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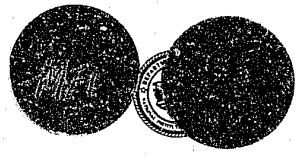

Program Review and Internal Audit in Corrections

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FOREWORD

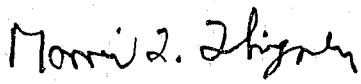
Program reviews, or internal audits, are a vital function of all corrections organizations. Through the use of accepted review/audit techniques, the organization can improve its economy and efficiency in operations and achieve better program results.

Program review serves as a proactive tool for administrators by providing a "reality index" as to where an organization stands at any time with respect to its operations and programs. Such reviews will prove more efficient, effective, and productive when all staff are involved in the process rather than just a few staff in an isolated unit in the department. In this sense, program review requires commitment from the very top of the organization to ensure its use as a positive force in evaluating and directing organizational activities.

The program review/internal audit functions documented in this report were based on a survey of departments of corrections. However, the principles and practices presented are applicable in all correctional settings, including jails, probation and parole, and community corrections.

It is anticipated that these materials will assist corrections organizations in upgrading performance and in developing new areas of expertise through the application of the program review/internal audit process.

Morris L. Thigpen



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Major participants in the field work are shown here by organization or affiliation.

Federal Bureau of Prisons: Kathy Hawk, Director, Bureau of Prisons, and former Assistant Director in charge of the Program Review Branch. For the Program Review Branch: James B. Jones, Acting Assistant Director; Dick Clark, Senior Deputy Assistant Director; Gary Driver, Chief, Program Review Branch (Programs); Dick Tatton, Chief, Program Review Branch (Operations); Bill Muth, Chief, Program Analysis Branch; Sharla Rausch, Management Analyst; Jama Acuff, Chief, Internal Control Branch; Babe Crocket, Chief, Strategic Planning; Jesus (Al) Garcia, Chief, Health Services Section. For the Office of Research and Evaluation of the Information Policy and Public Affairs Division (IPPA): Gerald Gaes, Evan Gilman, William G. (Bo) Saylor, and John Hardwick. Project staff accompanied a program review team led by Dick Snyder, Evaluation Specialist, to the Federal Prison Camp at Boron, California, Larry F. Taylor, Warden.

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New Jersey Department of Corrections: Stan Repko, Deputy Director, Division of Policy and Planning, Jim Adkins, Chief, Management Information Systems; Richard Waldis, Assistant Commissioner, Administration; Richard Bernstein, Deputy Director, Administration; Paul Rebovich, Chief, Audits and Accounts; Jim Dooley, Supervising Auditor; Bill Cashel, Assistant Chief, CICS; Hank Pierre, Chief, Correctional Information and Classification Services; Donald R. Bearce, Business Manager; Tony Rosetty, Assistant Director, Office of Institutional Support Services; Robin Miller and Chris Cermele of the OISS staff.

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Copies of this report are available from the NIC Information Center, 1860 Industrial Circle, Suite A, Longmont, CO 80501; telephone 800-877-1461; 303-682-0213; FAX 303-682-0558.

CHAPTER I

INTRODUCTION TO THE STUDY

The nature of program review/internal audit systems in U.S. correctional agencies and facilities is addressed in this report. Findings have applicability to all government organizations. A model program review/internal audit system is provided based on an analysis of the few review systems currently in place and a review of management literature and related research. The model is a reference for administrators who plan to incorporate the review/audit process into their overall system of internal controls. Chapters VII through X provide detailed information on the field work completed for this study.

"Program review" and "internal audit" are terms used interchangeably throughout this report. "Performance review" is used more broadly to include these terms as well as traditional management review and evaluation activities. Program review/internal audit refers to a specific process by which an organization (or unit or department) systematically examines its activities to find out how well it is performing. It asks specific and difficult questions, not to assure itself that things are running smoothly, but to find out how they could be better and where problems may arise. Is the unit meeting its objectives and goals? Is the unit complying with laws, policies, regulations, and procedures? Is it operating in an efficient and economical way? Are employees satisfied? Are inmates?

