ATWOOD PROGRAM, LEXINGTON FEDERAL MEDICAL CENTER

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INTRODUCTION

This document reports findings on the Atwood Program, a residential treatment program for women inmates at the Federal Medical Center at Lexington, Kentucky. The report is based on interviews with personnel at the program and materials provided by program staff and the Bureau of Prisons. All the information provided here is based on these interviews and documents alone, no attempt was made to verify (from other sources) anything that was said or provided as documentation. Because part of the data is based on interviews, from time to time in the discussion, what was said has been quoted or paraphrased so as to convey the flavor of the comments.

The Federal Prison System

According to an article by Donald W. Murray ("New Initiatives in Drug Treatment in the Federal Bureau of Prisons," *Federal Probation*, June 1991, pp. 35-41), the Federal Bureau of Prisons (BOP) has experienced a rapid increase in population. There were more than 60,500 individuals incarcerated in over 60 federal facilities throughout the country as of March 1, 1991. By 1995 it is projected that the offender population will reach 95,000, 69% of whom will be incarcerated for drug crimes (Bureau of Prisons, *State of the Bureau*, 1991, p. 5). The systemwide overcrowding rate was at 148 percent at the end of 1990 (*ibid*). There are six Federal Institutions for women. Of these, Lexington is the only Medical Center Facility.

Drug-Crime Indicators

New female commitments demonstrated a higher level of substance dependence (37.1%) than new male commitments (30.2%) (Murray, *op. cit.*). A BOP report (*op. cit.*) characterizes addiction as a "multiplier" of crime. "While criminality often occurs prior to addiction, the onset of addiction results in increased criminality" (p. 5).

Approximately 51% of all offenders were serving time for drug offenses (Murray, *op. cit.*). In 1990, an admissions cohort assessment of 1,165 offenders from more than 90% of all BOP facilities. The report revealed that in the 6-month period immediately preceding their arrest for their current offense. 51.7% met the criteria for a diagnosis of either Psychoactive Substance Abuse (20.9%) or Psychoactive Substance Dependence (30.8%).

Differences in ethnic groups and overall substance abuse rate (based on this cohort) revealed the following percentages: Native Americans, 78.9%; Hispanics, 60.2%; Blacks, 54.3%; Whites, 49.3%; and Asians, 11.1% (Murray, *op. cit.*). "The data have...indicated that the need for treatment is significantly greater among members of different special offender populations--particularly Native Americans, Hispanics, Blacks, and females" (Murray).

The Prison Treatment System

According to an Operations Memorandum (June 16, 1992, # 128-92) the BOP has been providing treatment services to offenders with drug abuse problems over the past quarter century. The Federal Bureau of Prisons (BOP) developed a series of multi-tiered programs, involving interventions of progressive intensities and durations. These, arranged hierarchically,

are: (1) Drug Education; (2) Drug Abuse Counseling; (3) Comprehensive Residential Drug Abuse Programs; (4) Pilot (Residential/ Research) Drug Abuse Programs; and (5) Transitional, Pre-release/Community Aftercare Services (Murray, *op. cit.*).

Drug Education is open to all inmates but is mandatory for most inmates with a substance abuse history and is generally to be completed during their first 6-12 months of incarceration. It is used to educate inmates about substance abuse and motivate them to pursue more intensive drug abuse programming. Topics covered include: motivation for drug use; development of habits of drug/alcohol use; effects of various drugs on the body and mind; and, the negative consequences of abuse. The program uses lectures, discussions, printed information and videotapes. Inmates who are required to complete the program but fail to do so experience sanctions. These may include restriction to the lowest inmate pay grade and ineligibility for a halfway house placement and other community activities available to others.

Drug Abuse Treatment Counseling is available to any inmate who volunteers for services at any institution on an "outpatient" basis. Services include individual counseling, group therapy, self-help groups, stress management, personal development training and vocational and pre-release planning. This service also may act: (1) as a "holding pattern" until an inmate can get into a more structured program; (2) as aftercare for those who have completed residential treatment (in the institution); or (3) as the entire treatment regimen for inmates with low impairment levels and/or short sentences.

