United States General Accounting Office

GAO

DRUG PREVENTION

Developing a New Strategy for Federal Prevention Research

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

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September 16, 1991

The Honorable John Conyers, Jr.
Chairman, Committee on
Government Operations
House of Representatives

The Honorable Frank Horton
Ranking Minority Member
Committee on Government Operations
House of Representatives

The nation's drug control strategy has contributed to the imprisonment of an increasingly greater number of persons convicted of drug-related crimes, many of whom have drug addictions or abuse problems. Concerned about whether these individuals have access to treatment in federal prisons, you requested that we determine whether the Federal Bureau of Prisons (BOP) provides drug treatment to inmates and arranges for continued care upon their release.[1] As agreed with your staff, we obtained information on the

- number of federal inmates needing drug treatment,
- BOP's strategy for providing drug treatment services to federal inmates,
- access by inmates to treatment, and
- costs of providing treatment.

Results in Brief

Drug treatment in the federal prisons is reaching only a small fraction of the inmates with serious substance abuse problems.[2] BOP's new strategy to provide treatment seems generally well designed, but implementation falls far short of meeting the needs of federal inmates. As of April 1, 1991, only 364 inmates were receiving treatment in the intensive residential programs, and less than half of the treatment slots were filled.[3] For inmates who complete the intensive program, aftercare services to help inmates from returning to drug use are not in place. BOP did not undertake an aggressive outreach effort to encourage more inmates to participate in these programs and did not hire an aftercare coordinator until recently.

[1]We plan to address the issue of drug treatment in state prisons in a forthcoming report.

[2]Data were available only on inmates using both drugs and alcohol.

[3]Prison residential treatment programs provide living quarters and treatment facilities for participating inmates, separate from the general inmate population.

For inmates with less serious substance abuse problems, needed services are not available in all prisons. Largely due to its failure to hire needed prison staff, BOP has fallen behind in meeting its own timetable for standardizing drug education and counseling for inmates.[4]

Despite these difficulties, BOP plans to expand its treatment program. The cost of this expansion is projected to triple from an estimated $7.2 million in 1990 to $21.8 million in 1992.

Background

As of April 1991, BOP had custody of about 62,000 individuals in 67 federal prison facilities. Since the escalation of the war against drugs in 1986, the federal inmate population has risen by more than 50 percent, with a 139-percent increase in the proportion of incoming inmates convicted of drug-related offenses.

Drug treatment experts agree that incarcerated persons often need more extensive treatment than drug education and infrequent counseling to successfully overcome their addiction problems. Critical elements have been identified that enhance prison drug treatment programs.[5] These include separating inmates enrolled in treatment from the general prison population and providing for aftercare or services after release.

Throughout most of the 1980s, however, drug treatment services for federal inmates were a low priority with little attention paid to a centralized approach that would attempt to ensure treatment for all inmates. In September 1988 BOP met with leading professionals to discuss methods to improve drug treatment in the federal prison system. During fiscal year 1989 BOP developed its new treatment strategy and began to implement it in October 1989.

A key feature of the strategy was its design for providing intensive treatment programs to inmates with moderate to severe substance abuse

[4]BOP could not provide us with reliable data on the number of inmates using the less intensive counseling services and drug education.

[5]Model of Comprehensive Care, Office for Treatment Improvement, U.S. Department of Health and Human Services, provided to GAO in April 1991; Intervening With Substance-Abusing Offenders: A Framework for Action - The Report of the National Task Force on Corrections Substance Abuse Strategies, National Institute of Corrections, U.S. Department of Justice, Bureau of Justice Assistance, June 1991; and G.P. Falkin , H.K. Wexler, and D.S. Lipton, "Drug Treatment in State Prisons," 1990, as quoted in D.R. Gerstein and H.J. Harwood, eds., Treating Drug Abuse, Volume 2, 1990, National Academy Press, Institute of Medicine, as referred to in D.R. Gerstein and H.J. Harwood, eds., Treating Drug Problems, Volume 1, 1990, National Academy Press, pp. 176-77.

problems in a separate setting.[6] These programs would require individual treatment plans to be prepared and for inmates to have separate living quarters and treatment facilities. Two fundamental components of these intensive programs are transitional services and aftercare. Both are designed to help inmates from returning to drug use.[7] Aftercare services upon the inmate's release from prison would be arranged for those released under the jurisdiction of local probation offices and provided by BOP for inmates released without supervision. An inmate wanting this intensive treatment could request transfer to a prison that offers it. Eight intensive programs were planned for implementation by the end of fiscal year 1990. Another 7 programs are planned for by the end of fiscal year 1991, with a total of 31 programs planned for by the end of fiscal year 1992.

Evaluation of the effectiveness of the new intensive programs was built in as an integral component of the strategy. This evaluation, sponsored by the National Institute on Drug Abuse (NIDA) as part of a $2.7 million interagency agreement with BOP, was scheduled to begin once the programs were fully operational.[8] The evaluation was to assess the effectiveness of the intensive drug treatment programs. This would be done by monitoring the delivery of services and analyzing treatment outcome data on inmates collected for up to 36 months after their release. Another assessment would follow 2 years later.

BOP's strategy also required that each prison would at a minimum offer (1) a standardized 40-hour drug education program, and (2) individual and group counseling services that address such matters as personal development and prerelease planning. In addition, prisons would sponsor self-help programs, such as Alcoholics Anonymous and Narcotics Anonymous.

