Federal Probation

JOURNAL

Mission of the Federal Bureau of Prisons

It is the mission of the Federal Bureau of Prisons to protect society by confining offenders in the controlled environments of prison and community-based facilities that are safe, humane, and appropriately secure, and that provide work and other self-improvement opportunities to assist offenders in becoming law-abiding citizens.

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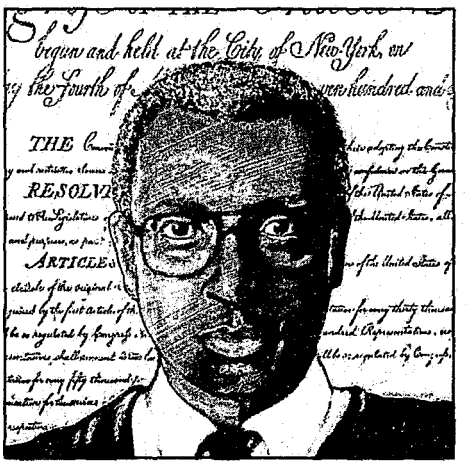

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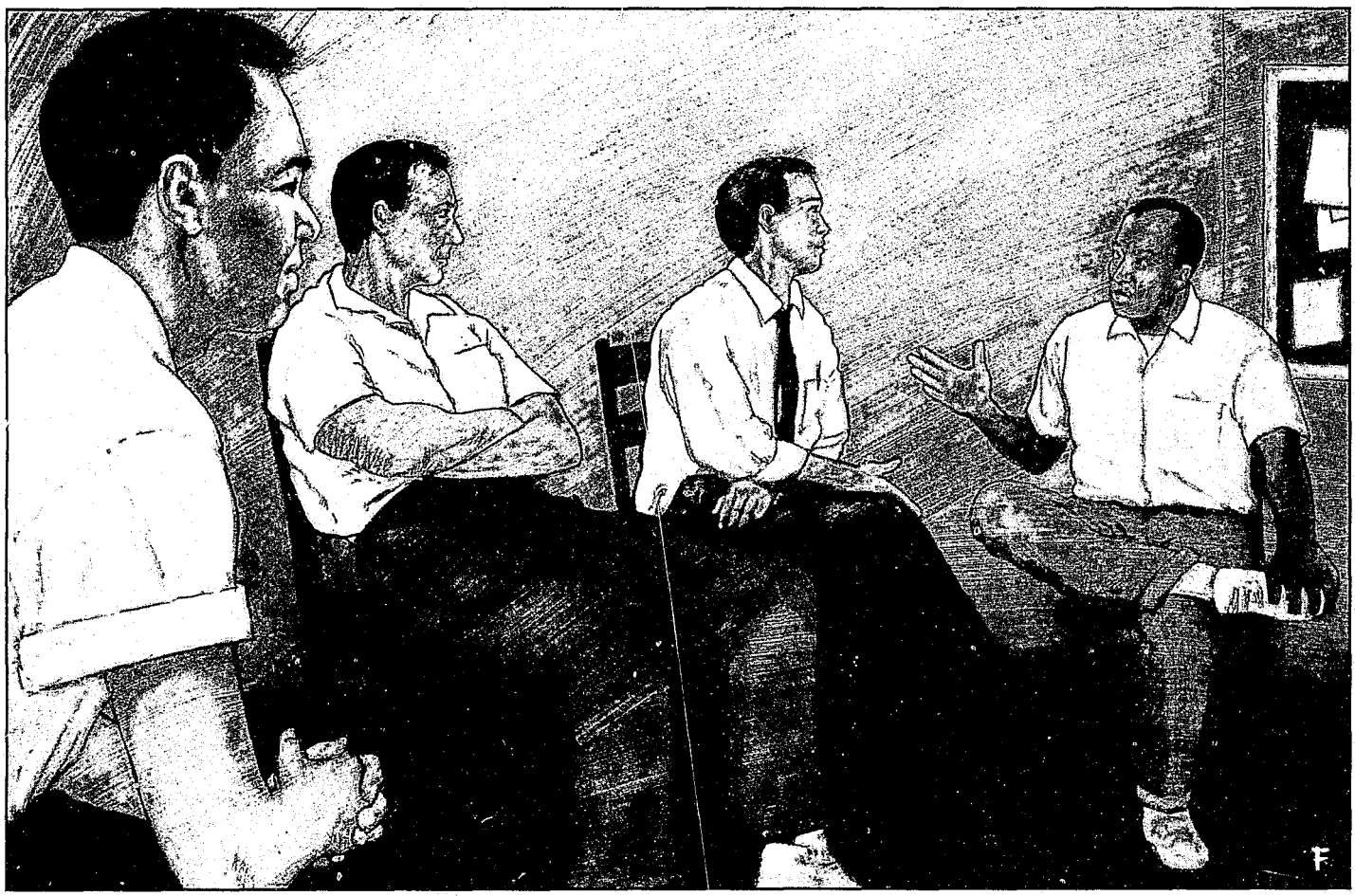

