent \$57,244 on dental treatment. For those completing the treatment cost per patient ranged from \$564 to \$3761, with an average of \$2275 (N = 24). The cost was higher on average for participants in need of dental prosthetics. For participants receiving either dentures or partials, the cost ranged from \$1628 to \$3761, with an average of \$2589 (N = 19). The cost for persons completing the dental plan without need for prosthetics ranged from \$564 to \$1502, with

¹ Some participants received both a full denture (either upper or lower) and a partial. As such, the frequencies provided for dentures and partials are not mutually exclusive.

an average of \$1082 (N = 5). In total, the program paid \$2628 for treatment of participants who did not complete the program. The range in cost for these participants was from \$214 to \$1087, with an average of \$657 (N = 4).

Length of Treatment and Appointments

Participants were responsible for making and keeping appointments with the dental office. The amount of time necessary to complete the dental work depended on the type and severity of dental problems. For those completing the treatment program (N = 24), the length of time in treatment ranged from 31 to 253 days with an average of 125 days. Some participants completed treatment in as few as 3 visits, with others taking up to 17 visits. The average number of visits to the dental office was 10. Although the number of visits per participant was similar, the length of time in treatment varied significantly by the phase of enrollment. Participants who entered the program during the first phase of enrollment averaged 143 days in treatment (N = 16), compared to an average of 90 days for those entering during the second phase (N = 8).² This difference was largely the result of the program funding deadline. Participants entering the program in 2008 simply had more time for additional appointments than those entering in 2009.

Among those making at least one visit to the dentist (N = 28), 79% either no showed or cancelled at least one appointment. The number of missed/rescheduled appointments ranged from 1 to 5, with an average of 1.7 (N = 22). For most, this was a onetime happening (N = 13). Overall, it does not appear as if missing and/or rescheduling appointments added significantly to the time necessary to complete treatment. Seven participants, who are classified as completing the dental treatment, failed to show for the last scheduled appointment. The final appointment was arranged as follow up to the treatment, especially for those requiring adjustment for prosthetics. All but one of those missing the last appointment received either a partial or dentures. Three in this group reported having adjustment problems during the post-interview.

Objective 4: Outcome Assessment

In order to evaluate program outcomes, we examined the effects of population characteristics (demographic, education, employment, criminal history, and corrections history) on three outcomes--completion of the dental treatment, completion of the program, and probation/parole performance. We also examined whether and how pre-treatment perceptions of program impact affected actual outcomes.

Program Completion

Fifty-one percent of enrollees completed all stages of the dental treatment program. There were 37 participants originally enrolled in the program. Four of these failed to show for the initial pre-treatment interview. Enrollees who did not complete the pre-treatment interview were dropped from the program. Thirty-three participants completed the first interview; of these, 24 completed

² The standard deviation for days in treatment for phase one enrollment group is 61.287 and the phase two group is 13.622; $t = 2.38$, $df = 22$, 2 Tail Confidence Level = 97%

the dental treatment plan provided by the treatment provider. Of those who did not complete the dental treatment, four received partial dental treatment. The remaining five participants never went to the dentist. Nineteen of the twenty-four participants who completed treatment returned for the post treatment interview. We also conducted one post-treatment interview with a participant who received partial treatment. Table 1 summarizes attrition from the program at each stage; percent completion is calculated by both the number of enrollees and the number of participants completing the pre-interview.

Table 1. Percent of Participants Completing the Dental Treatment Program by Program Stage

	Completion of Program by Stage		
	N	% of Enrollees	% of Interviewees
Enrolled	37	100	-
Pre-Treatment Interview	33	89	100
At least one Dental Visit	28	76	85
Dental Completed	24	65	73
Post-Treatment Interview	19	51	58

In the sections that follow, we define the program participant population as all enrollees completing the pre-treatment interview (N = 33). We have little to no information on the 4 enrollees who were dropped from the program before completing the pre-treatment interview. All four had a recorded probation and/or parole violation close to the time of program enrollment. However, we cannot say whether the violation was cause for removal. In correspondence with program organizers, we learned that two moved outside of the Albuquerque area where the treatment was being offered. The reasons for nonparticipation are unknown for the remaining two enrollees. Since we have no information with which to compare these participants with those whom we were able to interview, we have excluded them from the remainder of findings presented in this report.

In the following sections we also compare those who completed dental treatment to those who completed all program requirements, including a post-treatment interview. We begin by looking at the characteristics of those who completed dental treatment.

Completed Dental Treatment

We identified participants as completing dental treatment if the documents regarding treatment provision indicated that all dental procedures were performed and identified a treatment end date. As discussed in the description of treatment, some participants did not show up for their final appointment. These participants are counted as completing treatment, so long as they had received all of the dental work outlined in the treatment plan. Table 2 compares demographic and supervision characteristics of participants completing the intake interview only to those continuing on and completing the dental treatment.

Table 2. Comparison of Demographic and Supervision Characteristics of Interviewees to Participants Completing Dental Treatment

	Total	Completed Dental Treatment	Did Not Complete Treatment
	N = 33	N = 24	N = 9
	%	%	%
Sex			
Male	39	46	22
Female	61	54	78
Race/Ethnicity			
Hispanic	58	58	56
White	39	38	44
Bi-Racial	3	4	0
Family and Residential Statuses			
Married	15	17	11
Minor Children	67	54	100
Transitional Housing Program	45	29	67
Restricted Movement	21	8	55
Highest Level of Education			
Less than High School	27	21	45
At least a HS Diploma/GED	73	79	55
High School Diploma/GED	21	21	22
Some Post-Secondary	52	58	33
Employment Status at Intake			
Currently Employed	39	54	22
Looking for Employment	18	13	22
Not Actively Seeking Employment	42	33	56
Corrections Supervision			
Probation	52	50	56
Parole	48	50	44
Parole only	21	17	33
Both Probation and Parole (dual)	27	33	11
At least one violation before program end	39	29	67

Most participants completing the dental treatment (N = 24) were female (54%), Hispanic (58%) or non-Hispanic White (38%), and had minor children (54%). The mean age was nearly 43 years old. Most had a high school education or above; 21% completed high school and 58% had participated in post-secondary education. Slightly less than 30% of persons completing treatment participated in a transitional housing program after release from prison. The majority of participants completing treatment were currently employed (54%); some were seeking employment (13%), and some were not actively seeking employment (33%) at the time of the intake interview. The most common types of offense participants reported being involved in leading to their current supervision were drug offenses (42%) and property offenses (37%). Approximately 13% of participants had been involved in prior violent offenses and 17% had

been charged with DWI. Half of those completing the dental treatment were on probation only, 17% were on parole only, and 33% were on dual supervision (both probation and parole).