[6]Based on a psychological assessment, BOP determines that an inmate has a moderate to severe substance abuse problem if one or more major life areas, such as family, work, school, or health, has been negatively affected by the use of drugs or alcohol in the 2-year period before arrest. BOP created two intensive residential treatment program models called "pilot" and "comprehensive." These two programs use similar treatment approaches, but differ in length, inmate-to-staff ratio, and capacity. See appendix III for further details on these programs.

[7]Transitional services and aftercare can include treatment services, such as professional counseling provided on an outpatient basis, drug-use monitoring (e.g., urinalysis), as well as referrals to self-help programs. Transitional services are provided in a halfway house setting; that is, a supervised residential community corrections center. Aftercare services are provided after the inmate is released back into the community. Up to 6 months of each type of service would be provided to inmates who successfully complete the intensive residential programs.

[8]BOP planned that eight intensive programs would be fully implemented and have reached capacity by September 30, 1990.

For all prison drug treatment programs, inmates would participate voluntarily because treatment cannot be mandated.[9] The Sentencing Reform Act of 1984, in abolishing parole, eliminated what could have been an attractive incentive for federal inmates to seek such treatment.[10]

A year after BOP began to implement its new treatment strategy, the Congress, through the Crime Control Act of 1990, reinforced the intent of BOP's initiatives. The act directs BOP, to the extent practicable, to make appropriate substance abuse treatment available for each prisoner the Bureau determines has a treatable condition of substance addiction or abuse. The act, however, does not set a time frame for implementing new treatment programs. Accordingly, BOP has established its own time frames.

Scope and Methodology

To determine the number of federal inmates needing drug treatment, we conducted a mail survey of BOP treatment staff in 51 federal prisons during the summer of 1990 and analyzed the results of a BOP study conducted during the same time period. We reviewed BOP's new drug treatment strategy, including descriptions of the intensive and less intensive programs and other program components, such as aftercare and evaluation, as well as BOP's timetable for implementation. We then assessed the progress BOP has made towards meeting this timetable. We also gathered data on the number of inmates accessing the intensive treatment programs and on the costs of providing treatment. We conducted most of our work at BOP headquarters and at five prisons—three offering intensive treatment and two not offering intensive treatment programs. This approach enabled us to corroborate data obtained at BOP headquarters with local prison data. We did not attempt to identify drug treatment services provided in BOP's jails.[11] To assess BOP's new treatment strategy, we compared a comprehensive list of prison treatment program elements shown to enhance program effectiveness against the BOP strategy. This list is based on our review of the current literature and discussions with leading drug treatment experts.

[9]BOP policy states that certain inmates with a substance abuse problem should take its new standardized 40-hour drug education course. However, inmates may choose not to take the course. BOP's policy is to penalize those inmates who refuse participation by reducing their pay rate to the lowest level and denying eligibility for halfway house placement.

[10]All federal inmates whose crimes were committed on or after November 1, 1987, are ineligible for parole.

[11]BOP has five jails. These jails house inmates awaiting trial and sentencing and detainees primarily held for immigration violations.

A complete description of our scope and methodology is provided in appendix I. Expert judgments on what constitutes effective treatment in the prison setting and the manner in which these elements are encompassed in BOP's strategy are summarized in appendixes II and III, respectively. A status summary of NIDA's and BOP's interagency evaluation effort is provided in appendix IV. Information on the progress BOP has made in meeting its planned timetable to implement all components of its new treatment strategy is provided in appendix V.

About Half of Federal Inmates May Need Drug Treatment

BOP estimates that 27,000 of its 62,000 inmates (44 percent of the prison population), have moderate to severe substance abuse problems. BOP's estimate is extrapolated from a survey of inmates entering one prison. In our survey, prison officials estimated that an additional 14,000 inmates have some type of substance abuse problem, including less severe problems. In this report, we use BOP's estimate of 27,000 because it is the figure BOP used in implementing its strategy and is the relevant figure for BOP's intensive programs aimed at inmates with moderate to severe problems.

Only Small Number of Inmates Needing Intensive Treatment Receive It

Most inmates with histories of significant substance abuse are not in treatment despite BOP's initiatives to provide them with an intensive treatment program. Only 364 of the estimated 27,000 federal inmates with moderate to severe substance abuse problems are receiving treatment within these programs. The intensive residential programs specifically designed for these inmates are substantially underenrolled, having space for more than double the number of inmates currently enrolled. Limited outreach may have contributed to the small numbers of inmates volunteering to enroll in the intensive drug treatment programs.

Lack of Federal Inmate Volunteers

Few inmates have volunteered to enroll in BOP's intensive drug treatment programs, although they can transfer from one prison to another in order to receive this treatment. Since October 1989, when the first of the eight intensive programs opened, programs have been underenrolled. Initial attempts to solve this problem are described in table 1. The table shows that BOP relaxed the original inmate admission criteria. For example, at the outset BOP targeted the intensive treatment to inmates with 15 to 24 months remaining on their sentences; now

inmates can join the intensive programs at any time during their incarceration.[12]

Table 1: BOP Changes to Inmate Admission Criteria for Intensive Drug Treatment Programs

Criteria	Original	Revised
Inmate characteristics	Fluency in English	No language fluency requirements
	No detainees[a]	Open to detainees
	No state inmates boarded in federal prison	Open to boarders
	Absence of a history of violence or assaultive behavior during current incarceration	Disciplinary problems not considered
	Absence of serious medical, psychiatric, or psychological problems	No change
Timing of treatment	15-24 months before expected release date	Open to inmates at any time during incarceration
Prerequisite for treatment	Successful completion of 40-hour drug education course	No change, but not always required
Other requirements for pilot intensive programs only[b]	Inmates approved for release to Southeast United States only	Open to inmates released to any region
	Inmates were to be randomly assigned from a volunteer pool	Open to all volunteering inmates

[a]Inmates who are to be released to other jurisdictions or are subject to other legal proceedings upon release from BOP.