Susan Wallace, Bernadette Pelissier, Donald Murray, and Daniel McCarthy

The proportion of State and Federal inmates who have a history of substance abuse is large and continues to increase. According to the Bureau of Justice Statistics, 62 percent of all State inmates in 1986 reported having used illicit drugs on a regular basis, while about 43 percent reported using drugs daily during the month before committing the offense for which they were currently imprisoned (Innes, 1988). According to a recent National Institute of Justice report, more than 50 percent of all U.S. inmates regularly used drugs before their last arrest but received no programmatic help while incarcerated (Chaiken, 1989). Self-report assessments of inmates recently admitted to the Federal Bureau of Prisons (including inmates transferred from other Federal institutions) indicate that between 30 and 44 percent of this population have substance abuse histories (McCarthy et al., 1990; Whittenberger, 1990).

The association between substance abuse and criminal behavior has been widely debated and researched. There is considerable controversy over the precise manner in which substance abuse may or may not directly result in criminal behavior. Nonetheless, recent research has consistently found that addiction acts as a "multiplier" of crime; while criminality often occurs prior to addiction, the onset of addiction results in greater levels of criminal involvement (Nurco et al., 1985). Research has also demonstrated reductions in criminal activity following both prison-based and non-prison-based drug treatment programs.

In September 1988, the Bureau of Prisons convened a national conference to address the issue of drug treatment programming due to the rising number of drug offenders confined in Bureau institutions. Following this conference, the Bureau began to develop a more comprehensive approach for dealing with

inmates who have chemical dependency treatment needs. While the Bureau has made drug treatment programs available to its population in the past, its recent emphasis had been on drug education and limited group and individual therapy. The Bureau's new strategy, however, is to expand programs for substance abusing offenders and provide "unit-based" treatment opportunities followed by prerelease community-based programs and a period of aftercare services.

In accordance with initiatives outlined in the Anti-Drug Abuse Act of 1988 (21 U.S.C. 1504) and the National Drug Control Strategy (The White House, 1989), the Bureau provides an array of drug treatment programs to inmates, and will closely evaluate the implementation, delivery of services, and effects of these treatment efforts. There are three goals:

- To develop more effective drug treatment programs.
- To understand the etiology of drug addiction among the inmate population.
- To provide accurate and useful information on which to base national efforts in controlling drug use.

This article reviews previous drug treatment programs within the Bureau of Prisons, describes the current program initiatives, and discusses the research and evaluation component, raising some policy-relevant questions that the program and evaluation may help to answer.

Previous drug treatment efforts within the Bureau

Since the 1960's, the Federal Bureau of Prisons has provided Federal inmates with numerous drug treatment programs in a variety of contexts. What began as limited assistance, primarily to narcotic-dependent inmates, eventually expanded to comprehensive treatment programs for abusers of narcotics, nonnarcotic drugs, and alcohol.

Recent research has consistently found that addiction acts as a "multiplier" of crime; while criminality often occurs prior to addiction, the onset of addiction results in greater levels of criminal involvement.