Participant Demographic Characteristics

Three participant demographic variables were useful in comparing the group of participants who completed treatment to the participants who did not complete treatment. Participants with minor children were less likely than those with no children to complete dental treatment ($X^2 = 6.188$, $p = .013$). Custodial arrangements for minor children were not systematically collected for this study. As such, we cannot determine the precise reason for this relationship. It is possible that having minor children may have lead to scheduling conflicts that made it difficult for participants to meet dental appointments. Those with at least a High School diploma and/or GED were more likely than those without a diploma and/or GED to complete the treatment plan ($X^2 = 6.131$, $p = .013$). Older participants were also statistically significantly more likely to complete treatment ($r = 0.588$, $p = .000$). Unfortunately, we are unable to specify exactly why participants without children, those with high school educations, and those who were older were more likely to finish the dental treatment. It may be the case that these variables are reflective of other barriers or facilitators that made it more difficult or easier to complete the treatment. For example, participants with children may have experienced difficult in obtaining child care to attend the treatment sessions, while younger and less educated participants may have fewer resources in terms of transportation and perhaps less flexibility in their employment situations. Similarly, participants with high school or higher educations and participants that are older may have access to additional resources that made it easier for them to complete treatment. Other demographic characteristics (sex, race/ethnicity, marital status, and employment status) were not significantly related to the completion of dental treatment.

Offending and Corrections History

Participants with a violation prior to the end of the treatment period (whether before or after intake) were less likely to complete treatment when compared to those with no violations. Twenty-nine percent of those completing treatment had a violation, while 67% of those not completing the dental plan had at least one violation before or during the treatment period ($X^2 = 3.855$, $p = .050$). We found no other relationships between offending and corrections history variables and treatment completion.

Other Program Participation

Most participants reported taking part in various education and self-help focused programs while in prison (67%) and while on probation and/or parole (82%). Overall, whether or not enrollees participated in either prison or post-release programs was not related to completing dental treatment. When we looked at specific types of programs reported by respondents in the intake interview, only one significant relationship was identified. Compared to those not in housing programs, participants living in transitional housing ($N = 15$) were no more or less likely to

complete treatment. However, participants living in transitional housing programs who were free to work and conduct personal business during the day (e.g. halfway houses, N = 8) were more likely to complete treatment than those in restricted movement programs (N = 7, $X^2 = 6.857$, $p = .009$). All of the participants in restricted movement housing were located in one program, the Women's Recovery Academy in Los Lunas. This program is located outside of the County in which the treatment was provided. We noted in the first report that including these participants was incongruent with the participant selection criteria. Although, the facility provided transportation for program participants, organizers identified problems with transport during the early stages of the dental treatment. We are unable to expand on this issue, as only two of these seven participants completed the dental treatment and none returned for the post-treatment interview.

Intake Interview Variables

Participants who started the program in the second enrollment period were significantly more likely to complete the dental treatment—in fact all of those enrolled in the second phase (N = 9) completed the dental treatment, compared to 64% of those admitted in phase one (N = 24; $X^2 = 3.960$, $df = 1$, $p = .047$).

We also examined whether or not the types of changes anticipated in the pre-interview were indicative of completing the dental treatment. We found no significant relationships between the anticipated effects (changes in self-perception, perceptions of others, interactions, self-confidence, pain/functionality, appearance) and the likelihood of completing dental treatment.

Completed All Program Requirements

The above section spoke to the characteristics of those who completed the dental treatment portion of the program. This portion of the report focuses on those who completed all program requirements, including post-treatment interview. Nineteen participants completed all program requirements, including the post-treatment interview. The items associated with completing all program requirements were similar to those related to completing the dental treatment. Table 3 compares demographic and supervision characteristics of participants completing the intake interview to those completing all program requirements, including the post-treatment interview.

The majority of participants completing all program requirements (N = 19) were female (53%), Hispanic (53%) or non-Hispanic White (42%). Most completing the post-interview did not have minor children (58%). The mean age was nearly 44 years old. Most had a high school education or above; 21% completed high school and 63% had participated in post-secondary education. Thirty-seven percent of persons completing the post-treatment interview had participated in a transitional housing program after release from prison. The majority was currently employed (53%); some were seeking employment (16%), and some were not actively seeking employment (32%) at the time of the intake interview. The most common types of offense participants reported being involved in leading to their current supervision were drug offenses (47%) and property offenses (37%). Approximately 11% of participants had been

involved in prior violent offenses and 11% had been charged with DWI. Thirty-seven percent of those completing the post-interview were on probation only, 21% were on parole only, and 42% were on dual supervision (both probation and parole).

Participant Demographic Characteristics

When compared to participants without children, those with minor children were less likely to return for the post-treatment interview ($X^2 = 12.158$, $p = .000$). Participants with at least a High School Diploma or GED were more likely to complete the post-interview than those with less than a high school education ($X^2 = 6.414$, $p = .011$). Age was also related to meeting all program requirements, as older participants were more likely to complete the post-interview than younger participants ($r = 0.651$, $p = .000$).

Offending and Corrections History

We found that type of corrections supervision was significantly related to completing the post-treatment interview. Specifically, participants who were on either parole or dual supervision (as opposed to probation only) were more likely to complete the post-interview ($X^2 = 3.862$, $p = .049$). We were only able to interview one participant who did not complete the dental treatment. This participant identified many of the factors described above as contributors to her inability to complete the program. After leaving a transitional housing program, the participant took up residence approximately 30 miles from the dental office. Once on her own, she was unable to access regular transportation and secure child care for her four minor children. She also indicated that these same factors made it difficult to find and maintain employment.

Other Program Participation

In general, participation in other programs was not significantly related to the completion of all program requirements. Only participation in transitional housing programs is significantly related to the successful completion of program requirements. While there were no statistically significant differences between those participants living in a transitional house and those that are not, there were significant differences within the subset of participants that lived at a transitional house. Participants living in programs that afforded freedom of movement (i.e. halfway houses) were more likely than those enrolled in restricted movement programs to complete the post-treatment interview. None of the participants in the restricted movement program at intake returned for the post interview.