[b]These additional requirements were originally planned under NIDA's and BOP's evaluation effort.

However, even with the relaxed admission criteria, there has not been a significant increase in the number of inmate volunteers and the programs are not filled to their designed capacity. Enrollment figures provided by BOP's Drug Treatment Coordinator as of April 1, 1991—6 months after the intensive programs were scheduled to be operating at full capacity—reveal that less than half of the treatment slots are filled. See table 2 for program enrollment data.

[12]This change will result in some inmates completing the intensive residential programs and returning to the general inmate population to complete their sentences.

Table 2: Underenrollment in Eight Intensive Drug Treatment Programs
(As of April 1, 1991)

Prison	Actual start date[a]	Treatment slots[b]	Number of inmates enrolled[c]
Pilot program			
Butner, N.C.	2/90	100	74
Lexington, Ky.	10/89	100	47
Tallahassee, Fla.	6/90	100	45
Comprehensive program			
Fairton, N.J.	3/91	100	40
Oxford, Wisc.	11/90	100	30
Rochester, Minn.	1/91	100	67
Seagoville, Tex.	8/90	100	40
Sheridan, Ore.	3/91	100	21
Total		**800**	**364**

[a]These eight programs were scheduled to be fully implemented and have reached capacity by September 30, 1990.

[b]The three intensive pilot programs are 12 months in length and have an annual capacity to treat 100 inmates. The five comprehensive programs are 9 months in length and thus can treat an additional 25 inmates per year, for an annual capacity of 125.

[c]Excludes inmates who enrolled in the programs and completed them or left because they were released from prison, transferred, or dropped out. BOP could not provide us with reliable data on the number of these inmates.

BOP Has Not Implemented an Effective Outreach Strategy

BOP did not actively recruit inmates for treatment because agency officials originally thought that the increased availability of drug treatment services would create an increased inmate demand for these services. The Office of National Drug Control Policy (ONDCP) in the 1989 National Drug Control Strategy reported that "relying on the addict alone to initiate treatment is insufficient."[13] The report also noted that "[e]xpanding the capacity of the treatment system will not, in and of itself, cause those users who now resist treatment to change their minds."[14] To get drug-addicted inmates into these programs, ONDCP suggests that measures be taken that will persuade or encourage addicts to receive treatment. An inmate at one prison corroborated this perspective. He told us that drug treatment would not work in prison because inmates have no motivation to seek treatment, and have nothing more to lose by not going for treatment. In the absence of self-motivation, outreach to inmates is especially important.

[13]National Drug Control Strategy, October 1989, the Office of National Drug Control Policy, Executive Office of the President. Washington, D.C., p. 41.

[14]National Drug Control Strategy, October 1989, p. 42.

Although outreach programs are often used in community-based drug treatment programs to attract drug addicts, BOP did not implement such an effort for its intensive programs. The limited outreach to inmates and availability of program information to prison staff may have contributed to the small number of inmates enrolling in the intensive programs.

A prison psychologist told us that the intensive treatment programs were not adequately advertised outside the eight prisons housing the programs and that there was a general lack of information on inmate admission criteria among treatment staff. Another psychologist we spoke with was not aware of the ability to transfer inmates between prisons for the purpose of enrolling them in drug treatment. Our visits to three prisons with intensive programs revealed that outreach was limited to the Admission and Orientation phase when inmates first enter the prison. However, some inmates who were enrolled in three intensive treatment programs we visited told us that they heard about the program from psychology staff at other prisons, from other inmates, or from notices posted on the bulletin board in their units. In one of the two prisons we visited that were not offering intensive treatment, however, treatment staff did not know enough about the availability of these programs in other prisons to inform the inmates about them.

To increase outreach to inmates, BOP is developing a newsletter to keep all prison staff better informed about the intensive drug treatment programs. In addition, BOP is considering other means of attracting inmates to these programs and hopes that the new standardized drug education programs—once fully implemented in all prisons—will also encourage inmates to seek intensive treatment.

Essential Aftercare Not Assured

Sufficient provisions for aftercare treatment have not been made. Such treatment minimizes the chances of relapse after inmates successfully complete the intensive residential treatment programs. Aftercare is an integral part of BOP's drug treatment strategy and is considered essential to successful treatment outcomes. Under its treatment strategy BOP had originally planned to establish the aftercare component by October 1, 1990. BOP did not hire any one to implement the aftercare component

until April 1991.[15] As a result, aftercare is not assured for inmates completing the intensive program, even though some inmates have completed or are nearing completion in four intensive programs.[16]

The strategy calls for up to 6 months of transitional services and 6 months of aftercare treatment upon the inmate's release from prison. Aftercare services would be arranged for those released under the jurisdiction of local probation offices and provided by BOP for inmates released without supervision as a key component of the intensive programs. Transitional and aftercare services include individual and group counseling, employment assistance, and urine testing for drug use.