Comprehensive Residential Drug Abuse Treatment Programs are one of the only two types of residential treatment programs in the federal prison system. The other type is the Pilot Program, described later. Comprehensive Residential Treatment Programs are unit-based programs that have a treatment staff-to-inmate ratio of 1:24. Each program requires/provides: (1) program participation of 9 months and 500 program hours minimum; (2) individualized treatment plans based on comprehensive assessment; (3) a prerequisite of 40 hours of Drug Education; (4) between 3 and 4 hours of drug treatment programming per day; (5) comprehensive assessment; (6) 280 hours of core group/individual treatment; (7) 100 hours of wellness lifestyle training; (8) 40 hours on transitional living issues; (9) full team reviews every 90 days; (10) treatment team review every 30 days; and (11) increased frequency of random urinalysis surveillance. Each unit handles between 100 and 125 offenders during a 9-month program (Murray, *op. cit.*, p. 38). There are at least 15 such facilities in operation at this time and, by the end of FY 1993, 31 facilities will be established (Hayes and Schimmel, p. 63).[1] The Comprehensive Units for women are in Pleasanton, California; Bryan, Texas; Alderson, West Virginia; and Danbury, Connecticut.

Pilot (Residential/Research) Drug Abuse Treatment Programs are operational at Federal Correctional Institutions located in Butner, North Carolina; Tallahassee, Florida; and Lexington, Kentucky. The only Pilot program for women offenders is in Lexington and it is housed in the Atwood Hall living unit. These programs are considered research programs as part of a National Institute of Drug Abuse (NIDA) evaluation and, as a result, have a strong research emphasis. They will remain pilot programs until an outcome evaluation indicates whether the

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[1]Hayes, T.J., and Schimmel, D.J. "Residential Drug Abuse Treatment in the Federal Bureau of Prisons," *Journal of Drug Issues, 23*(1), 61-73.

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. Also, a social learning philosophy (at FCI Tallahassee and Butner) and a traditional AA/NA 12-step model (FCI Lexington) is added to the biopsychosocial model designed for all Comprehensive Programs.

Transitional Services (Community Re-entry Phase) are required after release from the prison environment for completers of the comprehensive and pilot residential programs. Elements include: (1) the transfer of information between systems; (2) continuous and substantial inmate supervision; and, (3) continued treatment. There are four options for transitional services: (1) return to general population; (2) transfer to a Community Corrections Center; (3) release to supervised release or parole; or, (4) release with no continued criminal justice supervision. Service delivery through the transitional phase includes individual and group counseling, treatment focus on family, work adjustment, residential living issues, relapse prevention planning, employment assistance, random urinalysis and documentation and monitoring of service delivery. (See also, Pre-Release and Aftercare" section in the narrative, below).

ATWOOD: OVERVIEW AND HISTORY

Generally, an inmate is designated to the closest of the four Federal prison treatment facilities for women. At times a judge may specifically request the Atwood program in Lexington. In that case, the decision to place an inmate at the facility is still up to the Bureau of Prisons. According to program staff, the Lexington Institution is now the largest of the Bureau of Prison's female facilities with 2006 female inmates. The typical length of stay in the institution is 6 years.

Staffing. The Atwood program structure has two tracks of staff deployment: unit staff (corrections), which includes a unit manager, 2 case managers, 2 correctional counselors, 1 unit secretary, and 1 correctional officer; and treatment staff, which includes the program director, 7 treatment specialists, 1 psychologist, and 3 graduate students. Unit staff are responsible for institutional paperwork, liaison with other institutional units/services. Clerical needs of treatment staff are shared among the treatment specialists and the unit secretary.

Locale. The Drug Abuse Program is located on the first two (of three) floors and the basement of Atwood Hall, a 206 bed unit of the Lexington Facility. The two units are described as being "completely isolated" (from the third floor). "Inmates from the general housing section [on the third floor] have restricted access to the drug treatment program at its facilities" (Orientation Handbook) Some graduates from the Atwood Treatment Program may also reside on the third floor.

Clients. The program received its first clients in August of 1989. Program capacity is 86 inmates and there are no plans to expand the treatment program beyond the 86 bed-capacity at this time. In July 1993, of the 81 women in the program: 39 were Caucasian, 40 were Black, 1 was American Indian, and 1 was Asian. Six of the Black or Caucasian participants also identified themselves as Hispanic. The average age of the participants is 33, with a general

range of between 19 and 50 years of age. A little more than half have not completed high school.

Client Drug-Crime History. Program staff estimate that approximately 70% of the Atwood inmates are in prison due to drug related crimes, i.e., conspiracy, transporting drugs across state lines, being an accessory, or drug distribution charges. About 30% of the Atwood inmates are not U.S. citizens. According to staff, about 92% have no history of being perpetrators of violence. In comparison to the other Lexington inmates, Atwood inmates are older and more are polydrug users. Many Atwood program participants were addicted at a young age. Drugs of choice include crack and powder cocaine, marijuana and methamphetamine.