Table 3. Comparison of Demographic and Supervision Characteristics of Interviewees to Participants Completing All Program Requirements

	Total	Completed Post-Interview	Did Not Complete Post-Interview
	N = 33	N = 19	N = 14
	%	%	%
Sex			
Male	39	47	71
Female	61	53	29
Race/Ethnicity			
Hispanic	58	53	64
White	39	42	36
Bi-Racial	3	5	0
Family and Residential Statuses			
Married	15	21	7
Minor Children	67	42	100
Transitional Housing Program	45	37	57
Restricted Movement	21	0	50
Highest Level of Education			
Less than High School	27	16	43
At least a HS Diploma/GED	73	84	57
High School Diploma/GED	21	21	21
Some Post-Secondary	52	63	36
Employment Status at Intake			
Currently Employed	39	53	36
Looking for Employment	18	16	14
Not Actively Seeking Employment	42	32	50
Corrections Supervision			
Probation	52	37	71
Parole	48	63	29
Parole only	21	21	22
Both Probation and Parole (dual)	27	42	7
At least one violation before program end	39	21	64

Probation and Parole Performance

In order to assess probation and parole performance for each participant, we collected information on all probation and/or parole violations associated with the current sentence. Violation data were extracted one month after the final post-treatment interview, allowing for approximately three months of post-treatment information on probation and parole performance. Given the short amount of time between the end of the dental treatment and the post-interview follow-up, this assessment should not be interpreted with regard to any lasting effects on reentry success.

We divided violations into categories based on three specific time periods. Those prior to program enrollment are violations occurring after the begin date of the current supervision and prior to the intake interview. Violations during program enrollment are those occurring after the intake interview but before the dental treatment end date. Violations after program end are those occurring after the participant’s dental treatment end date. We identified violations for three months following the dental treatment end date. For participants not completing the dental treatment, we used the date associated with the expiration of treatment funds, since beyond this date treatment was no longer available to participants. Table 4 shows the frequency of violations by timing of violation for all participants. In total, 15 participants (45%) had at least one violation on record. Three with a violation prior to enrollment also had a violation during program enrollment. One participant had a violation both before enrollment and after program end. And one had violations both during the program and after completing the dental treatment.

Table 4. Frequency of violations by timing of violations (N = 33)

Timing of Violations	Participants With Violation	
	N	%
Before Enrollment	11	33
During Enrollment	5	15
After Program End	4	12

Table 5 shows the timing of violations by completion of the dental treatment program. Thirty-three percent had a violation prior to enrollment (N = 11) and of that group, 7 (64%) went on to complete treatment.³ Failure to report and substance use and/or a failed substance test were the most frequently reported violations. A few were also cited for criminal conduct and failure to maintain employment. There is no clear pattern of violation type differentiating those with pre-enrollment violations who completed the dental treatment from those who did not. None of these violations led to supervision revocation. Fifteen percent of participants had a violation during program enrollment (N = 5), only 1 of whom went on to complete treatment. We also observed a similar pattern of failure to report and substance related violations in this group. It may have been the case that participants violating during the program were dropped. In a few of these cases, the sanction for the violation was still pending. However, at the time of data extraction none had been revoked.

In total, 4 participants had a recorded violation after the dental treatment end date, 3 of whom had completed their dental plan. Those completing the dental treatment were each cited with substance related violations and failure to report. One participant had violated 4 times in the 3 months following the end of treatment. Two of these participants were awaiting revocation hearings at the time of data extraction. The remaining post-treatment violator also had a violation during enrollment. She was cited with failure to report just after the intake interview and never visited the dentist. The post-program violation was for criminal conduct and substance related violations. This participant was also awaiting a revocation hearing. There were generally

³ Violations prior to program entry were discussed in the first installment of this report. Although we expressed concern that violations were incongruous with participant selection criteria, it turns out that having a violation prior to program participation was not significantly related to program completion.

no statistically significant differences in the likelihood of violation based on the probation/parole status of participants. Participants on parole alone and participants on probation alone were equally like receive violations both during, and after treatment. Parolees on probation and parole were less likely to receive a violation before treatment ($r = -0.433$, $p = .012$), but were statistically no different in terms of violations during and after treatment.

Table 5. Timing of violations by completion of treatment program

Timing of Violations	Participants With Violation Completing Treatment		Participants With Violation Not Completing Treatment	
	N	%	N	%
	Before Enrollment	7	64	4
During Enrollment	1	20	4	80
After Program End	3	75	1	25

Objective 5: Perceived Impact of Program Participation

In this section, we review the anticipated benefits of the dental treatment reported in the intake interview and compare these to the perceived benefits reported in the post-treatment interview. From this point forward, the data are derived from interviews with the 19 participants who completed dental treatment and the post-treatment interview. Participants anticipated and reported effects on employment, education, and relationship experiences. As described by participants, the mechanisms connecting the treatment to changes in these areas can be summarized into four categories: improved physical appearance, improved interactions with others, increased self-confidence, and reduction of pain/improved functioning. A description for each of these mechanisms is provided below.

- The *improved physical appearance* category reflects instances in which respondents reported either that they believed that the dental treatment improved their physical appearance or that they felt others viewed their physical appearance more favorably after dental repairs.
- The *increased self confidence* category captures those responses where participants articulated that the dental treatment (and subsequent improvements to physical appearance and interactions with others) has boosted their self-confidence or improved their self-esteem.
- The *improved interactions with others* category designates responses where participants indicated that the treatment lead to less frequent alterations to their behavior based on beliefs about how others perceive their dental problems. In the intake interview, many participants indicated that they avoided certain types of interaction because of their dental problems. We identify improvements to interaction where participants reported either

less inhibition (i.e. smile more, talk more, etc...) or beliefs that others interact with them differently after the dental treatment.

- The *reduction of pain/improved functioning* category indicates instances where participants reported that the treatment reduced physical pain and discomfort associated with dental problems.

Anticipated Effects (Pre)

In the intake interview, we asked participants to explain how the dental problems affected various life areas (education, employment and personal relationships). This allowed us to understand more completely how and in what ways participants believed their dental problems affected these areas and get a sense of how they believed the dental treatment would affect their lives. Most participants reported that their dental problems affected employment and relationships in some way. Many participants indicated that the dental problems affected their self-esteem and that they expected their self-esteem would improve as a result of the dental treatment. With improved self-esteem, participants also expected improved interactions with others. They anticipated that these changes would in turn have a positive effect on one or more of the major life areas or their lives more globally.