For those inmates released under the jurisdiction of local probation offices, BOP's strategy provided that aftercare services would be coordinated by BOP and the Probation Division within the Administrative Office of the U.S. Courts through an interagency agreement. Since 1978, the Director of the Administrative Office has had the authority to contract for aftercare services for released inmates under its supervision.[17]

In the past, coordination between BOP and the Probation Division has been a problem. BOP's new strategy has not overcome this problem, due in part to its delaying appointment of an aftercare coordinator. Other coordination problems were cited by several probation officers who determine and arrange for aftercare treatment for inmates released under their supervision. They told us that BOP officials often fail to send them critical information in reference to the released inmate's participation in prison drug treatment. Other officers commented that prison records frequently arrive after they have developed their plans for supervision. This delay hinders the probation officers' ability to ensure that the inmates they are supervising receive appropriate aftercare services that build on the treatment received in prison.

[15]The aftercare coordinator's primary responsibilities include providing information and assistance to the Probation Division for inmates released under its supervision and developing and managing BOP's aftercare services for inmates released without supervision.

[16]The three pilot 12-month programs—in Lexington, Kentucky; Butner, North Carolina; and Tallahassee, Florida —were scheduled to begin releasing inmates in October 1990, February 1991, and June 1991, respectively. One comprehensive 9-month program—at Seagoville, Texas—was scheduled to release inmates beginning May 1991. BOP could not tell us how many inmates have completed the intensive programs and have been released to the community or back to the general inmate population.

[17]This authority was established by P.L. 95-537, Contract Services for Drug-Dependent Federal Offenders Act of 1978.

For inmates released without supervision, BOP planned to provide aftercare services either by contracting with non-BOP treatment providers or providing these services directly.[18] This plan is not in place. Currently, these inmates will not receive aftercare services unless they arrange for it themselves.

BOP's strategy does not address the aftercare needs of inmates who have completed the intensive programs and then are returned to the general prison population. This is because BOP originally designed its strategy to target aftercare services for inmates before their scheduled release from prison. However, when BOP relaxed its eligibility criteria, in order to encourage more inmates to enroll in its intensive programs, some inmates began receiving intensive treatment at an earlier point than originally anticipated.

Less Intensive Treatment Not Available to Majority of Those in Need

Less intensive services, such as drug education and counseling, are not available in all BOP prisons. BOP planned to offer these services to inmates with less serious substance abuse problems and those with moderate to severe problems who had not enrolled in an intensive program.

In response to our June 1990 questionnaire, BOP treatment staff indicated that 47 of 51 prisons offered a mix of drug education, individual and group counseling, or self-help groups.[19] Standardizing the drug education and counseling available at prisons was another key aspect of the new BOP treatment strategy. Our prison visits and interviews, however, indicated that BOP has not standardized such services.

BOP missed its September 30, 1990, target to provide a standardized 40-hour drug education program in each prison because it did not provide the needed staff to teach the courses. Because these staff would also be responsible for providing counseling services, their not being hired has also limited BOP's ability to counsel inmates not enrolled in the intensive programs. For example, two prisons we visited with less intensive treatment had limited services. The prisons had neither a structured treatment program nor counseling services that focused on drug treatment. At both prisons, psychologists provided individual drug counseling to

[18]BOP's Drug Treatment Coordinator explained that BOP may decide to independently contract with a nationwide treatment provider or to build on the contracts already negotiated by the Probation Division with community-based providers.

[19]Specifically, 43 prisons reported providing drug education; 38 group counseling; 41 individual counseling; and 42 self-help.

inmates requesting it; no scheduled counseling services dealing with substance abuse problems were provided. Other services at these two prisons consisted largely of self-help programs that met once a week. BOP's Drug Treatment Coordinator also told us that, in general, basic services such as counseling are limited and sporadic at best in most prisons.

In light of the lack of drug education in some prisons and unstandardized drug education in others, BOP's Drug Treatment Coordinator told us that BOP has allocated funds to hire drug treatment specialists to provide the standardized 40-hour drug education program and counseling for up to 56 prisons with a population of 500 inmates or more. These funds were made available for these positions in July 1991; prisons that had available funds were authorized to fill these positions earlier. BOP also noted that there have been some problems in hiring drug treatment specialists with the appropriate skills. This has also delayed the implementation of standardized drug education and counseling services.

BOP's Treatment Cost Estimates

BOP projects that the planned expansion of its drug treatment strategy will triple original program costs by 1992—from an estimated $7.2 to $21.8 million. These projected costs are based on estimates and not on the actual costs of providing treatment.

BOP estimated its drug treatment services in fiscal year 1990 at $7.2 million.[20] Its cost projections for fiscal years 1991 and 1992 are $10.7 and $21.8 million, respectively. Both the 1991 and 1992 figures reflect BOP's plans to expand its intensive treatment programs. Within these cost parameters, BOP plans to have 31 intensive treatment programs available by the end of fiscal year 1992, establish an aftercare program, and implement less intensive standardized treatment services at all its prisons.

The estimated cost of treatment in the intensive programs is about $5,000 per inmate, per year, BOP's Drug Treatment Coordinator told us. This is in addition to the $18,000 average cost of incarceration in fiscal year 1990. The Drug Treatment Coordinator did not, however, provide us with any data supporting this treatment cost estimate.

