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New Initiatives in Drug Treatment in the Federal Bureau of Prisons

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THERE HAVE been marked variations in the social, political, and academic climates with regard to correctional rehabilitation over the past three decades. Perspectives have ranged from decidedly pro-rehabilitation to "nothing works." Regardless of the prevailing "zeitgeist" of each period, the Federal Bureau of Prisons (BOP) has traditionally perceived the provision of program opportunities for offenders to be an important part of its mission. In particular, the BOP has provided specialized treatment programs for drug abusing or addicted offenders for well over the past quarter century (Wallace, Pelissier, McCarthy, & Murray, 1990).

Like many state correctional systems, the BOP has experienced a rapid and dramatic increase in population. As of March 1, 1991, there were more than 60,500 individuals incarcerated in over 60 facilities throughout the country. Approximately 51 percent of all offenders were serving time for drug offenses. Projections indicate that the total offender population will reach 95,000 by 1995, and more than 69 percent will be incarcerated for drug offenses—more than the total existing Bureau population.

The Bureau of Justice Statistics reported in 1986 that 62 percent of state inmates reported using illicit drugs on a regular basis, and 43 percent reported drug use on a daily basis during the 30-day period prior to committing their offense for which they were imprisoned (Innes, 1988). While the exact percentage of incarcerated Federal offenders with drug abuse problems is unknown, the results of an admissions cohort assessment involving offenders who entered the system between July 11 and August 10, 1990, are revealing.

In an admissions cohort of 1,165 offenders from more than 90 percent of all BOP 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 met the criteria for Psychoactive Substance Dependence.

The criteria used to determine a diagnosis of abuse or dependency, incidentally, were rather rigorous. They matched the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised (DSM III-R) of the American Psychiatric Association. These definitions of abuse and dependency are the most commonly accepted in the academic and professional communities.

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

There were also marked differences in various racial and ethnic groups. Members of the Native American admissions cohort had the highest substance abuse problem rate in the cohort--78.9 percent. Blacks demonstrated an overall substance abuse problem rate of 54.3 percent, while whites demonstrated a problem rate of 49.3 percent. Asians demonstrated a substance abuse problem rate of only 11.1 percent. Of great interest was the finding that new Hispanic admissions demonstrated a substance abuse problem rate of 60.2 percent.

Clearly, caution must be exercised in the interpretation of 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 admissions cohort analysis have identified a substantial number of individuals entering the system with drug abuse problems in need of treatment. The data have also indicated that the need for treatment is significantly greater among members of different special offender populations—particularly Native Americans, Hispanics, blacks, and females.

Prior to detailing some of the BOP's current drug treatment strategy initiatives, it is impor-

tant to note that some items on the assessment instrument attempted to determine the extent to which new commitments were motivated for participation in drug treatment programming while incarcerated. Of tremendous interest was the finding that a significant number of individuals in the admissions cohort, who were identified as having a substance abuse or dependency problem, indicated a desire for treatment. Approximately 43.8 percent of the sample indicated a desire to participate at least 1 hour per day in a drug abuse treatment program at admission. If this finding remains stable for future admissions cohorts, it would imply that 22.5 percent of all new commitments to the BOP would be willing to voluntarily participate in drug abuse programs for the period described.

As the data from the above admissions cohort indicate, the problem of substance abuse within members of the incarcerated Federal offender population is substantial, and the motivation to participate in treatment appears to be at least moderately high. As such, what strategies have been put into place in order to facilitate treatment for the substance abusing offender while incarcerated?

Current BOP Strategy Initiatives

Chaiken (1989) noted that more than 50 percent of all inmates in the United States were routinely using illegal drugs prior to their last arrest but were not receiving treatment while incarcerated. The lack of effective treatment programs within correctional institutions and the reasons underlying this unavailability have been noted by a number of authors, perhaps most articulately by Gendreau and Ross (1987).

Clearly the need exists to develop new program efforts in correctional settings. Numerous studies have demonstrated that treatment is effective in reducing post-treatment drug use (Tims, 1981; Tims & Ludford, 1984; Wexler, Lipton, & Foster, 1985; Simpson, 1988; Hubbard, Rachal, Craddock, & Cavanaugh, 1988; Anglin & McGlothlin, 1988; BJA, 1988) and in lowering future criminal behavior following both prison-based and community-based programs (DeLeon, 1985; Gendreau & Ross, 1987; Anglin & McGlothlin, 1988; Simpson & Friend, 1988). These findings, and others involving long-term outcome studies of offenders who have received treatment while incarcerated, are among the forces which have imparted renewed emphasis on providing drug-impaired individuals expanded treatment opportunities within the BOP.