Table 6. Anticipated effects of receiving dental treatment (N = 19)

	Anticipates change	
	N	%
Appearance	11	53
Confidence/Self-esteem	14	74
Interactions/Expressions	15	84
Pain/Improve functioning	5	26

Reported Effects (Post)

In the post-treatment interviews we explored participant perceptions of treatment benefits on employment and education experiences, specifically; and then in regard to relationships and social situations more generally. Each participant indicated that the dental treatment has improved one or more life areas. Almost 75% indicated that the dental treatment has either affected their employment experience or they anticipate that it will affect their chances of obtaining employment; 21% detailed how treatment has/will impact their educational experiences, and 38% described how the dental treatment has improved personal relationships. Given that little time had elapsed, for some participants the reported benefits were speculative. However, others described changes they had already experienced in these areas. Here we document how many participants report either speculative and/or experiential changes for each area. We also present findings on whether and how participants connected the dental treatment to life improvements. We begin with general descriptions of treatment effects and follow with those specifically articulated as affecting employment/education and personal relationships.

General Impact of Treatment

Congruent with the anticipated effects documented during the intake process, improvements were largely described as resulting from changes in appearance, confidence, and interactions with others, and for some with reduced pain and/or improved functioning. As we will show in the discussion below, these changes are interrelated. Table 7 summarizes the frequency with which participants described these changes in general. With the exception of interactions/expressions, each category shows an increase in the number of participants reporting the effect in the post-treatment interview when compared to the expectations reported in the pre-interview.

Table 7. Effects of dental treatment (N = 19)

	Affects one or more life areas	
	N	%
appearance	18	95
confidence/self-esteem	16	84
interactions/expressions	16	84
reduce pain/improve functioning	8	42

Almost twice the number of participants (95%) spoke directly about how the dental treatment improved their appearance in the post-treatment interview (N = 18) when compared to those who anticipated such improvements in the intake interview (N = 11), though it should be noted that all 11 of the participants that anticipated a positive change in appearance described a positive change in appearance. In articulating changes in appearance, participants most often compared their perceptions of how they believed others viewed them prior to the dental treatment to how they believe others view them now. Reflecting on these beliefs, participants recalled that others might have viewed them as “scary” and/or “a criminal.” Some also noted that prior to treatment they looked “like a drug user” or “a street person.” Counter to those assessments were new beliefs about being perceived as “normal” or “like a nice person.” Participants believed that changes in how others perceived their appearance had not only increased their likelihood of interacting with others, but also changed the ways in which they expressed themselves.

A few participants described how the dental treatment changed their own perceptions regarding appearance. One reported, “I see myself as a...as a new man, different. I look in the mirror and I’m like different...” This shift in perception had affected his attention to his appearance and concern for how he presented himself to others. One female participant stated, “[before the dental treatment] I always thought I was ugly. I was just disgusted with my body. Period. From head to toe. Everything about me, and I’m not now. And that’s all due to the dental.” Another described in the intake interview how the appearance of her teeth contributed to low self-esteem; after the dental treatment she described herself as “beautiful.” Self-assessments regarding appearance were typically connected to improved self-esteem and confidence.

Eighty-four percent of participants reported improved self-confidence/self-esteem (N = 16, including 12 of the 14 participants that described improvements in self-esteem as an anticipated change). For the most part, participants stated outright that they had more self-confidence and/or improved self-esteem after receiving the dental treatment. A few elaborated on how these changes were related to appearance and interaction. For example, one participant reported that receiving dentures has increased his self-confidence and that has led to changes in interaction: “when I speak to people...I don’t have to be concerned as much with how I appear to other people,” which he believes “gives me the opportunity to be more honest in relating to other people.” Like those indicating appearance helped them to fit in, another suggested that feeling “more confident and more assured” was important for making new friends. Confidence and self-esteem were directly tied to issues of appearance and were also believed to be necessary for success in all life areas.

Eighty-four percent of participants reported improved interaction/expression after receiving treatment (N = 16, including 14 of the 15 participants that anticipated a positive improvement on their interactions due to dental treatment). Most indicated that they express themselves more often and many noted that they smile more often. One described the importance of smiling, “my package comes with a smile so being that I didn’t have my front teeth for the longest time, it was just kind of hard to be myself.” Others reported that they talk much more in public than they did before the treatment. For example, one suggested that she was “more at ease carrying on a conversation with a stranger now,” while another suggested that the treatment changed her desire to interact with others. Specifically, she discussed plans to share more and reach out to others in her 12-Step program. Some participants also reported that they were able to look at people directly, “eye to eye” and that they were generally more comfortable in social settings.

Just over 40% of post-treatment interviewees spoke about the elimination of dental pain and/or improved dental functioning, including 3 of the 5 participants that indicated that they anticipated improvement in this area as a result of the treatment. Not having to think about and/or prepare for pain management every day was articulated as one of the benefits of receiving treatment. The reduction in pain also improved mental focus and overall physical well-being. Those highlighting improved functioning benefits discussed the enjoyment of having the ability to eat certain foods and to eat in the company of others without embarrassment. Some noted that the dental work had implications for their overall health because both the nutritional content of their diets and their digestion had improved. Others suggested that decreased pain and sensitivity also led to increased confidence and improved interactions with others. One participant noted that she was more pleasant to be around, “[not being in pain] makes a difference in how you feel...and how you act to other people.”

Employment & Education

Overall, 74% of participants perceived some kind of relationship between receiving the dental treatment and employment. Table 8 summarizes the distribution of the 19 participants who completed treatment by their employment status at intake and their employment status as recorded during their post-treatment interviews. Specifically, 10 of the 19 (53%) participants

were employed during the intake interviews and 9 of 10 (90%) these participants were still employed during the post-treatment interview. In contrast, 9 of the 19 (47%) participants were unemployed during the intake interviews and 2 of these 9 (22%) participants acquired employment by the time that their post-treatment interviews were conducted. These results indicate that there were very few changes in employment among participants. This finding is possibly a reflection of the relatively short time-period between the intake and post-treatment interviews and should not be taken as evidence for or against a potential relationship between dental treatment and employment outcomes.

Table 8. Changes in employment from the intake to post-treatment interview sessions

	Employed Post Treatment		Unemployed Post Treatment	
	N	%	N	%
Employed At Intake (N=10)	9	90	1	10
Unemployed At Intake (N=9)	2	22	7	78

In general, most participants reported no change to either their employment or education status since the intake interview (N = 13). While in the aggregate overall employment figures look similar at both periods, six participants reported some changes between the pre and post interview. In addition to the participants that acquired and lost jobs as indicated above, 1 participant changed to a different job, 1 changed from not looking for employment to looking for employment, and 1 participant changed from looking for employment to not looking to not looking for employment. At intake, two participants were enrolled in college full-time and not looking for work. Both were still enrolled in school at the post-treatment interview. However, one was newly employed at her boyfriend’s home-based business.