[20]BOP reported to ONDCP that the fiscal year 1990 drug treatment cost was $8 million. BOP's finance office chief provided us with an updated estimate of $7.2 million, explaining that the original $8 million estimate included $800,000 for prison renovations that was never spent.

Conclusions

BOP's strategy to treat the many federal prisoners with substance abuse problems appears sound. If fully implemented, this strategy could assist in the treatment of seriously addicted inmates. However, BOP has been slow to implement its strategy and, as a result, it is reaching very few inmates in need. BOP's efforts, particularly in outreach and arranging for aftercare, have been very limited.

Recommendations

We recommend that the Attorney General direct the Director of the Bureau of Prisons to

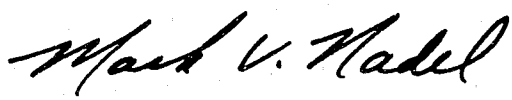
- undertake an aggressive outreach effort to encourage inmates with moderate to severe substance abuse problems to enroll in BOP's intensive treatment programs, and
- assure that provision is made for both aftercare treatment services for released inmates who participated in the intensive programs as well as for education and counseling services in all prisons.

Agency Comments

As requested, we did not obtain written comments on this report but discussed it with BOP officials. Where appropriate, we incorporated their comments into the report. BOP officials believed that we did not adequately portray their drug treatment strategy, saying that we presented only a "snapshot" of the treatment program early in its implementation. A BOP official thought that our report did not provide a perspective on the ambitious goals BOP has established but reported only on the fact that they missed their deadlines.

In general, we believe that the report reflects our attempts to continually update enrollment data and information on BOP's progress toward meeting its established time frames. In cases where we criticize BOP's progress in meeting these time frames, we do so by using the agency's own milestones.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the appropriate congressional committees, the Attorney General, and the Director of the Office of National Drug Control Policy. If you have any questions about this report, please call me on (202) 275-6195. Major contributors to this report are listed in appendix VI.



Mark V. Nadel
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Health Issues

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Abbreviations

BOP	Bureau of Prisons
GAO	General Accounting Office
IOM	Institute of Medicine
NIC	National Institute of Corrections
NIDA	National Institute on Drug Abuse
ONDCP	Office of National Drug Control Policy
OTI	Office for Treatment Improvement

Scope and Methodology

To identify the extent to which federal inmates need drug treatment, the treatment services—existing and planned—that BOP offers, and inmate access to treatment, we gathered national and local data. At the national level, we conducted a survey of 51 federal prisons on the drug treatment services they provided.[1] We also analyzed the results of a 1990 internal BOP study of 65 federal prisons on the substance abuse problems of incoming inmates.[2] We reviewed BOP's new drug treatment strategy and the agency's timetable for implementation. We also determined the progress BOP has made toward implementation (such as the number of inmates accessing the intensive treatment programs and the status of aftercare and evaluation efforts). We conducted this review by interviewing headquarters officials at BOP, such as the Drug Treatment Coordinator responsible for designing and implementing the treatment strategy, including the provision for aftercare treatment. In addition, we reviewed policy memoranda and guidelines for prison drug treatment programs. To identify the aftercare services available to released inmates, we met with officials from the Administrative Office of the U.S. Courts, Probation Division.[3] At the local prison level, we obtained an in-depth picture of treatment services by visiting five federal prisons and nearby probation offices. The prisons we selected provide coverage of a geographical cross section of the country and prisons with and without the new intensive treatment programs. These prisons are in Butner, North Carolina; Lexington, Kentucky; Seagoville, Texas; Englewood, Colorado; and Lompoc, California. Two prisons offer pilot intensive programs, Butner and Lexington; one prison offers a comprehensive intensive program, Seagoville; and two were scheduled to offer less intensive programs, Englewood and Lompoc. At each federal prison, we spoke with prison officials, including the drug treatment coordinator and psychology staff, and obtained local drug treatment policies and procedures. At each of these prisons, we also reviewed the files of 10 randomly selected treatment participants and interviewed 5 of those participants to corroborate information about the provision of treatment

[1]The study universe originally consisted of 65 BOP prisons in operation as of June 1990. Four medical facilities and five jails were excluded from the study population because the treatment provided at these facilities was unlike treatment provided elsewhere in BOP's prison system. Five additional facilities with limited time in operation were also excluded. Therefore, the study population was adjusted to include 51 prisons that had been in operation before January 1, 1990.

[2]The original universe of the BOP study consisted of 78 institutions, including satellite camps and jails. Of these, only 65 responded. However, BOP decided to generalize data obtained from only one prison because it determined that these data were representative of the national results.

[3]The Probation Division of the Administrative Office of the U.S. Courts is responsible for supervising inmates released by BOP to complete their sentences in the community. Local supervising probation offices arrange for the community-based drug treatment, particularly for inmates whose release is conditioned on their enrollment in treatment.

by BOP programs. We met with local probation officials to discuss the aftercare arrangements for inmates released under their supervision. We did not attempt to identify the drug treatment services provided in federal jails.

To analyze BOP's drug treatment strategy we developed a comprehensive list of prison treatment program elements that have been shown to contribute to successful treatment outcomes. We developed this list based on a review of the current literature and discussions with leading drug treatment experts on elements of prison treatment programs that enhance program effectiveness. The program elements include those reported by the Office for Treatment Improvement (OTI), Department of Health and Human Services; National Institute of Corrections (NIC), Department of Justice; and the Institute of Medicine (IOM). (See app. II.) We then determined the extent to which BOP's new treatment strategy encompasses these treatment program elements. (See app. III.)