The comprehensive drug abuse treatment strategy of the Federal Bureau of Prisons calls for the development of a series of multi-tiered programs, involving interventions of progressive intensities and durations, for dealing with offenders with drug abuse problems. There is one level for the delivery of drug education services, three treatment levels, and one level of transitional services. The hierarchy is as follows:

1. Drug Education Program
2. Drug Abuse Counseling Services (Centralized)
3. Comprehensive Drug Abuse Programs (Residential)
4. Pilot Drug Abuse Programs (Residential/Research)
5. Transitional Services (Pre-Release/Community Aftercare)

A comparison of the elements of these five program tiers is provided below.

Drug Education Program

Drug Education is a mandatory program for inmates with a substance abuse history who meet the following criteria: a) all inmates for whom there is evidence in the presentence investigation that alcohol or other drug use contributed to the commission of the instant offense; b) individuals whose alcohol or other drug use was a reason for a violation of parole or probation supervision for which the subject is now incarcerated; and c) inmates for whom there is a court recommendation for drug programming. The program will also be available to volunteers; however, priority will be given to inmates with alcohol and other drug abuse histories. Participants will be required to complete a standardized course during their first 6 months of incarceration. The criteria for program completion include class attendance and a passing score on an objective standardized 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. Additionally, they will be ineligible for a halfway house placement and other community activities which are available to carefully screened individuals during the latter portions of their sentences.

The primary objectives of the course are 1) to promote an understanding as to how and why individuals abuse substances or become addicted; 2) to facilitate understanding of the effects that

continued abuse can have on one's health and life; 3) to assist the student in understanding the difficulties in the treatment of abuse; 4) to demonstrate that treatment can be successful; 5) to convey the understanding that programs are available while incarcerated and in the community; and 6) to develop a sense of trust and cohesion in small group settings that motivates a desire for further treatment for those who are in need of additional intervention.

The specific content of the course includes chapters on the following topics:

1. Overview of Drug Education Program
2. Models of Addiction
3. Explaining Addiction
4. A General Overview of Drugs and Drug Terminology
5. Alcohol and Other Sedatives
6. Narcotics
7. Cocaine (and Crack)
8. Stimulants Other Than Cocaine
9. Tobacco
10. Hallucinogens
11. Cannabis (Marijuana)
12. HIV Infection and AIDS
13. The Impact of Alcohol and Drug Abuse on the Family
14. Relapse Prevention

The text and materials were prepared in their entirety by psychologists from within the Bureau. Small groups will undergo the course from between 4-10 hours per week, at the institution's prerogative, until it is completed. Students who do not meet the mandatory criteria for successful completion will be given specific feedback regarding deficit areas and given an opportunity to remediate. A minimum score of 70 percent mastery on field tested exams is required to successfully complete the course. Both English and Spanish versions will be available, and all exemptions by reason of cognitive impairment or other disabilities will be provided by a mental health professional. A standardized certificate of completion will also be awarded to all who successfully complete the course.

Drug Abuse Counseling Services

Centralized Drug Abuse Counseling Services will be available to volunteers at all institutions at any time during their incarceration. These services will include individual counseling with a drug abuse treatment specialist or a psychologist, group therapy sessions on drug related topics, self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), stress management and personal development training, and vocational and pre-release planning. Some programs will have specific lengths and completion criteria, while others will allow inmates to participate in on-going therapy.

All individuals enrolled will have a treatment plan for the specific group or individual sessions in which they are involved, with the exception of self-help groups. These programs may be recommended, however, as a part of the individual's treatment needs, and participation monitored by treatment staff. The frequency and duration of each inmate's participation in centralized counseling services will be tracked using the BOP's computerized Psychological Data System.

The Drug Abuse Counseling Program is intended to provide maximum flexiblilty to the needs of the offender, particularly those individuals who have a relatively minor or low level of impairment from substance abuse. Such offenders often do not require the intensive levels of treatment required of individuals with moderate to severe addictive behavioral problems. However, a second very important purpose of the program is to provide those offenders who do have moderate to severe drug abuse problems with supportive program opportunities during the time period that they are waiting to participate in the highly structured residential programs. Additionally, supportive services will be offered to those individuals who have completed the residential programs but are waiting for release to the community.

Comprehensive Drug Abuse Treatment Programs

Comprehensive Drug Abuse Treatment Programs (residential programs) are in the process of being developed in a number of facilities throughout the Federal Bureau of Prisons. Currently, five units are operational, and plans call for the development of five additional units by the end of 1991. More are planned for 1992, with a goal of having approximately 29 treatment units, or analogous type programs, fully operational by the end of 1992.