Prior to the enactment of the Narcotic Addict Rehabilitation Act (NARA) of 1966, selected Federal inmates who had histories of narcotic abuse received assistance and supervision in one of two U.S. Public Health Service hospitals located in Federal institutions in Lexington, Kentucky, and Fort Worth, Texas. NARA mandated in-prison drug treatment for narcotic addicts who were convicted of violating Federal laws. It called for the creation of unit-based programs (i.e., inmates assigned to live in specific housing units that are separate from the general inmate population and staffed by a team that includes treatment professionals) and for aftercare services (postrelease counseling and urinalysis).

The first such drug treatment unit was opened in March 1968, at the Federal Correctional Institution (FCI) in Danbury, Connecticut. Additional NARA units opened during 1969 and 1970 at institutions in Terminal Island, California; Alderson, West Virginia; Milan, Michigan; and La Tuna, Texas.

These drug treatment units were developed based on the therapeutic community model (a 24-hour learning environment using both peers and staff as role models), with an emphasis on group therapy. All NARA participants were required to participate in postrelease aftercare, which usually consisted of frequent urinalyses and community-based counseling programs.

Several evaluations were conducted on the effectiveness of NARA drug treatment programs in decreasing criminal behavior and drug use among releasees. Self-report findings of studies conducted in the early 1970's by universities, private research organizations, and the Bureau of Prisons's Office of Research and Evaluation included:

- Some groups of NARA graduates showed less frequent drug usage and involvement in drug sales after release than comparison subjects.
- Inmates who were more involved in the programs were more successful in terms of decreased criminal behavior and drug use after release.
- Women who graduated from the NARA program tended to be more successful on outcome measures than men who completed the program.
- Inmates felt that group and individual counseling was the most helpful element of the programs.

Long-term evaluations of the NARA treatment programs, published as recently as 1988, have concluded that the programs "...worked reasonably well, or as well as any other type of intervention has worked for the narcotic addict" (Anglin, 1988).

With the successful operation of NARA drug treatment units, it became evident that there was a large population of inmates who could benefit from such drug treatment programs, but were not sentenced under the restrictive NARA statutes. For example, repeat offenders and inmates whose current offense involved violence were excluded from NARA sentencing. Beginning in July 1971, drug treatment units were opened to serve inmates who had a demonstrated need for drug treatment programming but were not sentenced under NARA. By 1972, all of these programs were authorized to provide aftercare services for program participants. By 1978, there were 33 drug treatment units in Federal institutions.

A typical treatment unit during this period would house 100-125 participants and have a staff of one unit manager, one psychologist, one or two caseworkers, and one or two correctional counselors. Outside consultants (sometimes ex-addicts) and education staff also provided services to participants. While the elements of these treatment programs were not standardized, they generally included an orientation period, unit-based programming (such as group therapy sessions and individual counseling), eventual participation in institution programs (educational, vocational, recreational), prerelease counseling, and postrelease aftercare.

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By 1979, the Bureau required drug treatment programs in all of its institutions to meet the standards applied to NARA programs and to have the authority to conduct NARA study evaluations. Thus, NARA commitments could now be designated to any institution, rather than restricted to facilities that had NARA programs. This resulted in the decline of "NARA-only" drug units and the publication of the system-wide Drug Abuse Incare Manual.

The manual, released by the Bureau in July 1979, called for the establishment of unit-based drug treatment programs in all institutions. It also specified minimum standards for:

- Certification of each drug treatment program.
- Staff qualifications.
- Staff program involvement.
- Treatment phases.
- Inmate certification for completion of program.
- Aftercare arrangements.
- Data collection for evaluation purposes.

While the publication of the Incare Manual led to an improvement in the Bureau's drug treatment programs for several years, the quality of these programs began to decline in the early-to-middle 1980's due to changes in the social and political climate regarding "rehabilitative" programs. Correspondingly, drug treatment evaluation efforts during this period were less intensive than during the early and middle 1970's. Evaluation techniques (e.g., controlling for severity of addiction, motivation for selection, and quality of program delivery) were not built into the design of these later programs, and researchers had difficulty in retrospectively reconstructing the data, severely restricting the possibility for a thorough evaluation of these programs.