Treatment effects on employment were primarily identified as changes to “on the job” experiences. Eight of the eleven who were already employed reported that the treatment had improved their workplace experiences. An additional six participants indicated that they expected the treatment to make it easier for them to find employment.

Changes to on the job experiences are most often reported as the result of increased confidence and the impact of that change on improved interactions. One participant received a promotion to supervisor at her current job. While she was in line for this promotion prior to enrolling in the program, she indicated that the treatment helped her embrace her new role. She noted that prior to the treatment, “I was always working...hiding myself” and since receiving the treatment, “I’m always on front. I’m even at the register.” Similarly, others suggested that their interactions with bosses, co-workers, and customers/clients had improved. One participant described this change in terms of how others treat him: “The look on their [co-workers] faces is a lot different...and the way they act toward you is a lot different. The questions they seem to ask you are a lot different.” While another stated, “I could communicate with people better, customers or anybody.” Interactions were tied to both changes in confidence on the job and their beliefs about how others perceived them based on appearance. For example, the participant citing improved communication above also reported that he believed it was important to “present yourself proper” when dealing with customers and that he feels “like a new man...like I’m one of them.”

Table 9. Experienced and speculative improvements in employment from dental treatment (N = 19)

	Reporting improvements to area	
	N	%
Employment (experienced)	8	42
Employment (speculative)	6	32

Six of the eight unemployed participants speculated that the dental treatment would improve their prospects for future employment. Most believed improvements to dental appearance translated into increased credibility among potential employers, co-workers, and potential clients/customers. One participant currently looking for work indicated that improvements to his appearance gave him the confidence for direct interaction with potential employers... “I’m able to look at the employer guy more...the guy that interviews you. I’m able to look at him better. I’m not keeping my head ducked or anything.” Others indicate that improved appearance elicited less suspicion from others: “[I] probably don’t look like I’ve been in so much trouble.” One participant summarized the connection between future work related experiences and improvements to self-esteem and interaction, while identifying how these improvements affect the perceptions of others:

“Having the ability to smile, and the ability to eat, it makes a real difference in how I feel about myself and the reaction that I get from other people is different... there is a definite sense of apprehension on people’s faces when they talk to you and you smile or you talk...it’s as if you’re trying to hide something and they’re not really sure why you’re not smiling”

Some participants also discussed ways in which their educational experiences were and/or will be enhanced after receiving the dental treatment. Two participants spoke about how they had already experienced change. One participant reported that she feels “more confident” in the classroom. The other indicated that her classmates respond to her “more positively” and that they “pay more attention” to what she has to say. Others who plan to go back to school also believe that having their teeth fixed will help them in a classroom environment. A male participant with a desire to go back to school indicated that the elimination of dental pain improved his prospects for returning to school: “now I won’t be in pain...I could study a little bit and be more focused.” Another indicated that his improved appearance would make him feel less suspect in a school environment.

Personal Relationships

While most participants indicated that close friends and family members were happy for them and complimented them about their appearance, only 7 participants reported that receiving the dental treatment affected their personal relationships. Most indicated that for those with whom they were close, appearance was not important. However, some indicated that they had noticed

that improvements to their appearance and subsequently their interactions with others changed some aspect of their personal relationships, predominately with family members.

Some reported that the dental treatment improved their relationships with romantic partners. A few reported that their partners (or potential partners) found them more attractive. A female participant, who cited a dramatic change in her own feelings about her appearance, noted that she and her boyfriend were “a lot closer now...we were close, we were friends, but [the build up and bad breath was] just a turn off...[now] our relationship’s better...” Another reported that his wife was “much more openly attracted” to him after the treatment. A single man lamented that prior to the treatment missing teeth “killed” his chances with potential romantic partners. Others indicated that their social lives had improved as a result of the treatment. Such improvements were attributed to changes in confidence and interaction. One participant reported that he and his wife engage in more social activities and that he finds such activities more fulfilling: “like I smile and...and talk with other people like we go out to dinner or with the church.” These findings may seem superficial. However, at intake participants identified supportive relationships, particularly those with family members, as important for achieving both short and long-term goals. This finding is not surprising, as a number of criminologists have found that positive relationships are an important component of desistance more broadly (Laub, Nagin, and Sampson, 1998) and of the re-entry process more specifically (Naster and La Vigne, 2006)

One participant indicated that the treatment program gave her the opportunity to set a good example for her children and grandchildren. She reported that before the dental treatment—her dental problems were evidence of her prior drug use...and the dental treatment represents an opportunity to show how she has changed. “Hopefully I can pass it on to my kids, my grandkids, too...hopefully that’ll never happen to them, because it does make a difference in your life. I hate getting up and having to put this [prosthetic] on every morning, you know” [but]...my daughter...it makes her see me differently, shows that I’m trying to take care of myself, I’m...I try to look pretty, and I smile more, you know what I mean, than just not caring...”

In the first report, we noted that participants were skeptical about establishing personal relationships outside of those with family members. During the intake interview many suggested that they tried to avoid old friends or others who might be a bad influence. Some reported that they would like to meet “good people.” Overall, this continued to be a widely held sentiment. Some participants indicated that changes to their physical appearance may open up the possibility for meeting new people. By removing visible cues for prior drug use, the dental treatment helped participants feel more comfortable socializing with others who did not have a history of drug use or criminal activity. This was evidenced by statements like “I look like one of them” and “now I look like somebody.”

Summary

Overall, the perceived effects of the dental treatment were similar to those anticipated in the intake interviews. Three months after treatment participants reported that they were more comfortable and satisfied with their appearances. They also indicated that the treatment boosted

their self-esteem and gave them more confidence in interactions with others. Most discussed how these changes helped them to be more outgoing and open, both at work and in personal relationships. In the post-treatment interview, participants were much more explicit about the role appearance played in their self-perceptions and the perceptions of others. At intake, the role of appearance was often implied but not directly addressed. The discussion of appearance helped us identify three larger concepts that may explain how this type of program can increase reentry success: neutralization of negative personal characteristics, increasing the appearance of credibility and trustworthiness, and providing visible evidence of a life transformation.

In the intake interview, we asked participants to identify barriers to successful reentry.⁴ The most frequently identified barrier was the lack of supportive social relationships. Although some participants reported the dental treatment as life changing, others viewed the impact more conservatively. Specifically, they described the treatment as a precursor to changes in interaction via the elimination of a negative first impression. One reported that receiving the dental treatment meant making “a non-issue where it used to be an issue.” He elaborated by saying, “...in dealing with people, you know, it’s not... getting a reaction really I think speaks a lot.” One participant who had 17 teeth extracted and received a full set of dentures also described the impact of treatment as neutralizing something negative:

[Before treatment] “Here I am with all my sunken in mouth, you know, without my teeth so...you know...it seems like a huge negative. [After treatment] It’s like maybe now it’s a neutral...I mean it’s not such a huge negative anymore, you know, so that can help.”