PHILOSOPHY, GOALS AND OBJECTIVES

The philosophy of Atwood is based on the firm belief that drug addicts can make meaningful changes in order to live drug-free and productive lives among other members of society. The goal is abstinence from all mood-altering drugs including alcohol.

To implement its philosophy, the program staff characterize the Atwood program as a modified therapeutic community or residential community. The program combines cognitive behavioral training, intervention, 12-step, peer support, Rational Emotive Therapy, and Rational Behavioral Therapy. Criminal thinking, attitude formation, relapse prevention, and lifestyle changes are addressed through these processes.

The Atwood program differs from traditional therapeutic communities in that it does not use intensive encounter groups or "hot seat" techniques designed to "tear down" a person's defenses (*Orientation Handbook*).

OUTREACH, REFERRAL, AND SCREENING PROCESS

Institutional staff are made aware of the program through presentations at case manager and unit manager meetings. Staff are also made aware as part of the "institution familiarization" that take place for new staff or annual training that everyone receives. The BOP sends out brochures and video tapes to judges and other criminal justice officials informing them of the program at Atwood. All new inmates to Lexington are screened for drug abuse problems. During their initial admission, orientation, and unit team meetings they are informed by staff, video tapes and an application for drug programming is made available to them. Also, program staff say that it is the inmates themselves that really sell the program to other inmates.

Screening and Eligibility Requirements

The program is voluntary. Candidates may self refer or be referred by institutional staff, judges and from the institutional drug education program. If a person is incarcerated for a drug-related crime or violation of probation/parole due to drugs, she is automatically referred to the program. Inmates must have at least 18 months to serve for the 12-month program and at least

12 months for the 6-month program since 6 months of aftercare is a mandatory part of the program. Additionally, there must be no other legal/criminal cases pending.

Program staff indicate that they have a "lot of discretion" in accepting clients. Other than having a minimum length of stay, there are few reasons that a candidate would be screened out. History of violence (pre-institutional placement) does not disqualify the candidate. However, if the inmate has a history of violent behavior while in the institution or is the "terror" of her current living unit, she probably would not be accepted until she could show that she had been violence-free for at least six months.

A history of mental illness is not necessarily a criterion for exclusion. Dual diagnosis (mental health and chemical dependency) clients are taken if they are stabilized. Certain diagnoses/histories preclude admission including having a "thought disorder" and/or a history of psychotic breaks. Also, participants must be able to read, write, and speak English fluently.

In rare instances, participants may be on psychoactive medicine while in the unit. The participant would not be continued with her institutional psychologist or therapist, but would continue to see the psychiatrist as needed for monitoring of medications.

Assessment and Intake Procedures

Upon admission to the facility, one of two screening instruments are used to rate each inmate: the Substance Abuse Signs Checklist (SASC) or the Drug Use Review/Referral Form. Based on the findings of the screening, the severity rating, motivation of the inmate and various logistical factors Drug Abuse Treatment Program staff will recommend appropriate drug abuse programming to the inmate. If considered for residential treatment, an Eligibility Checklist for Applicants to Residential Drug Abuse Treatment Programs is completed.

The structured interview form used is called "DATAR," and was developed by Texas Christian University. It includes a detailed drug, alcohol, and family background. The Bureau is convening a work group to change the assessment tool to a more streamlined intake procedure.

Motivation to participate is taken into consideration. In fact, according to a BOP Operations Memorandum, a "Motivational Program" to increase inmate motivation for treatment is required at each Pilot Program facility and at some Comprehensive Treatment Programs. The goal of this program is to "increase the interest of the inmate who has a moderate to severe substance abuse problem, but has been resistant to volunteering for the program." This is a 4-hour program consists of a video series entitled "Steps to Freedom," an inmate handout and an instructor's guide. The program is offered every six months to groups not exceeding 25 participants at a time (Ops Memo *op. cit.*).

After the screening and assessment process is completed, a "Staff Response to Application to Drug Programming in the Federal Bureau of Prisons" informs the candidate of the decision regarding placement. If the inmate agrees to enroll in the Atwood Program, she completes and "Agreement for Participation" which describes the four phases of the program, explains staff responsibilities, the requirements for inmate participation and consequences for non-compliance.

The program is set up on a quarterly phase system, each quarter one phase is completed. Inmates are allowed to enter the program at the beginning of a new quarter only. A waiting list

is maintained until the new phase opens up. Approximately 20-28 new slots open up each quarter.