Because of this lack of evaluation results, a task force was assigned in 1985 to review the Bureau's drug treatment programs. The task force members concluded that the programs had begun to erode due to the diversion of resources for other high-priority purposes, the pressures of an increasing inmate population, a lack of leadership and coordination within the Bureau, and a shortage of properly trained staff. As a result, a policy statement was issued in 1986 calling for the establishment of a Chemical Abuse Program Coordinator in each institution. Each warden was to decide on the type of program to be offered and the number of staff to devote

Federal drug education and treatment programs

Program	Participants	Point in incarceration	Hours required	Duration	Completion criteria	Urinalysis	Staff/inmate ratio
Education programs	Required if drug/crime history	First 6 months	40	4-10 hours/week until completion	Attendance, pass test	Same as inmates in general population	Variable
Counseling services	Volunteers	Any time during incarceration	Variable	Ongoing	Attendance	Same as inmates in general population	Variable
Comprehensive programs	Volunteers	Preference to inmates within 18-24 months of release	500	9 months plus supervised aftercare	Attendance, review by treatment staff	More often than inmates in general population	1:24
Pilot programs	Volunteers	Preference to inmates within 18-24 months of release	1,000	12 months plus supervised aftercare	Attendance, review by treatment staff	More often than inmates in general population	1:12
Transitional services	Volunteer inmates who have completed a drug program	CCC placement and post-release	Variable	6 months CCC plus 6 months supervision	To be determined	Variable, more often in early months of CCC placement	To be determined

Table 1

to drug treatment. Most institutions chose centralized programs, whereby inmates housed throughout the institution participated in program activities at a central location. By 1987, only three unit-based drug treatment programs remained.

Current program initiatives

In 1988, the position of National Drug Abuse Program Coordinator was established to oversee the development and implementation of new drug treatment strategies for Federal inmates. In addition to continuing the existing low-intensity programs, revised drug education programs and new unit-based intensive treatment programs are currently in operation. Additionally, a Drug Abuse Program Coordinator position has been established in each institution. Among other duties, the institution coordinator ensures that incoming inmates are screened to assess any program needs. Each inmate is rated as having no significant problem, a moderate problem (the use of drugs or alcohol negatively affected at least one major life area—work, school, health, family, financial or legal status—in the 2-year period prior to arrest), or a serious problem (the frequent or heavy use of drugs or alcohol negatively affected two or more major life areas in the 2-year period prior to arrest).

The multidimensional approach to serving the growing population of drug-abusing inmates includes the following types of programs:

- *Drug Education Programs*—Mandatory participation for inmates who have committed offenses related to drug use.
- *Centralized Drug Abuse Counseling Services*—Similar to currently existing counseling programs (NA/AA groups, personal development training, etc.) for volunteer inmates.
- *Comprehensive Drug Abuse Treatment Programs*—Unit-based 9-month programs for volunteer inmates.
- *Pilot Drug Abuse Treatment Programs*—Unit-based 12-month programs for volunteer inmates.

■ *Transitional Services*—CCC (Community Corrections Centers) and other community aftercare services provided after release from prison for those completing either the comprehensive or pilot programs.

A comparison of elements of these five program types is provided in Table 1 on the previous page.

Drug Education Programs

Drug education is the only mandated drug program for inmates who have a history of substance abuse. Participants include: all inmates for whom there is evidence in the Pre-Sentence Investigation (PSI) that alcohol or other drug use contributed to the commission of the offense; individuals whose alcohol or other drug use was one reason for a violation of parole or probation supervision for which the subject is now incarcerated; and inmates for whom there is a court recommendation for drug programming. The program will be available to volunteers; however, priority will be given to inmates who have substance abuse histories. It is anticipated that 12-15,000 inmates will have completed drug education programs by the end of fiscal year 1992. Fifty-six Drug Abuse Treatment Specialist positions were allocated to this program during fiscal year 1991.

The criteria for program completion include class attendance and a passing score on a written test. As an incentive to stay in the program, inmates who are required to complete the program but fail to do so will be restricted to the lowest inmate pay grade and will be ineligible for a halfway-house placement.