BOP does not have a system to track and compile data on the actual costs of providing treatment to its inmates. As a result, we relied on BOP's overall cost estimates but could not verify the bases for them because BOP did not have supporting documentation.

We conducted our review from March 1990 to April 1991 in accordance with generally accepted government auditing standards.

Elements of Effective Prison Drug Treatment Programs Reported by OTI, NIC, and IOM

Research specific to providing drug treatment to incarcerated persons is limited. Sufficient data, however, are available to demonstrate that providing drug treatment in prison can and does work to reduce both inmate recidivism and drug use. Studies have found that the inmate population generally needs more intensive treatment than drug education and occasional counseling. Data also suggest that more entrenched and chronically addicted inmates need to be treated in an environment separate from the general inmate population and ensured aftercare treatment upon their release from prison. Some program elements have been shown to be effective. These elements—as reported by the Office for Treatment Improvement (OTI), Department of Health and Human Services; National Institute of Corrections (NIC), Department of Justice; and the Institute of Medicine (IOM) are presented below. In appendix III we assess the extent to which BOP has encompassed each element under its new treatment strategy.

Table II.1: Elements of Effective Prison Drug Treatment Programs

	Reported as elements contributing to effective treatment by[a]		
Program element	**OTI**	**NIC**	**IOM**
Encouragements to treatment (includes outreach and incentives)		X	
Identification of all treatment needs—screening/ assessment	X	X	X
Matching inmate needs with treatment type	X	X	
Individual treatment plans	X	X	
Separate treatment setting	X	X	X
Length of treatment[b]	X	X	X
Timing of intervention			
Near release only		X	
At any time	X		
Staffing			
Professionals	X	X	
Role models (such as ex-offenders)		X	X

(continued)

Program element	Reported as elements contributing to effective treatment by[a] OTI	NIC	IOM
Components of prison treatment			
Drug education		X	
Self-help programs	X	X	X
Group therapy	X	X	
Individual counseling	X	X	
Life skills development	X		
Physical and mental health	X	X	
Prerelease planning		X	X
Emphasis on relapse prevention	X	X	
Drug-free environment			
Urine testing	X	X	
Pharmacotherapeutic intervention (for example, methadone maintenance)	X		
Treatment designed for populations with special needs (for example, women)	X	X	
Aftercare upon release	X	X	X
Program evaluation	X	X	

[a]OTI reported these program elements in its comprehensive care model, which it has begun to implement and more rigorously evaluate under its demonstration grant programs for critical populations that include incarcerated persons. NIC reported these elements in its task force report, Intervening with Substance Abusing Offenders. IOM cited elements found in G.P. Falkin, H.K. Wexler, and D.S. Lipton, "Drug Treatment in State Prisons," 1990, as quoted in D.R. Gerstein and H.J. Harwood, eds., Treating Drug Abuse, Volume 2, 1990, National Academy Press, Institute of Medicine, as referred to in D.R. Gerstein and H.J. Harwood, eds., Treating Drug Problems, Volume 1, 1990, National Academy Press, pp. 176-77.

[b]Neither OTI, NIC, nor IOM specified the length of treatment that should be provided. However, studies of community-based treatment programs have produced convincing evidence pointing to the length of treatment rather than the type of treatment as a key factor for positive outcomes. As reported in a 1989 study, (see Robert L. Hubbard, and others, Drug Abuse Treatment: A National Study of Effectiveness, The University of North Carolina Press (Chapel Hill and London: 1989), p. 171) the Treatment Outcome Prospective Study revealed that a minimum of 3 months was found necessary to produce positive changes and beyond those first 3 months outcomes improved with the time spent in treatment. An evaluation of the Stay'n Out prison-based drug treatment program in New York City found 9 to 12 months to be the optimum length of in-prison treatment. (See Harry K. Wexler, Gregory P. Falkin, and Douglas S. Lipton, A Model Prison Rehabilitation Program: An Evaluation of the "Stay'n Out" Therapeutic Community, A Final Report to the National Institute on Drug Abuse, Narcotic and Drug Research, Inc. (New York: 1988), pp. 3-4.)

Effective Drug Treatment Program Elements Encompassed in BOP's Treatment Strategy