A female participant highlighted how eliminating one barrier decreases the negative impact of another: “being a convicted felon who smiles with...gross, compared to a convicted felon, you know, that has a nice smile, there’s a big difference.” This was the intended outcome of the program: to eliminate visible barriers to employment.

Along similar lines, some participants described how improvements to their appearance and the subsequent boost in confidence led them to appear more credible both in the workplace and in personal relationships. Throughout this report, we have provided examples of participants describing themselves as appearing less suspicious and more honest because they are able to look at the people with whom they interact. Some reported that others are more likely to “listen to what I have to say”, and take their ideas seriously. This is especially true in the workplace, where participants reported that they were more likely to have job security and be given opportunities for advancement when they could be perceived as knowledgeable and trustworthy by customers and clients. Being taken seriously, in general, has reciprocal effects—building more confidence and improving interactions.

In personal relationships, the impact of improved appearance was largely described in terms of how it symbolized a transformation in the participant’s life. One reported, “what makes me feel good...to see people...like that see me, the turnaround...that I made...it feels good...like I got another chance...” [says he believes the dental treatment will show people] “this time he is trying to do it.” While most participants reported that appearance did not matter to family

⁴ The findings on barriers to success and needed resources are detailed in the first report.

members, many also indicated that they owed it to those who provided support to succeed. One participant in this group stated, “I think they view me favorably. I mean, they see that I’m...I’m making honest efforts in the things that I’m doing.” He also notes that family members have remarked on his improved patience and maturity and that “having received the teeth is...another one of the steps that I’ve been taking to...be a right person, you know, as opposed to being a selfish person, being somebody that is non-damaging, but instead somebody that is able to benefit others.” In some sense, the improved appearance allows others to see beyond the participant’s history and witness other areas of progress.

Objective 6: Participants on Program Organization and Delivery

In the post-treatment interview, we asked participants to talk a bit about their experiences at the dentist. In addition to inquiring about the types of treatment received (and not), we also asked participants to comment on scheduling and making appointments, issues related to pain management and prescription medications, and whether or not the dental work and program in general met their expectations.

Scheduling and Transportation

Overall, participants indicated that the dental office was flexible and scheduled appointments around work and other obligations. We noted earlier, that a few participants missed or cancelled appointments with the dentist. Program participants missed and/or cancelled appointments for the same reasons most do: work conflict, child care issues, etc... Generally, appointments were easily rescheduled.

Reliable and efficient transportation was frequently mentioned as problematic. We did not systematically collect information on participant transportation options, but it appears that most were dependent on public transportation. Some reported that the dental office was not easy to get to on the bus.

Pain Medication

We anticipated some issues with the acquisition of prescribed medications. As indicated in the first report, the program did not provide money for prescription medication. Eleven participants reported that the dentist prescribed some kind of pain medication following invasive procedures. Most indicated that the medication was relatively inexpensive and effective. However, one participant reported that she was prescribed multiple medications (pain medicine and antibiotics). While she was able to cover the cost (\$180), it was an unexpected expense.

Managing pain medication as a substance abuser seemed to be the more serious issue for this population. A few participants were hesitant to take narcotics, as one reported: “I choose not to take anything stronger than over the counter.” Another took the pain medication but expressed concerns regarding the potential for abuse; “I let my PO know...I didn't want to abuse it so I just

took [it] if I was really, really in pain. And then the rest of the pills I just threw them away...I flushed them..." These expressions indicate some participants took proactive measures to maintain their sobriety. One participant expressed a similar awareness, but engaged in behaviors inconsistent with her recovery plan:

"When they pulled all the wisdom teeth they gave me hydrocodone. Well, I took two of those for pain and then I knew I had to get rid of them...being a drug addict...I took two when I was hurting. I took one more when I wasn't hurting just...to see what would happen. I said, oh no, this isn't a good idea. We got to get rid of these..."

These comments suggest that future program planning should take pain medication and substance abuse counseling into account before treatment delivery.

Dentist and Dental Office Evaluations

We did not directly ask participants to comment on the performance of the dentist(s). However, participants frequently praised the dental staff. One commented: "the doctor was great...it's a great office...they were really professional, caring, empathetic...they were very good at their job." Others mentioned the dentist by name and some indicated that they intend to either use the clinic for future dental care or follow the dental intern to private practice. Detailed comments about the dental staff centered on various aspects of professionalism, including: providing reassurance, keeping patients informed about procedures, and treating patients with respect.

Some program participants expressed that they were initially nervous about the dental work and the dental staff provided reassurances that eased these fears. One reported, "I had a fear of the dentist and I told them when I first went in and he's like, oh, we'll take care of you, no problem. So it was good. Normally, I mean, I panic." Anxiety related to dental work is not uncommon. However, these participants were not accustomed to seeing the dentist with any regularity, and this led some to report heightened levels of anxiety. For example, one participant noted "...I felt so uncomfortable and when I seen the chair where you lay down I was so scared. I said do I have to sit on that? But they calmed me down because I was very scared. I haven't been to the dentist in many years."

The second type of comment on the professionalism of the dental team concerned the provision of patient information. Most participants underwent intensive treatment that required multiple procedures and ended with a new prosthetic to be worn, cleaned, and maintained. A number of participants commented on the thoroughness and patience of the dental team in relaying such information. One participant who had multiple extractions and received dentures said "I asked a lot of questions...they were really nice, they actually take time to talk to you about it and kind of guide you through the steps." Another receiving a full set of dentures commented,

"it was very well explained, what they were going to do and how things were going to happen. They advised me on different aspects of the dentures and what

kind of things that I could expect having dentures...how to care for them, how to get the best use out of them. They were really very thorough on everything.”

The third aspect of professionalism concerns participant perceptions of the manner in which the treatment activities and relayed information were delivered. A number of participants indicated surprise at being treated like real patients. One commented, “you know, they didn’t judge about coming out of the penitentiary...[and] all the dental work that hadn’t been done.” Another reported that he really liked the dentist because, “he seemed like he cared...I mean...I’m coming out of prison, I’m getting this done for free...I thought...they might have a grudge or something...but it wasn’t like that.” Others indicated that they expected to receive perfunctory dental care and were pleased to find out that covered treatment included cosmetic procedures.