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Centralized Drug Abuse Counseling Services

Centralized counseling services will be available to volunteers at all institutions at any time throughout their incarceration. These services are currently operational at many institutions and include self-help groups such as AA and NA, group therapy sessions, stress management and personal development training, and vocational and prerelease planning. Some programs have specific lengths and completion criteria, while others allow inmates to participate in ongoing therapy. A psychologist or drug abuse treatment specialist coordinates all activities, and is involved in direct service delivery. These services are analogous to the "low-intensity" group and individual services currently available at most facilities, but will be enhanced by additional staff and resources. The frequency and duration of each inmate's participation in drug counseling services will be tracked using the Bureau's computerized Psychological Data System (PDS).

Additionally, the Bureau is currently considering offering more intensive outpatient counseling services. In such programs, staffing levels and resource allocations would be similar to those of the residential treatment programs discussed next. However, the treatment services would be provided at a central location in the institution, and participants would continue with their normal work or education schedules.

Residential Drug Abuse Treatment Programs (DAP's)

There are two types of residential programs—pilot programs and comprehensive programs. The pilot DAP's are located at three institutions within the Southeast and Mid-Atlantic regions: FCI Butner, North Carolina; FCI Tallahassee, Florida; and FCI Lexington, Kentucky. Butner and Tallahassee serve male inmates and Lexington serves females. Comprehensive DAP's will be located at various facilities nationwide. Five comprehensive programs, located at FCI Sheridan, Oregon; FCI Oxford, Wisconsin; FCI Seagoville, Texas; the Federal Medical Center (FMC), Rochester, Minnesota; and FCI Fairton, New Jersey, are currently operational.

Both the pilot and comprehensive programs accept volunteers only. Inmates apply for admission through their unit teams. Only inmates with a moderate to serious substance abuse problem will be considered eligible.

The major features of the comprehensive residential programs include:

■ Unit-based programs.

■ Treatment staff-to-inmate ratio of 1:24.

- Program duration of 9 months or 500 treatment hours.
- Prerequisite of 40 hours' drug education.
- About 4 hours of programming per day.
- Up to 40 hours of comprehensive assessment.
- 280 hours of group/individual counseling.
- 100 hours of wellness lifestyle training.
- 40 hours of transitional living issues.
- Full team reviews every 90 days.
- Treatment reviews every 30 days.
- Increased urinalysis surveillance.
- Individualized treatment plan based on assessment.
- Comprehensive transitional services component.

Three of the residential DAP's involve larger investments of staff and fiscal resources and are to be considered pilot research programs until an outcome evaluation indicates whether additional resources produce more positive postrelease outcomes. The pilot research DAP's are very similar to the comprehensive DAP's, with the following exceptions:

- Treatment staff-to-inmate ratio of 1:12.
- Program length of 12 months.
- 1,000 hours of treatment.

Both the pilot and comprehensive residential programs are based upon a "biopsychosocial" understanding of substance abuse. A biopsychosocial model takes into account a variety of factors leading to substance abuse, including hereditary, psychological, and sociological influences. Treatment includes a strong relapse prevention component aimed at providing individuals with the behavioral and cognitive skills necessary to cope effectively with high-risk situations (Marlatt and George, 1984; Marlatt and Gordon, 1980 and 1985). Individuals are taught how to respond to a lapse (i.e., a single incidence of return to drug use), and how to achieve a positive lifestyle characterized by a balance between work and recreation and by healthy habits, such as exercise, to reduce stress.

Pilot and comprehensive residential program treatment includes a strong relapse prevention component aimed at providing individuals with the behavioral and cognitive skills necessary to cope effectively with high-risk situations.

While the pilot and comprehensive programs are based on this biopsychosocial model, there are some treatment differences among the programs:

- The three programs emphasize a "social learning" philosophy toward treatment. However, the program at Lexington also applies the AA/NA 12-step model.
- The number of treatment hours per day differs between the Tallahassee and Butner programs (4 hours treatment, 4 hours work) and the Lexington program (10.5 hours treatment).
- Tallahassee and Lexington are both low-medium security level institutions; FCI Butner is an administrative facility, serving inmates of all security levels.

Currently, staffing and funding have been approved for 15 residential programs (12 comprehensive and 3 pilot programs) that will house an estimated 1,860 inmates per year. Eighty-four treatment staff positions have been allocated to these programs. By the end of fiscal year 1992, treatment units will be available in 16 additional institutions for residential drug treatment services. Thus, a total of 31 residential programs housing 3,860 inmates will be available by the end of 1992. These units will be staffed by psychologists, drug abuse treatment specialists, psychology technicians, and support personnel.