Program elements	BOP treatment strategy[a]
Encouragements to treatment (includes outreach and incentives)	The only BOP-wide encouragement offered is a certificate of completion to inmates who finish the intensive programs. At some of the intensive programs, inmates also are given articles of clothing and/or some compensation for lost pay. BOP's policy calls for certain inmates with histories of substance abuse problems to participate in a standardized 40-hour drug education course. This is subject to acceptance by the inmate. However, inmates who fail to complete this course are restricted to the lowest pay level and are ineligible for halfway house placement.
Identification of all treatment needs—screening/assessment	All inmates are routinely screened for their individual needs upon entry into federal prisons. These may be medical, vocational, psychological, educational, or other types of needs. They are documented in their case files. Inmates are also assessed for their substance abuse severity by a psychologist during their admission and orientation; their problems may be classified as moderate, severe, or insignificant on the BOP's Psychological Services Screening Summary. Other screening instruments that may be used in the future include the Inventory of Substance Use Patterns, Substance Abuse Signs Checklist, and the Addiction Severity Index.
Matching inmate needs with treatment type	Based on the assessed severity of the inmate's addiction, a BOP psychologist recommends that an inmate enroll in an intensive treatment program or take advantage of the less intensive treatment services. Inmate participation in any treatment program is strictly voluntary, however.
Individual treatment plans	All inmates who are enrolled in the intensive treatment programs or are availing themselves of less intensive treatment services (except self-help) are required to have a treatment plan. We found, however, that this was not done for all treatment participants at the prisons visited.
Separate treatment setting	In the intensive programs, inmates are housed separate from the general population. However, they mingle with other inmates for all nontreatment activities, such as recreation, meals, and work. Inmates utilizing the less intensive services are not separated from other inmates.
Length of treatment	BOP intensive pilot programs consist of 1,000 hours of treatment over 12 months, while the intensive comprehensive programs consist of 500 hours over 9 months. The duration of counseling services not provided under the intensive program is not prescribed; sessions may be held as frequently as the inmate and counselor determine is necessary. Other less intensive treatment courses may have set lengths, such as 10 weeks.
Timing of intervention	
Near release only	Originally, BOP targeted enrollment in the intensive programs to inmates who had 15 to 24 months left in their sentences.
At any time	Now inmates may enroll in the intensive programs, as well as access the less intensive treatment services, at any time during their incarceration. Inmates who participate in the standardized drug education course must do so during the first 6 months of their incarceration.

(continued)

Program elements	BOP treatment strategy[a]
Staffing	
Professionals	BOP employs psychologists with a doctoral degree and trained drug treatment specialists in its drug treatment programs. In the pilot programs, the staff-to-inmate ratio is scheduled to be 1:12, while the staff-to-inmate ratio in the comprehensive programs is scheduled to be 1:24. Based on the enrollment figures given to us by the BOP Drug Treatment Coordinator on April 1, 1991, the ratio of staff to inmates was higher in all except one of the eight programs. For the other program, the ratio was the reverse.
Role models (such as ex-offenders)	BOP does not utilize ex-offenders in their drug treatment programs.
Components of prison treatment	
Drug education	Out of the 51 prisons we surveyed, 43 reported that they offered some form of drug education. Under BOP's new treatment strategy, a standardized drug education course was developed for inmates with substance abuse histories where the abuse contributed to their present incarceration, their parole or probation violation, and/or where the court recommended a drug program. BOP's strategy also makes this course a prerequisite for enrollment in the intensive treatment programs. We found that because BOP has not made this standardized course available in all prisons it is not a prerequisite for the intensive programs.
Self-help programs	Most federal prisons offer self-help programs to substance-abusing inmates. Forty-two of the 51 prisons we surveyed reported that self-help programs were available. The groups usually met once a week, and could be moderated by persons from outside the prison system. Any inmate may attend these meetings. One of the two pilot programs we visited required their participants to attend as part of their treatment.
Group therapy	Of the 51 prisons surveyed, 38 reported that they offered group therapy. Group therapy is a component of the intensive treatment programs, but also may be offered to other inmates as part of the less intensive treatment services.
Individual counseling	Forty-one of the 51 prisons we surveyed reported offering individual counseling. Individual counseling with a psychologist or drug treatment specialist is a part of every intensive program. It may also be offered to other federal inmates on an ad hoc basis.
Life skills development	Depending on the individual prison's intensive program, various courses may be offered to enhance inmates' practical life skills. These types of courses also may be offered to inmates utilizing the less intensive services, depending on the facility. These courses are not necessarily offered as part of drug treatment, but may be available to the general population.
Physical and mental health	Wellness is a key component of all BOP intensive treatment programs and may take the form of regimented exercise. Programs also may consist of courses with topics such as stress management or behavioral modification, but these courses are not standardized across all BOP's drug treatment programs.
Prerelease planning	All intensive programs are to provide prerelease services as the first part of inmates' transition back into the community. Once eligible inmates have completed the in-prison portion of the treatment programs, they may spend up to 6 months in a halfway house. During this time, they will still be under the supervision of BOP staff and participate in drug treatment programming. This part of treatment has not been implemented.

(continued)

Program elements	BOP treatment strategy[a]
Emphasis on relapse prevention	BOP's intensive treatment programs stress relapse prevention in an effort to reduce recidivism. Most components of the intensive programs relate to this topic, and some institutions have specific courses on this subject as part of their treatment services.
Drug-free environment	Due to BOP regulations that the prison system be drug-free, all treatment services and programs base their philosophies on this premise.
Urine testing	BOP tests 5 percent of all inmates randomly each month for drugs. Inmates in the intensive programs are scheduled to be tested more frequently. At the pilot and comprehensive programs we visited, not all inmates were tested more frequently. At two pilot programs we visited, 10 participating inmates would be placed on a monthly list of drug users to be tested on a random basis.
Pharmacotherapeutic intervention (for example, methadone maintenance)	Usage of drugs to aid in recovery is not employed in the federal prison system.
Treatment designed for populations with special needs (for example, women)	While inmates themselves are a critical population, the female and Spanish-speaking inmates within this group have special needs. One of the pilot programs is for women only, and one of the comprehensive programs treats Spanish-speaking inmates along with English-speaking inmates. Another critical population, inmates who have tested positive for the human immunodeficiency virus, cannot be singled out for special treatment services due to the issue of confidentiality, thus, there is no specific program for this population.
Aftercare upon release	Aftercare services are intended to be part of all intensive programs. BOP has not implemented these services. In addition, BOP has not coordinated with the Probation Division or determined whether it will provide this service with its own staff or through a contract provider.
Program evaluation	NIDA is sponsoring a 5-year study that will focus on all BOP intensive treatment programs. The study was originally scheduled to evaluate the three pilot prison and three comprehensive programs. BOP's start-up problems have forced NIDA and BOP to delay the intensive work by several months. Additionally, each prison is required to conduct a full program evaluation each year.