As part of the treatment planning process and for research purposes, continued client assessment goes on the first seven months of the program. During Phase I of the treatment regimen, other assessment instruments are administered. The core battery includes the following scales: Shipley Institute of Living Scale; Inventory of Substance Use Patterns; Substance Abuse Signs Checklist; Millon Clinical Multiaxial Inventory; Interpersonal Behavior Survey; Inventory of Drug Taking Situations; Drug Taking Confidence Questionnaire; Family Environment Scale; and, the Personalized Aerobics Lifestyle System.[2] Staff indicate that it is really the daily interaction with other clients, instead of the assessment tests, that provides the best assessment of the client's ongoing progress.

Priority admission is given to inmates with the most serious drug abuse problems. Also, those with court-recommended program involvement, and those nearing the time of their release to the community who desire treatment will be given priority.

According to program staff, the Bureau has given to this program. "The warden wants the program to run well." Staff feel they "have the money and support to keep the program running." For these reasons, there are few perceived barriers to eligible clients being admitted. The general exception is when it comes to competing interests. A woman may have to choose between the Atwood program and other activities such as taking college classes or working in prison industries. The Atwood program structure is such that a woman may be able to hold a job in the morning hours, since program activities don't start until 1 PM also, depending upon treatment progress, clients may be allowed to participate in off-unit activities if it doesn't conflict with their treatment program.

Staff identified the following institutional barriers to admission: lack of support among institutional case management staff on campus; units not wanting to give up good workers; resentment of Atwood's political visibility, its greater funding and support "from the Attorney General on down"; and the belief held by many custody staff that "you can't change people and that prisons are here solely to lock people up."

Barriers relating to client decision making are generally related to the inmates being comfortable where they are (in other units). If they entered Atwood they would have to give up their inmate lovers, lose a possibly favorable case manager, and lose seniority in housing. Other units may have single or double-occupancy rooms. In Atwood, there were 6 to 7 women in some rooms. There are lots of activities. The participants' lives are scrutinized.

SERVICES PROVIDED

The general Lexington population (including Atwood) may access the following services: primary medical care, acute care, postpartum care, medical examinations, HIV/AIDS testing and counseling, TB testing, medical detoxification, academic services, individual and group

[2] As of October 15, 1993, only the Shipley Institute of Living Scale and the Millon Clinical Multiaxial Inventory are being used.

psychotherapy, job training and placement, vocational rehabilitation, legal services (through Legal Aid), and peer and 12-step support groups (such as survivors of sex abuse, spouse abuse). These services are provided by prison staff or through contracts with local facilities (such as hospitals).

Variety of Services/Programming Offered

Individuals within the Atwood program receive 20 hours per week of program activities or an average of 1000 hours per program year. Services are generally focused on weekdays, with fewer structured activities on the weekends. Atwood services include: psychoeducation, drug education, individual and group therapy, substance abuse counseling, and case management services. Participants engage in physical fitness activities, self-help groups, and other groups focusing on interpersonal skill development and self-understanding.

Group focus. Program staff indicate that treatment is focused on the group setting. Because participants are seen as having dependent personalities, dealing with them individually may reinforce their sense of isolation (versus reaching out) and they may be able to mask more of their interpersonal issues. Also, it is good to set limits on the amount of individual time spent with an inmate. This helps them in learning to wait, negotiate time commitments and be humble enough to share their problems at group level. The inmates learn to use the group to get their counseling needs met.

Group activities may focus on a variety of topics or be targeted to a special subsection of clients. Groups including parenting, anger management, childhood abuse survivors, communication, lifestyle changes, sexuality and intimacy, vocational rehabilitation, wellness, and other substance abuse recovery issues.

Case management. Within the Atwood program, the unit staff and program staff share in participant's case management services. If it is a drug-related issue, the program staff perform the case management activities (monitoring, follow-up , client advocacy, coordination of appointments and services). If it is not drug-related, the custody staff handle the case management.

Social activities such as picnics on the grounds, sobriety birthdays and program anniversaries are enjoyed by program participants. Once yearly, there is a family day during which inmates' children come on the grounds and participate in recreational and social activities.

Treatment Planning

The primary drug treatment specialist develops the plan within a few weeks of the inmate's admission to Atwood. As part of the treatment plan, clients complete and sign a "Goal Statement for Participants in Drug Abuse Treatment Programs." One statement is completed for each goal. Generally participants list 10 goals they wish to accomplish.

Client involvement in choosing their treatment regimen is minimal at the beginning. Staff say that if inmates were left to choose what they could do, it is perceived they would try to avoid the "hard stuff."