Each unit is capable of handling between 100 and 125 offenders, during a 9-month program, yielding a comprehensive program treatment capability of approximately 3,600 offenders annually when all units are fully operational. Planning for

the projected growth in the population of substance abusing offenders beyond 1992 is ongoing at this time.

Inmates identified as in need of the program, and who volunteer, will be referred to an institution psychologist for assessment of drug abuse problems through a self-report survey, Inventory of Substance Use Patterns (ISUP) (Whittenberger, 1989) and a record review. Inmates with a moderate to severe substance abuse problem (DSM III-R) who meet the above criteria will be considered eligible for program assignment.

All Comprehensive Treatment Units will include the following components:

1. Unit-based programs
2. Treatment staff-to-inmate ratio of 1:24
3. Program participation of 9 months and 500 program hours minimum
4. Individualized treatment plans based on comprehensive assessment
5. A prerequisite of 40 hours of Drug Education
6. Between 3 and 4 hours of drug treatment programming per day
7. Comprehensive assessment
8. 280 hours of core group/individual treatment
9. 100 hours of wellness lifestyle training
10. 40 hours of transitional living issues
11. Full team reviews every 90 days
12. Treatment team review every 30 days
13. Increased frequency of random urinalysis surveillance

The group and individual treatment issues will focus on a variety of skills development issues, both cognitive and behavioral in nature. Criminal thinking confrontation and pro-social values development will be included whenever indicated. Family issues, vocational/educational issues, relapse prevention, self-help, personal development, and support groups will be a routine part of the individual's program.

The focus on the individual will hopefully assist in avoiding the "uniformity myth" (Donovan, 1988) that all addictions are the same. This belief is common to many traditional programs, both in prison and in the community. Indeed there are marked differences among addictions, in the mechanisms which underlie their development, maintenance, and, hence, potential for modification of the addictive behavior.

There are parallel differences among substance abusers in age, gender, socioeconomic background, family and social support resources, culture, ethnicity, personality, cognitive functioning, attributional styles, belief systems, and medical conditions. It is the heterogeneity of the substance abusing population, rather than its homogeneity, which is of increasing interest, both in the community (Lawson & Lawson, 1989) and in prison settings (Murray, 1990).

As such, it seems only prudent that drug abuse programs incorporate comprehensive assessments in these areas with the results integrated into individual treatment plans. This is not to say, however, that many drug impaired individuals do not have common needs, which can be effectively met in a group format. It seems, however, in reviewing the history of treatment programs, particularly in correctional settings, that there has been more interest in treating addictive behavior based upon pharmacologic classification (i.e., "alcoholics," "heroin addicts," cocaine or "crack" addicts) rather than according to variables which have a greater relationship to the development and maintenance of the behavior. With this in mind, it seems unremarkable that some programs from years past, and some contemporary ones, achieve the low to modest "success rates" that have in fact been reported.

The comprehensive residential programs will be based upon a biopsychosocial model of substance abuse. Treatment will include a strong relapse prevention emphasis. The goal of relapse prevention treatment is to provide individuals with the behavioral and cognitive skills necessary to cope effectively with high-risk situations (Marlatt & George, 1984; Marlatt & 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.

It is in this latter regard that a strong commitment to a rigorous wellness lifestyle schedule will be maintained and integrated into the community. Indeed, daily wellness program activities are expected of participants, in assisting them to modify their abusive and addictive lifestyles. This will be an interesting area of future research, in comparing the relative effectiveness of programs with and without wellness program components.

The offender is prepared throughout the program for release to the community, upon successful completion of the program, through a Commu-

nity Corrections Center (CCC) facility operated or contracted by the Bureau. A tremendous amount of readiness preparation, however, occurs during the last few months, particularly in the relapse prevention area. High risk situations are discussed, family issues, job issues, supervision concerns, and a specific relapse prevention plan is prepared for the individual. Individuals will have an opportunity to be gradually phased into the community over a period of up to 6 months, dependent upon a variety of factors related to the offender's criminal history, assessed risk to the community, institutional adjustment, program performance, and assessed need.

Pilot Drug Abuse Treatment Programs

Three Pilot Drug Abuse Treatment Programs are operational at Federal Correctional Institutions located in Butner, North Carolina; Tallahassee, Florida; and Lexington, Kentucky. The programs at Butner, North Carolina, and Tallahassee, Florida, serve male offenders, while the facility at Lexington, Kentucky, serves women offenders.

These pilot programs have a strong research emphasis and will involve larger investments of staff and fiscal resources. They will remain pilot programs until an outcome evaluation indicates whether the additional resources produce more positive post-release outcomes.