[a]BOP's adoption of each treatment element applies to both the intensive and less intensive treatment programs in the BOP strategy unless otherwise indicated.

[b]Halfway houses are residential community corrections centers for offenders who are eligible to spend the last few months of their sentences in a supervised setting. However, some inmates may not be appropriate for halfway house placement due to their use of weapons, history of violence, or other factors.

Status of Interagency Evaluation Effort

An insufficient pool of inmate volunteers has delayed key research needed to evaluate the effectiveness of BOP's intensive treatment programs. Further, until the aftercare component has been implemented, treatment outcomes (such as postrelease drug use and criminal behavior) cannot be evaluated. The evaluation of these treatment efforts (and their outcomes) was intended to (1) develop more effective drug treatment programs in prisons, (2) understand the root causes of drug addiction among the inmate population, and (3) provide accurate and useful information on which to base national efforts in controlling drug use through effective drug treatment programs. NIDA sponsored the evaluation of BOP's intensive drug treatment programs to help fill a gap in knowledge regarding the effectiveness of drug treatment in correctional settings.[1] NIDA and BOP had planned that the in-depth work would start at the beginning of fiscal year 1991. However, due to the lack of inmate volunteers for the intensive treatment programs, research has not begun as originally planned and is several months behind schedule.

Shortages of volunteers created problems, such as an inability to randomly assign participants into the pilot intensive drug treatment programs.[2] Based on random assignment of volunteers to BOP's intensive pilot treatment programs, four comparison groups were to be formed.[3] A total of about 1,200 inmate volunteers were needed to conduct this design in the first year of the study. Since only 364 inmates have volunteered for the program, this aspect of the study has not been implemented.

NIDA and BOP are redesigning the original evaluation plan due to changes BOP has made to the admission criteria for the intensive programs. For example, NIDA and BOP initially planned to study the effects of providing residential treatment and aftercare services to those inmates nearing release. However, because few inmates volunteered, BOP opened the intensive programs to inmates at any point in their incarceration rather

[1]BOP, in turn, is supplying the staff needed to undertake this research effort.

[2]Randomization, if properly done, can eliminate confounding variables that may influence an inmate's selection of a specific treatment program. Because of this strength, study designs that include randomization are considered to provide more powerful support for why programs do or do not work.

[3]One comparison group was to consist of volunteers who met admission criteria and who would be randomly assigned to the 12-month pilot residential program. Volunteer inmates not randomly assigned to this program could choose to go into one of two comparison groups—(1) the 9-month comprehensive program or (2) the no-additional or low-intensity treatment. The fourth comparison group would consist of a sample of nonvolunteers who would have been eligible for admission to the pilot residential program.

than just prior to release. As a result of this relaxation of the initial admission eligibility criteria, NIDA and BOP may not be able to effectively study the transitional process for inmates from prison drug treatment into aftercare in the community. This is because some inmates successfully completing the intensive programs will return to the general prison population and may not be released until years later.

Another factor that negatively affects the evaluation is BOP's failure to establish the aftercare component of the intensive treatment program according to the planned timetable. Consequently, NIDA and BOP cannot study the outcomes or effects of the complete programs on postrelease drug use, criminal behavior, occupational and social functioning, as well as mental and physical health.[4]

[4]This aspect of the evaluation would have shown treatment outcomes after incarceration through a study of the inmates' participation in aftercare services for up to 36 months postincarceration along with follow-up assessments 2 years later.

BOP's Progress in Implementing Treatment Strategy Components

Strategy component	Date operational
Intensive treatment	
Pilot and comprehensive programs[a]	
Planned	
3 pilot and 5 comprehensive	9/30/90
Actual	
3 pilot	10/01/89 2/01/90 6/18/90
5 comprehensive	8/01/90 11/01/90 1/01/91 3/01/91 3/01/91
Additional programs	
Planned	
7 comprehensive	9/30/91
Actual	
1 comprehensive	7/17/91
Additional programs	
Planned	
16 comprehensive	9/30/92
Actual	•
National aftercare program	
Planned	10/01/90
Actual	As of 7/22/91, program not begun; BOP's Aftercare Coordinator not hired until April 1991.
NIDA program evaluation	
Planned (to begin)	6/01/90
Actual	As of 7/22/91, NIDA and BOP are redesigning the study of the intensive program.
Less intensive treatment	
Standardized drug education course	
Planned	9/30/90
Actual	As of April 17, 1991, not available in all prisons; funds to hire prison drug treatment specialists were not made available until July 1991.
Structured counseling	
Planned (to begin)	9/20/90
Actual	As of April 17, 1991, not available in all prisons; funds to hire prison drug treatment specialists were not made available until July 1991.

[a]BOP planned to have 31 programs in operation by September 30, 1992.

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Ordering Information

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