Treatment plans are reviewed and may be revised through both formal and informal processes. At informal weekly case conferences, all counseling staff talk about their caseloads

and suggestions for treatment plan changes may result from input from one or more of the counselors. Currently, there is also a formal review of plans at the intake and discharge stages. This review is done by the Program Director at the intake and discharge stages. A future goals is for each plan to be reviewed every 30 days by the Program Director.

Most clients get the same treatment regimen in terms of group participation. There are three groups that not everyone attends: the sexual abuse group, the Saturday group for "higher functioning" participants, and an eating disorders group. Participation in both groups is determined by staff.

Treatment is individualized by applying therapeutic community processes. An individual's issues are brought up and dealt with on the community level. For instance, if someone has a problem with anger, they are going to be called on it in the community.

Program Content

The program is divided into four phases which last three months each. The First Phase is called the "Orientation" phase, the second is the "Psychoeducational" phase where Rational Behavioral Training and other concepts concerning criminal thinking are addressed. Phase Three is "Social Skills Training" and Phase Four is the "Transitional Phase." Within each Phase, 12-step work is done and lifeskills are taught and applied.

Phase One includes the administration of several assessment instruments. A brief introduction to the therapeutic process, discussion of the limits of confidentiality, treatment staff roles and the role of feedback from other inmates is explained. The client is assigned a primary counselor and given her group activity assignments. Denial, the effects of substance abuse on one's life, the 12-step philosophy, understanding of powerlessness, and the belief that things can change are elements of this phase. The primary counselor and Phase I participant begin to develop the individual treatment plan.

Phase Two includes a 40-hour module on criminal lifestyle. The "three Cs" of criminal causation are discussed: conditions, cognition, and choices. The focus is on identifying and correcting critical thinking errors. The issue of personal responsibility and choice is stressed repeatedly.

Phase Three includes about 60 hours devoted to the development of improved relationship skills. Communication and interpersonal skills are integrated with topics such as diversity, anger management and negotiation skills. Issues of guilt, shame and fear are examined and the inmate's own history of past and present relationships is explored.

Phase Four focuses on relapse prevention. Relapse is seen as a process, not an event. Practice of positive relapse prevention skills is part of this phase. Re-orientation to society, aftercare planning, clarification of post-release expectations and the development of a support system are addressed.

Activities generally occur between 1 and 4 PM on weekdays with additional hours in the evening. A weekly schedule would include small groups (phase, caseload, or special topic groups), AA/NA Big Book studies, "Straight Talk" (a client-led group), wellness activities (including weight training, aerobics, and nutrition topics), community meeting, communications or lifestyle changes meetings, and mandatory AA/NA meetings. (Overeaters Anonymous can substitute for one meeting, with permission).

Participants must also engage in some type of individual athletic/aerobic activity for at least 2 hours per week. An evening relapse prevention group is provided once weekly for those in the final phase of the program.

On Saturdays, there is a one hour "community group" and a mandatory NA meeting, and participants are expected to complete "homework" assignments. There is also a Recovery Discussion group on Saturdays for "high functioning" participants (generally clients who are further along in recovery).

Activities are mainly provided in a small group setting of from 10-12 people. Psychoeducation is conducted with 20-35 people. Community meetings and Straight Talk is conducted in a large group comprised of all program participants. Unit staff call a "Town Hall" meeting once a month and once a month there is a structured community (social) activity.

Communication and Linkages with CJS Providers and Others

Staff feel that the level and quality of communications within the institution is varied. Linkages with psychiatric staff are maintained to monitor the few participants who are taking medications. Generally, no psychotherapy is provided by institutional staff while an inmate is in the program. This reduces the possibility of "splitting" (pitting one therapeutic regime/therapist against another).

Staff state that the quality of interaction depends on the individual psychiatrist (there are three on campus). The program also maintains linkages with physicians who may be treating a client.

Linkages with the vocational and educational services on campus are informal and referrals are made to the career resource center. All inmates have access to these resources, so it is basically a matter of the inmate making the connection. If they have trouble, if they are on a waiting list for a service, or if the system prevents the client from obtaining services, then the Atwood staff will intervene.

The Religious Services Department on the main campus is involved with the Atwood clients. For instance, inmates experienced Native American Sweat Lodges coordinated by Religious Services.

Every six months the custody and Atwood treatment staff case management teams meet collectively. This includes the education component and other components that may interface with the clients. Otherwise, all the systems are generally independent.