The pilot research programs are very similar to the comprehensive programs with the following exceptions:

1. Treatment staff-to-inmate ratios of 1:12
2. Program length of 12 months
3. 1,000 hours of treatment
4. Extended participation in outcome studies

While most pilot and comprehensive programs will be based on this biopsychosocial model, there will be some treatment differences among all of the programs. Some of the differences among the three pilot programs include:

1. The programs at FCI Tallahassee and FCI Butner will emphasize a social learning philosophy toward treatment, while the program at FCI Lexington will use the traditional AA/NA 12-step model.
2. 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).
3. FCI Tallahassee and FCI Lexington are both low security level institutions, thus the programs at these institutions will serve primarily low security level inmates. FCI Butner is an administrative facility, thus its program will serve inmates of all security levels.
4. FCI Lexington will serve female offenders only, FCI's Butner and Tallahassee, males only.

It is hoped that the research programs will provide additional information regarding factors related to treatment processes and outcomes which will enhance future treatment efforts.

Transitional Services (Community Re-entry Phase)

Transitional services will be provided after release from the prison environment to both comprehensive and pilot residential program participants that successfully complete the programs. Post-release services are critical to the maintenance of drug-free lifestyle changes facilitated by the programs while incarcerated. It is during the first 3 to 6 months that offenders are at greatest risk for relapse following treatment and in need of well-coordinated comprehensive support services. The transitional services delivery component will consist of two phases.

The first phase, pre-release 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 BOP staff. The second phase, aftercare services, will consist of 6 months during which community services are coordinated jointly with the Administrative Office of the United States Courts, Probation and Pretrial Services Division. Several recommendations for service delivery have been adopted for the transitional phase:

1. Individual and group counseling sessions for varying timeframes throughout the 12-month period, at least 20 hours monthly for the first 3 months.
2. Treatment focus on family, work adjustment, residential living issues, and relapse prevention planning (coping with high-risk events) through written assignments and group discussions.
3. Assistance in identifying and obtaining employment.
4. Random urinalysis occurring with decreasing

frequency over 12-month program duration.

5. Documentation of all contacts by all service providers who are certified or appropriately licensed.
6. Transitional Care coordinators in each facility who arrange and monitor service delivery.

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 post-release transitional services. These services will be contracted in a number of communities or operated directly by BOP personnel around the country in those locations where inmates from the pilot and comparison comprehensive programs are to be released. Program coordinators recognize that the success of institutional drug treatment programs is to a great extent dependent upon the availability of high quality transitional care programs in the community, which deal constructively with the problems faced by the drug offender upon release. To this end, substantial resources will be dedicated to this critically important program area.

Program Evaluation

The development of high quality treatment programs is a foreboding challenge in any setting, particularly within the realm of corrections. Similarly, the development of both process and outcome evaluation strategies for the treatment interventions delineated herein has required extensive planning as well. Not only are such evaluations of interest for purely academic reasons—high quality evaluations are required to instill credibility and accountability of program efforts. They are necessary and useful in answering many of the questions heretofore only partially explicated by previous program experiences.

In developing an evaluation plan for the current intervention strategy, the groundwork has been established for one of the most comprehensive, longitudinal evaluations ever conducted with correctional populations regarding the effectiveness of professionally managed drug treatment programs. This is reflected in the *Proposal for the Evaluation of the Federal Bureau of Prisons' Drug Abuse Treatment Programs* submitted to the National Institute on Drug Abuse (NIDA) in March 1990 (Federal Bureau of Prisons, Office of Research and Evaluation, 1990). The resultant interagency agreement has provided the mechanism through which important information concerning the effectiveness of institution-based drug programs will be made available in the months and years ahead.

References

Anglin, M.D. (1988) The efficacy of civil commitment in treating narcotic addiction. In C.G. Leukefeld and F.M. Tims (Eds.), *Compulsory treatment of drug abuse: Research and clinical practice*. (NIDA Research Monograph 86 DHHS Pub. No. (ADM) 88-1578). Washington, DC: U.S. Government Printing Office.

Anglin, M.D., & McGlothlin, W.H. (1988). Outcome of narcotic addict treatment in California. In F.M. Tims & J.P. Ludford (Eds.), *Drug abuse treatment evaluation: Strategies, progress, and prospects* (pp. 106-128). Washington, DC: Department of Health and Human Services, NIDA.

Ball, J., Rosen, L., Flueck, J.A., & Nurco, D. (1981). The criminality of heroin addicts: When addicted and when off opiates. In J.A. Inciardi (Ed.), *The drugs-crime connection* (pp. 39-65). Beverly Hills: Sage Publications.