Treatment Expectations

Each participant reported that the dental treatment either met or exceeded their expectations. Some reported that the treatment was even better than expected. Two cited the comprehensive nature of the treatment, fixing both medical and cosmetic dental problems. Others referred to the professionalism of the dental team (discussed above).

We did receive a couple of critiques. A few were surprised that their work was being performed by a dental intern. Others lamented the length of time it took to complete the treatment program. The former was perhaps an oversight in the intake process—organizers could have provided this information up front. The latter is perhaps the result of inexperience in dental care.

We asked participants to comment on whether or not the program provided all of the procedures they had hoped to receive. Three participants reported that they would have liked to have received implants. Two of these participants were missing front teeth and were given partials. The other received full dentures, but wanted implants to improve fit. Each reported that the dental team told them that implants were beyond the scope of covered procedures. However, one participant received implants to anchor dentures. Another participant indicated that she returned to get a bleaching kit at her own expense to whiten her teeth in order to match the color of the partial. This seemed to be an isolated incident. Others spoke about the dentists’ attention to detail in selecting partials to match their remaining teeth. A few also noted that they did not receive work that was identified as needed during their initial visit—one needed a root canal, another needed a 2nd bridge both cited program time/expense limits as the reason why these procedures were not provided.

Plans for Future Dental Care

One of the results of receiving dental treatment was an increased awareness of dental hygiene overall. Seven participants indicated that they planned to have future dental work. Some planned to save money to get implants to either anchor dentures or replace partials. Others reported that they planned regular check-ups at the clinic to maintain dental improvements. At the time of the post-treatment interview, one participant had already scheduled a cleaning and

check-up. Participants generally reported a change in at home dental care behaviors. A female participant commented on changes to her brushing and flossing routine by stating, “I’m a big old fanatic about my mouth now.” Another reported that concerns about maintaining the benefits of the dental treatment led him to try and quit smoking in order to keep his teeth white.

Recommendations for Program Organization

Overall, there were no real complaints regarding program organization, but some participants highlighted things that they thought could make the program better. Primarily these recommendations concerned the provision of procedures not offered (implants, whitening) and assistance with transportation. Interestingly, the most frequently made comments about the program were those indicating a need for increased availability of dental treatment and similar programs for other probationers and parolees. Several participants commented that they knew of others who needed dental care. Some even suggested that there were others who were more deserving. These assessments were primarily based on the visibility of the dental problems—other people looked worse than they did. A few mentioned that they were not sure how they were selected for participation over others, given this discrepancy in need. A couple of participants also mentioned that they would like to have assistance getting tattoos removed.

A positive program experience may also have implications for reentry. A few participants made a connection between participating in the dental treatment program and their outlook for success. One reports that enrolling in the program gave him a “boost in confidence” and “kept [him] on the right track.” He also suggests that having received the treatment, “keeps [him] pushing forward with the confidence to succeed.” Striving to complete the treatment program also dissuaded some from engaging in old negative behaviors after leaving prison. A participant with a history of DWI stated, “normally, I’d get out and start using, drinking and I forgot all about this.” Others described their overall program experience as motivation for reentry success. One participant noted, “One of the big things with me is just knowing that there’s organizations out there that are willing to help us.” Two participants explicitly stated that because the program came from the DOC, the long-term impact was particularly salient:

“I think as long as probation and parole officers are aware of their clients, and the probation and parole people here—they are very professional...just to be able to recognize that this might really help somebody, help their lives and help them gain a new confidence, they can get a new life and they can do the right thing...”

“I also think that it’s a really good incentive because people...people who are making an effort to do right, to be right, to better themselves, I think should be afforded help and help having come from the corrections department and from other people who cared enough to partner with them ...it means a lot...there are quite a few good effects that come from it...[it] carries all sorts of consequences.”

In the first installment of this report, we noted that participants frequently mentioned their probation and/or parole officer as a positive influence in their lives. This sentiment was also present in the post-treatment interviews. Many participants expressed gratitude for the work of

their respective probation and/or parole officer, indicating that they were enrolled in the program because of their officer's recommendation.

Discussion and Conclusions

Summary of findings

Approximately 72% of participants completed dental treatment and 57% completed all program requirements including a post-treatment interview. In first examining completion of dental treatment, we find that three demographic characteristics are associated with the completion of treatment. Overall, participants with minor children were less likely than those with no children to complete dental treatment. It is likely that childcare and scheduling issues were the reason for this relationship but we cannot determine the precise reason as data was not collected on this. Other characteristics that affected program completion are age and education level. Older participants were more likely to complete treatment than younger ones. Similarly, participants with a GED or high school diploma were more likely to complete treatment than those who did not have a diploma or GED. It is possible that older participants and those with more education were able to draw on more resources and social support, which facilitated their ability to complete treatment. No other demographic characteristics significantly affected the completion of dental treatment.

In terms of criminal history we found that participants with a violation before the end of treatment were less likely to complete treatment as compared to those with no violations. The relationships between offending and corrections history variables and treatment completion were not significant. Additionally, participants who completed education or self-help focused programs were not more likely than others to complete the dental treatment. This may be reflective of a lack of variance in the sample for this study. The majority of participants (82%) took part in educational or self help programming while on parole or probation, while 67% participated in educational or self help programming while incarcerated.

Living situation was also related to program completion. While there were no statistically significant differences between those participants living in and out of transitional housing programs, there were significant differences within the group of participants living at transitional housing locations. Specifically, participants living in transitional housing programs with more freedom of movement were more likely to complete treatment than those in restricted movement housing. It is likely that this finding is reflective of the fact that it is easier for participants living in programs with more freedom of movement to arrange travel to and from appointments.

And finally, participants who enrolled in the program during the second wave of enrollment were significantly more likely to complete their dental treatment than participants who enrolled during the first wave of enrollment. These differences are not spurious by way of demographic characteristics, though it is possible that these differences are reflective of differences in dental treatment needs. Alternatively, it may be the case that the hastened treatment schedules for the second wave participants increased their motivation and drive to complete their dental treatment. Unfortunately, we are unable to examine these potential explanations with our current data.

The results for those completing all program requirements including a post-treatment interview were similar to those found for treatment completion with the exception of findings that participants on either parole supervision or dual supervision were more likely to complete a post-interview than those only supervised through probation. Similarly, participants without minor children, older participants, and participants with more education were all significantly more likely to complete all program requirements than other participants.