The program leverages resources by being a site for predoctoral psychology interns. At times, there may be one or more student interns that support the work of the staff by providing group and individual counseling, leading discussion groups or performing support functions (showing videos, for example).

The Prison Community Relations Board, an advisory board to the warden, assists in the scheduling of outside speakers, coordinates projects on units, such as making toys for shelters and organizing a recycling drive. Within the Wellness component of the program, outside speakers present programs on such topics as AIDS, physical fitness, domestic violence, codependency, sexual abuse and meditation. These are provided to the entire unit at one time.

The "Hospitals and Institutions" section of the local AA community hosts AA meetings in the prison. Staff also credit the local AA community with being very supportive of inmates

upon release. They keep in touch with the parolees and have been known to assist them in obtaining jobs.

Parole officers visit all the units to talk about what to expect upon discharge in terms of parole requirements. Otherwise, there is not much contact with parole prior to discharge.

Pre-release and Aftercare Activities

According to Murray's article, a tremendous amount of readiness preparation occurs during the last few months (Phase 4), particularly in the relapse prevention area. High-risk situations including family issues, job issues, and supervision concerns are discussed. Also, a specific relapse prevention plan is prepared for the individual. According to Hayes and Schimmel (*op. cit.*), the majority of inmates completing the residential programs have time remaining on their sentences and so there is a focus on both post-program community reintegration and adjustment back to the general institutional population. Institutional aftercare services "help to keep the inmate focused on a healthy lifestyle and the self-change process" (p. 71).

When an inmate is to be released from the Atwood program, program staff give unit case managers written documentation regarding the course of her treatment, family issues, strengths and weaknesses and what she needs in terms of post-program needs and/or community (post-discharge) services. The documentation is forwarded to the Transitional Services Manager in each Region and the probation office in that jurisdiction (if pending release from the institution). This documentation includes a case closure summary and a relapse prevention plan.

This treatment summary is to be received by the Transitional Services Staff 30 days prior to program completion. Additional information is logged and transmitted by unit staff. Completion information is documented in the inmate's file and entered into the institution's data base management system (SENTRY).

Actual release procedures are handled by unit staff. The Transitional Services Department of the Bureau of Prisons and parole departments are responsible for all post-program discharge services. This staff performs different functions depending upon whether the graduate is to remain in an institutional setting or be released to the community (either to a Community Corrections Center (CCC), under supervised release, or with a "no hold").

Release to an Institution

Once completing the twelve-month program, some inmates stay on the unit (or in the building facility) as "post-phasers." These individuals may participate in group activities, attend 12-step activities and act as mentors to program participants. Many of the "post-phasers" live in other parts of the institution, but may return for some activities.

If released to another institution, the Drug Abuse Treatment Specialist (correction staff) at the institution admitting the successful inmate will make contact with her no later than 15 days after her arrival. The graduate must have continued individual and/or group counseling at least one hour per month and at least 25 hours of transition programming within the last four months prior to her release from the institution.

Released from the Institution

Transitional Services contacts the regional offices and parole agents in the region as well as any contract agency (such as a half-way house) as part of the pre-release planning process. Information about the inmate is released to the Regional Transitional Services Manager (of the inmate's release locale) 90 days prior to release.

During this post-discharge phase, the individual's parole officer would assist her in identifying and accessing aftercare services. (Atwood staff may allow clients to make phone calls to hook up with recovery houses. But no one goes directly to a recovery house; they must first go to a federally contracted half-way (community corrections, or "CCC") facility.

With the exception of individuals who have a history of violence, virtually everyone who is a program completer is discharged to a half-way (community correction) facility initially. Program completers get priority admissions.

If treatment is stipulated via the court or parole board, structured and supervised treatment and drug testing is arranged in addition to other CCC or parole/probation supervision responsibilities. CCC residents must complete from one to four hours of community-based treatment each week, undergo supplementary drug testing and a Treatment Planning Assessment.

Within 15 days of the inmate's arrival at the CCC, a drug treatment program planning conference is held. Participants in this conference include the community-based drug counselor (who may or may not be CCC staff), the resident, and appropriate contractor (CCC) staff. At that time, written plans for drug aftercare counseling are developed, discussed and agreed to. If released to the CCC under Probation supervision, the U.S. Probation Office (USPO) will be notified and invited to attend the CCC meeting. A written summary of the meeting is also provided to the USPO.

An inmate may be released under Parole supervision and a court stipulation for continued treatment does not exist. In that case, the Drug Abuse Treatment Specialist in coordination with the Institutional Unit Team may attempt to seek out such a stipulation if it is determined to be necessary (based on assessment of the inmates continued treatment needs).