Bureau of Justice Assistance. (1988). *Treatment alternatives to street crime: TASC programs*. Washington, DC: Author.

Chaiken, M.R. (1989). *In-prison programs for drug-involved offenders*. Washington, DC: U.S. Department of Justice, National Institute of Justice.

DeLeon, G. (1985). The therapeutic community: Status and evolution. *The International Journal of the Addictions, 20*, 823-844.

Donovan, D.M. (1988). Assessment of addictive behaviors: Implications of an emerging biopsychosocial model. In D.M. Donovan & G.A. Marlatt (Eds.), *Assessment of addictive behaviors*. New York: Guilford Press.

Gendreau, P., & Ross, R.R. (1987). Revivification of rehabilitation: Evidence from the 1980's. *Justice Quarterly, 4*(3), 349-407.

Hubbard, R.L., Rachal, J.V., Craddock, S.G., & Cavanaugh, E.R. (1988). Treatment outcome prospective study (TCPS): Client characteristics and behaviors before, during, and after treatment. In F.M. Tims and J.P. Ludford (Eds.), *Drug abuse treatment evaluation: Strategies, progress, and prospects*. Washington, DC: Department of Health and Human Services, NIDA.

Innes, C.A. (1988). *State prison inmate survey, 1986: Drug use and crime*. Washington, DC: U.S. DOJ, BJS.

Lawson, G.W., & Lawson, A.W. (1989). *Alcoholism and substance abuse in special populations*. Rockville, MD: Aspen Publishers.

Lipton, D.S., & Wexler, H.K. (1988). *Reducing recidivism is goal of prison drug treatment program. Reform*, Vol. 1, No.1. New York, NY.: Narcotic & Drug Research, Inc.

Marlatt, G.A., & Gordon, J.R. (1980). Determinants of relapse: Implications for the maintenance of behavior change. In P.O. Davidson and S.M. Davidson (Eds.), *Behavioral medicine: Changing health lifestyles* (pp. 410-452). Elmsford, NY: Pergamon.

Marlatt, G.A., & Gordon, J.R. (Eds.). (1985). *Relapse prevention: Maintenance strategies in addictive behavior change*. New York, NY: Guilford.

Marlatt, G.A., & George, W.H. (1984). Relapse prevention: Introduction and overview of the model. *The Journal of Addiction, 79*, 261-273.

National Institute of Justice. (1989). *NIJ Research in Action: Drug Use Forecasting Update* (NIJ Reports). Washington, DC: Author.

Nurco, D.N., Ball, J.C., Shaffer, J.W., & Hanlon, T.E. (1985). The criminality of narcotic addicts. *The Journal of Nervous and Mental Disease, 173*(2), 94-102.

Simpson, D.D. (1988). National treatment system evaluation based on the Drug Abuse Reporting Program (DARP) follow-up research. In F.M. Timms & J.P Ludford, *Drug abuse treatment evaluation: Strategies, progress, and prospects*

(NIDA Research Monograph 51 DHHS Pub.No. (ADM)88-1329). Washington, DC: U.S. Government Printing Office.

Simpson, D.D., & Friend, H.J. (1988). Legal status and long-term outcomes for addicts in the DARP followup project. In C.G. Leukefeld and F.M. Tims (Eds.), *Compulsory treatment of drug abuse: Research and clinical practice* (NIDA Research Monograph 86 DHHS Pub.No. (ADM)88-1578). Washington, DC: U.S. Government Printing Office.

Tims, F.M. (1981). *Effectiveness of drug abuse treatment programs.* (National Institute on Drug Abuse Treatment Research Report. DHHS Pub.No. (ADM)84-1143). Washington, DC: U.S. Government Printing Office).

Tims, F.M., & Ludford, J. (1984). *Drug abuse treatment evaluation: Strategies, progress, and prospects.* (National Institute on Drug Abuse Research Monograph 51. DHHS Pub.No. (ADM)84-1329). Washington, DC: U.S. Government Printing Office.

Wallace, S., Pelissier, B., McCarthy, D., & Murray, D. (1990). Beyond "nothing works": Drug abuse treatment programs in the Federal Bureau of Prisons. *Federal Bureau of Prisons Journal, 1*(4), 23-26.

Wexler, H.K., Falkin, A., & Lipton, D.S. (1988). *A model prison rehabilitation program: An evaluation of the Stay N' Out therapeutic community.* National Institute of Drug Abuse, Narcotic and Drug Research, Inc.

Wexler, H.K., Lipton, D.S., & Foster, K. (1985). Outcome evaluation of a prison therapeutic community for substance abuse treatment: Preliminary results. Paper presented at the American Society of Criminology Annual Meeting, San Diego, CA.