There were a number of commonalities in both the perceived effects of dental treatment and perceptions of the dental program itself. It is notable that the overall impact of the program could be global rather than specific to employment. At the end of dental treatment participants' perceptions about themselves changed in such a way that improved their self-esteem led to more positive interactions with others, reduced visible and psychological barriers and strengthened their social and supportive relationships. After the program's completion 95% of participants reported that they felt that their appearance had improved as a result of treatment. Feelings of confidence and self-esteem due to dental treatment were reported by 84% of participants and 84% of participants reported that their interactions with other people improved as a result of treatment.

In terms of employment we found that overall there was not a drastic fluctuation in either direction (higher or lower employment) at the program's conclusion. The employment status of participants remained largely constant. Of the 19 people that completed both a pre-treatment and post-treatment interview, 13 reported no change to either education or employment status at the completion of dental treatment. Of the 10 participants that were employed at intake, 9 were employed at the time of the post-treatment interview. It is possible that this can be seen as a successful outcome because it could indicate that the participants were able to maintain steady employment. Unfortunately, without information on employment status of participants that did not complete treatment, we are unable to state investigate this possibility. Of the 9 participants that were unemployed at intake, 2 were employed at treatment completion. As previously stated, this could simply be due to the short time periods between intake, program completion and post-treatment interviews. In total 11 participants were employed at the time of post-treatment interviews. There were however, changes within employment. Eight of the 11 who were already employed stated that they saw improvements in their current employment. One participant reported that she received a promotion to supervisor after the treatment was complete.

About 74% of participants articulated that dental treatment has either affected or that they believe that the dental treatment that they received will affect chances of obtaining employment. 21% detailed how treatment has or will affect educational experiences and 38% said that dental treatment has improved personal relationships. Given the short amount of time that had passed between completion of dental treatment and the post-interview, some predicted these outcomes but others had already experienced improvements.

Overall, participants were appreciative of the professionalism of dental staff and how well the dental team informed them about dental work. However, there were several criticisms of aspects of program administration. At the program's start some participants were not given information about dental work that would not be covered in the program such as implants, root canals etc.

Others suggested that they had a hard time finding reliable and efficient transportation and that the clinic was difficult to get to using public transportation.

We found many commonalities in participants' reports at the completion of the dental program. But for some, there were impacts greater and the experience was a profoundly personal and specific. One participant described a complete cognitive shift in the way that he thought about himself, stating that he felt "like a new man". Some stated that they would like to participate in a tattoo removal program to further reduce visible barriers to employment because they were so pleased with the results of the current program. Others reported that their relationships with their family were impacted in such a way that made them want to be positive role models for children. Others felt doubly motivated to keep from engaging in substance abuse because they did not want to ruin their dental work.

Recommendations

In the following sections we suggest ways in which future programs of this nature can improve upon the program discussed here. First, it is critical that an effective needs assessment be conducted to both identify and ensure that the population most in need of the program has access to it. This was a small pilot program and a number of decisions regarding the target population were made in a somewhat arbitrary fashion (i.e. focus on parolees, preference for those participating in specific types of prison programming, preference for individuals with visible dental problems). Moreover, given the arbitrary nature of these participant criteria, program organizers were only mildly hesitant to change the criteria mid stream and admit participants who did not meet some or all of them. Additionally, having clear and well-grounded entry criteria would be beneficial to participants, as these criteria could then be relayed to them. Participants should understand why and how they were chosen for the program, but in this case, many did not. In fact, some participants stated that there were other potential participants who may have been more deserving or more in need of dental treatment.

Second, we suggest that future efforts along these lines begin with the design of a logic model. A logic model, which links expected program outcomes to program design, delivery and resources would promote a common understanding of the program and help articulate expected short and long term outcomes. The logic model should detail program entry criteria (and associated measures of these criteria) and should detail both expected outcomes and measurable criteria for assessing such outcomes. Choosing those believed to be "most likely to succeed" without clearly stating the criteria used to determine this or the measurable markers of program or reentry success problematizes evaluation of these criteria.

We also recommend that future similar programs select measurable outcomes and plans for long term follow up. This would ensure a more effective and thorough evaluation of the results of the program. It would be wise to have a comparison group or control group with which to compare the results and effects of the program on program participants. This would more clearly highlight key differences which could be suggestive of the impact of the program on reentry. Notably, in doing so program administrators might think about both specific and global outcomes that such an intervention might effect. Here, for instance, we did consistent evidence

that the treatment affected participants' global self-esteem and self-confidence, but only minimal evidence that it affected employment outcomes. However, these global shifts are likely as important in long term re-entry success as specific changes in employment experiences or status.

It is important that program organizers plan for attrition given the nature of supervision and other barriers faced by probationers and parolees. In this program, a second phase of enrollment was necessary as some of those initially selected either dropped out prior to starting treatment or did not complete treatment. Unexpected attrition led to a loose adherence to stated selection criteria, as many second phase participants did not meet the initial selection criteria. Moreover, both target selection and treatment during the second phase were somewhat rushed to ensure program completion within the program funding period. The implications of lack of planning for attrition and pre-completion drop were not just operational, but also affected participants directly. One participant had all of her remaining teeth pulled and then did not return for further treatment. This scenario suggests that program participants should be provided with information about low-cost dental care at intake as well as at commencement of the program. Additionally, several participants were not aware that certain procedures would not be covered by the program such as implants or root canals. Information about the limitations of dental care to be conducted as outlined by the program should be accessible to participants prior to onset of dental treatment. Also, second wave participants that completed the program found that time limitations due to program deadlines prevented them from completing all suggested dental work.

Many of the participants in this program had a history of substance abuse issues. Given the potential for pain associated with dental procedures and the necessity for medication participants should be provided with information on managing pain for persons with addictions. Given confidentiality issues, it is unclear whether this falls under the scope of dental services or should occur at intake for all participants. The "left over" medication scenario was troubling for some participants, which suggests that prescriptions could be adjusted on an "as needed" basis.

And finally, we strongly recommend that future research employ a research design with a longer follow-up period. A three month period is not long enough to evaluate the long-term effects on re-entry of providing dental treatment to probationers and parolees. It is possible that dental treatment has important effects on various outcomes related to re-entry and that these effects are only observable over a longer period of time.

Despite the noted problems with program design and fidelity, the qualitative findings reported here suggest that this pilot project was, in important ways, successful. The participants reported notable improvements in dental health and appearance, which they associated with significant improvements in both their own self-confidence and their interactions with others. The majority of participants indicated that the treatment had a positive impact on their efforts to transition out of offending and that it would facilitate their long term re-entry success.

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