Transitional Services

Transitional services will be provided after release from prison to both comprehensive and pilot residential program participants. The transitional services delivery component will consist of two phases. The first phase, prerelease services, will consist of up to 6 months in a community corrections center (CCC), with specialized drug treatment programming either contracted out or provided directly by Bureau staff. The second phase, aftercare services, will consist of up to 6 months, during which community treatment services are coordinated in conjunction with the Probation Division of the Administrative Office of the U.S.

Courts. Several recommendations for service delivery have been adopted for the transitional phase:

- Individual and group counseling sessions for varying time frames.
- A treatment focus on family/work adjustment, residential issues, and relapse prevention planning (coping with high-risk events) through written assignments and group discussions.
- Assistance in identifying and obtaining employment.
- Random urinalysis about 8 times per month during the beginning of the transitional services component and with decreasing frequency over the program's duration.

Inmates who successfully complete either residential program and who have a good record of institutional conduct (no serious rule infractions) will be given priority for receiving postrelease transitional services. These services will be contracted in a number of communities where inmates from the pilot and comprehensive programs are to be released. The number of such aftercare contracts is expected to increase substantially by the end of fiscal year 1992.

Assessment of the current substance abuse problem

In an environment such as a Federal prison where treatment resources are limited, it is very important to accurately assess the extent and severity of substance abuse among the target population. Toward that end, a staff psychologist, Dr. Gary Whittenberger of FCI Tallahassee, developed an instrument that is designed to use self-reported information from inmates upon their admission to prison to determine their level of past and present substance abuse, including both drug and alcohol use. The Inventory of Substance Use Patterns, Third Edition (ISUP3) is a 100-item questionnaire that creates a profile of the inmate's use of 12 different substances for the 6-month period prior to arrest. This instrument was developed in 1988 and revised in 1989 and 1990.

Federal inmate substance abuse and dependency study, 1990

New Federal committments	%
All admissions	51.7
Male	51.6
Female	52.9
Special populations	
Native American	78.9
Afro–American	54.3
White	49.3
Asian	11.1
Hispanic	60.2

Table 2

The ISUP3 was administered to all sentenced inmates who entered the system or were transferred from another institution during the period June 15-July 15, 1990. Of the 78 facilities expected to administer the ISUP3, 65 (83 percent) participated in the study. In addition, a second instrument, the Substance Abuse Signs Checklist (SASC), was completed for those inmates who were admitted through Butner, Lexington, or Tallahassee. The SASC is a behavioral checklist based on a documented history of substance abuse that a staff member (usually a treatment specialist) completes by reviewing an inmate's central file, paying special attention to the Pre-Sentence Investigation (PSI) report.

The ISUP3 data were analyzed for a cohort of 1,165 offenders who were newly admitted to Bureau facilities. It was found that 51.7 percent met the criteria for a diagnosis of either Psychoactive Substance Abuse or Psychoactive Substance Dependence in the 6-month period immediately preceding their arrest for their current offense. (These data are for alcohol, illegal drugs, and prescription drugs, and exclude tobacco and caffeine.) More explicitly, 20.9 percent of the admissions cohort met the criteria for Psychoactive Substance Abuse, and 30.8 percent for Psychoactive Substance Dependence. The criteria used to determine a diagnosis of abuse or dependency matched those outlined in the *Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised* (DSM III-R) of the American Psychiatric Association. These definitions are the most commonly accepted in the academic and professional communities.

Also of interest was the level of problem severity across members of selected special offender populations. With regard to gender, new female commitments demonstrated a slightly higher overall substance abuse problem rate (52.9 percent) than new male commitments (51.6 percent). Females also demonstrated a greater severity of impairment, as 37.6 percent met the criteria for substance dependence, compared with only 30.2 percent of the new male commitments.

There were also marked differences among various racial and ethnic groups.

Members of the Native American admissions cohort had the highest substance abuse problem rate—78.9 percent. Blacks demonstrated an overall problem rate of 54.3 percent, while whites' problem rate was 49.3 percent. Asians demonstrated a problem rate of only 11.1 percent, while Hispanic admissions had a rate of 60.2 percent (see Table 2).