If released under no continued criminal justice supervision, referral to treatment in the jurisdiction of release is made. Transitional Services in the Region is made aware of the referrals made.

COMPLIANCE ISSUES

The inmate Orientation Handbook gives examples of rule-breaking behavior and possible sanctions such as:

Rule Broken	**Sanction**
Not following procedures for missing group.	Incident Report
Tardiness to group	5 or more hours extra duty, loss of quarterly incentive pay
Missing a group or failing to get permission ahead of time	10 hours extra duty, incident report, loss of quarterly incentive pay
Tardiness and unexcused absences	Reduce the amount of monetary incentives inmates receive at the end of phases
Physical fighting/sexual misconduct	Program termination
Unwilling to commit herself to recovery	" "
Positive Urine Tests	" "

Also, inmates must follow the same rules for inmate discipline as the general population. Also, such behavior will be viewed by the unit staff in terms of the inmate's commitment to treatment. Behaviors that threaten the physical safety of inmates or staff are not tolerated and will cause an inmate to be immediately terminated from treatment. The breaking of any institution rule results in an incident report, possible referral to and sanction by the DHO, and loss of quarterly incentive pay.

Graduated Sanctions. Besides formal sanctions, there is some withholding or granting of privileges. For instance, inmates may be restricted from using the kitchen or watching TV.

If "someone is sliding," there are escalating means to confront her. First the issues is taken up with the primary counselor. Then it goes to the treatment team. The issue may also be brought to the community (by community members) and addressed in the "Straight Talk" component. Some sanctions may include being assigned lower level jobs. A behavioral contract may be written during any of these stages.

Program staff report a fairly low "expulsion rate" with only 5 or 6 out of the annual 84 clients being removed. There are "very few" graduated sanctions even though behavioral

contracts are written. They either "stay" or are "out." The only absolute criterion for dismissal is the violation of a behavioral contract. This includes disobeying program rules about sex, fights, and positive UAs. Once expelled, the woman may be able to return to the program. It depends on how long she has to serve and other factors. One person was expelled because she would not cease playing cards and had been counseled against this. The staff try to curb the inmates' "want-what-I-want-when-I-want-it" compulsions.

Voluntary terminations. Inmates may request to leave the program voluntarily. She must first discuss her reasons for leaving with her primary therapist, her small group and the community in Straight Talk group. Orientation materials state, "withdrawal from Atwood will not be used to prejudice any decision regarding [a request for transfer]" (p. 10). According to the BOP Operations Memorandum previously cited, voluntary withdrawal from a program (or disruptive behaviors leading to expulsion) is to be discouraged. Staff are to "discourage the breaking of long-term commitments and short-sighted thinking, which are often typical of substance abusing individuals" (p. 24).

Consequences for inmates who withdraw or are expelled from the program prior to completion include: (1) removal from the program unit; (2) incentives received earlier in the program are confiscated; and (3) the inmate is denied readmittance until she has stayed out for the same period of time that was spent in the program (Ops Memo, *op. cit.*, p. 24).

PROGRAM ACCOUNTABILITY

Inmate and program development progress is monitored through a systematic data management system called SENTRY. SENTRY maintains both current and historical records of inmate Drug Abuse Program participation. The Unit Team and Drug Abuse Program staff are responsible for entries into this system. Records are kept of assessment, referral and course of treatment as well as transition activities including progress in community-based treatment and/or the CCC.

Documentation forms may include: Record of Participation in Drug Abuse Treatment Programs; Chronological Record of Contacts; Withdrawal from a Drug Abuse Treatment Program; Expulsion from a Drug Abuse Treatment Program; Certificates of Completion; Summary of results of the Standardized Assessment Battery; Termination Summary; Treatment Summary; and Release of Confidential Information Consent Form for Transitional Services. Records of participant activity are made through inmate sign-in sheets (for group activities), an activity card that must be signed off by staff (for individual assignments) and counselors notes.

Program staff were asked if there was any checks and balances on how long someone stayed in the program. The response was that the program is funded for 84 inmates every 12 months. There are no provisions for inmates staying on longer. However, inmates are encouraged to stay on as "post phasers."

The program is the subject of a two-year NIDA study, but program staff report they have had no access to any reports or data from this study (to date). Researchers sit in on groups and come to the program periodically. A research article about the BOP programs (Murray, *op. cit.*) characterizes the NIDA study as setting the groundwork for "one of the most comprehensive,

longitudinal evaluations ever conducted with correctional populations regarding the effectiveness of professionally managed drug treatment programs" (p. 40).