Caution must be exercised in interpreting these findings, particularly with regard to projecting trends on the basis of a single admissions cohort. Additional population-representative cohort analyses will be necessary before future trends become more apparent and credible. Nonetheless, the results of this analysis have identified a substantial number of individuals entering the system who have drug abuse problems in need of treatment. The data also indicate that the need for treatment is significantly greater among members of different special offender populations—particularly Native Americans, Hispanics, blacks, and females. Table 2 summarizes these findings.

The data from the admissions cohort also revealed that 43.8 percent of those who were identified as having a substance abuse or a dependency problem indicated a desire for treatment. If this finding remains stable for future admissions cohorts, it would imply that 22.5 percent of all new commitments to the Bureau would be willing to voluntarily participate in drug abuse programs for the period described.

The results from the SASC portion of the study revealed an estimate of 44 percent of inmates having substance abuse histories (Whittenberger, 1990). However, the cohort described by the SASC part of the study is not representative of the national cohort who completed the ISUP3, as the SASC cohort consisted only of inmates from the three pilot drug treatment program institutions—Butner, Lexington, and Tallahassee.

In an environment such as a Federal prison where treatment resources are limited, it is very important to accurately assess the extent and severity of substance abuse among the target population.

Program evaluation plans

Bureau administrators recognize the importance of incorporating an evaluation component into program planning. Without information on postrelease outcomes, administrators are limited in their ability to justify continued funding for such programs. In addition, without process and outcome evaluations, program directors are not provided with enough feedback to make good decisions about program modification. Since the onset of plans to expand drug treatment programs, the Bureau's Office of Research and Evaluation (ORE) staff have participated in program planning.

The evaluation project involves a longitudinal, multidimensional assessment of the following groups: pilot DAP participants, comprehensive DAP participants, counseling program participants, drug education program participants, and several comparison groups. The comparison groups will include inmates who volunteer for other types of programming (vocational training, stress reduction programs, etc.), and inmates who do not volunteer for any form of programming and who have drug abuse and demographic characteristics similar to those of the drug program participants. Information on both in-prison adjustment and postrelease behavior up to 5 years after release will be collected.

The research plan incorporates three basic elements. The *process evaluation* will document actual service delivery: frequency and intensity of services, type of services, staffing patterns, physical condition of facilities, level of support services, integration within the institutional environment, etc. The *outcome evaluation* will address questions about effectiveness: to what extent did program participation result in prosocial behavior, such as decreased criminal behavior, decreased drug use, and increased periods of employment after release? Lastly, *cost-benefit analyses* will address questions about the relationship between resources expended and outcomes achieved for various programs.

Specific questions to be addressed include:

- What type(s) of incarcerated offenders are more likely to volunteer for in-prison drug abuse programs?
- Do particular offender types benefit more from participation in residential programs?

- Are longer-duration (pilot) programs more effective than shorter-duration (comprehensive) programs?
- Are residential (pilot and comprehensive) programs more effective than nonresidential (education and outpatient counseling) programs?
- What role do transitional services play in preventing postrelease criminal behavior or drug use?
- What are the relative effects of pretreatment characteristics (both psychological and behavioral), the treatment program, and postrelease environment on outcome?

The information from these research efforts is expected to assist program directors in improving the effectiveness and efficiency of their programs. In addition, it will provide administrators with information for use in future program planning allocation of treatment resources. For example, if it is demonstrated that the pilot DAP's are no more effective than the comprehensive DAP's in decreasing postrelease criminal behavior and drug use, then the long-term programs can be converted to shorter ones, saving staff and institution resources. This evaluation effort is also expected to be useful to State prison administrators and policymakers addressing drug use and crime at the national level.

The importance of increasing the knowledge base about drug-abusing offenders is recognized by policymakers, behavioral scientists, and researchers. This importance is reflected by the interagency agreement between the National Institute on Drug Abuse (NIDA) and the Bureau of Prisons, through which NIDA will provide substantial long-term funding to support a comprehensive evaluation of the Bureau's drug treatment programs. ■

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