The NIDA research plan incorporates process and outcome evaluations as well as a cost-benefit analysis. Specifics to be addressed include: the types of offenders most likely to volunteer for programs, if particular offender types seem to benefit more, whether longer-duration (pilot) programs are more effective than shorter-duration (comprehensive) programs, whether residential or non-residential programs are more effective, the role that transitional services play in preventing recidivism and relapse and the relative effects of pre-treatment characteristics, the treatment program, and the post-release environment on participant treatment outcomes.

Staff describe a "treatment success" as someone who does not use again and is not coming back to prison (versus a chronic relapser). She is not in an abusive relationship, is financially independent, is a responsible mother, and is giving back to the community.

SUMMARY

The discussion below will include items central to the study that have not been detailed earlier in the report. These include: sensitivity to gender issues in providing services; the use of recovering staff as role models; diversity issues; and the incorporation of peer support as part of the program. The final selection summarizes the program's stated strengths and weaknesses and areas for improvement.

Sensitivity to Gender Issues

Staff acknowledged the criminal orientation of these individuals, but questioned the perception that there are "special needs of women" versus "special needs of men." It is believed that men have most of the same issues, but they are just not as close to the surface as they may be for women. Topics particular to women may be issues regarding sexuality, intimacy, sexual abuse, and eating disorders.

It was reported that women understand that treatment is ongoing and that they will have to seek help and continuing services. Men, it was felt, complete a program and think they are through when they get out.

Staff suggested that both men and women should be working in the program so that women can work out their male-related issues (such as how to deal with male authority figures and trust members of the opposite sex). Staff relate that prisons are the only mandated health care systems in the country. Therefore, women in the institutions get far better medical care than they do on the streets. Women with HIV have longer survival rates. They get better food and have access to AZT.

Diversity Issues

The Atwood program is a multiracial-multicultural program, but it does not provide a lot of ethnic services; "every once in a while, we'll hold a sensitivity group." Workshops have

been held on cultural diversity. Racism and issues related to it are addressed as they arise since they are regarded as treatment issues.

At one time, inmates wanted an exclusively Black group. Program staff told inmates that they could not do this. Staff believed that it was more important for the women to be a part of the larger community. Of course, the inmates are free to talk among themselves as much as they want, but no structured, staff supervised activities were agreed upon solely for Black participants.

Recovering Staff as Role Models

Staff indicate that "it would be nice if more treatment staff were in recovery." But staff cannot have criminal records. Also, older recovering people can not get in because applicants have to be 37 or under to be hired into the system.

Peer Support

When inmates first enter the program, they are assigned a buddy who has completed at least six months in the program. The buddy is often used as a sounding board to begin talking about difficult challenges which arise in recovery. The use of the buddy system is voluntary, but strongly encouraged. Also, the therapeutic community nature of the program re-enforces positive peer support. Participants are assigned to work teams, they "call each other" on their issues, and they act as role models to newer program participants.

After being outside the institution for two years, program graduates may be eligible to return to the institution on the Atwood yearly "anniversary" day. One of the graduates said the thing she learned was to "hang with the women." She had linked up with a women's support group in the community. Staff are proud that prior inmates can come on the campus for this event as it is quite rare that this sort of allowance would be permitted.

Program Strengths

The staff reported the following staff strengths: highly trained staff compared to other BOP treatment programs; diverse educational backgrounds; no preconceived notions; staff act as peer support for each other; and, staff act as positive and diverse role models for the clients.

Staff reported the following system or program-wide strengths: staff and inmates engage in in-depth, intimate interactions; inmates can apply what they learned in a safe setting; the (client) buddy system; use of the criminal thinking module; specialty groups for specific needs; extensive behavioral expectations of inmates; and solid money and support from BOP.

Weaknesses and Areas for Improvement

It was reported that a better system of graudated discipline or sanctions was needed for inmate problems. Staff also felt the extraordinary amount of paperwork and institutional staff shortages detracted from their ability to provide services. Another concern was the cross-contamination created by the housing of the general inmate population on the third floor

of Atwood Hall. Sometimes there are conflicts regarding general population inmates using the treatment area facilities.

Staff also reported that more outside support was needed, especially if the individual leaving Lexington was not placed on supervised parole. There is a lack of uniformity in how women are served by parole. Each parole office is in one of the 92 separate U.S. District Courts, and this may inhibit the creation of uniform national policies.