A recent study of corrections management by the Robert Presley Institute for Corrections Research and Training (in California) found that experience and intuition are the basic resources used in management's daily decisionmaking (McShane et al., 1990). Given the shifting financial needs and changing environments, these are no longer adequate tools. Corrections administrators should know the principles of performance review and be prepared to apply them to their internal operations.

The most recent effort to provide guidance for internal performance review has been the development of national standards for adult and juvenile corrections. Standards have been promulgated by various national commissions, professional organizations, and the U.S. Department of Justice (see Fosen & Sechrest, 1983). Several states integrate these types of standards into their review systems, and 71% of correctional managers responding to a nationwide survey affirmed that American Correctional Association (ACA) accreditation guidelines positively influenced their management style (McShane et al., 1990; see also McShane & Williams, 1993).

While accreditation and performance review are complementary and share similarities, they are different procedures. Accreditation is an external process, although it requires an internal self-evaluation to be completed at specific intervals. Program review is an internal process that refers to the statutes, regulations, directives specific to the agency's own jurisdiction, and any standards adopted by the organization. It occurs more frequently and in greater depth than an external review. The achievement of accreditation, from whatever source, is not required to institute program review or internal audit. Many correctional agencies are learning how to make both accreditation and program review work together to improve the total quality of their operations. A sound program review based on specific jurisdictional criteria and drawing on accepted national standards should be sufficient to satisfy most types of outside review.

Project Research Design

One way to analyze an organization's performance is to examine its structure or hierarchy and its "built-in" review mechanisms. An earlier study (McShane et al., 1990) examined the organization flow charts of several departments of correction. The structural components that lead to better internal control and, therefore, to improved performance were identified. The key component was an effective management review system that allowed administrators to identify problems and implement an improved methodology. Program review/internal audit is such an improvement.

A primary goal of the project was to develop a model based on accepted program review/internal audit techniques identified in various agencies in order to help administrators evaluate their needs and design their own systems. To develop the model, project staff used available literature and information gathered from a study of six state program review systems, the Federal Bureau of Prisons, and the Correctional Service of Canada. The model includes information received from several state departments of corrections and information from many other sources, most notably the Institute of Internal Auditors.

The model program review/internal audit system presented here outlines the elements of an internal review system that will apply to departments of different sizes and organizational structures. It is concerned with lines of decisionmaking authority, current points of review, and the types of reviews now being done (informal, verbal, written, administrative, legal, and others). The model also provides a risk assessment method based on experience in several jurisdictions that allows participants to identify operational areas that require a higher level of review. The ultimate goal of the model is to enable users to develop a system for the evaluation of their own operations in relation to those studied, and in relation to national norms and audit guidelines. This project also addresses the impact of local (agency or jurisdictional) and national standards on the organizations studied. For many organizations studied, these standards have become a source for internal performance review systems criteria independent of their use in an external audit or in an accreditation process.

Selection of States

To project the most accurate picture of the current state of performance review systems, the project staff examined, summarized, and compared all facets of internal control systems currently in operation in the Federal Bureau of Prisons, Illinois, Utah, and New Jersey. It also examined a multistate auditing system for Oregon, Washington, and Idaho, and the information service and performance review system designed by the Correctional Service of Canada. Selection of these states was based on over fifteen contacts with state agencies to learn the status of their performance review and auditing systems. Several states had such a system or were developing one. Many have relied on their inspector general for auditing, which is often an external agency. Our concern was with the extent of the program review/internal auditing function and its link to management information.

The Correctional Service of Canada has one of the more comprehensive systems; it includes the Offender Management System, Executive Information System, and Offender Population Profile System. This system compares favorably with the Federal Bureau of Prisons key indicators system (KI/SSS), which was the subject of field work and is described in detail in this report. Both agencies have developed basic performance review systems that assess internal operations and contribute to the strategic planning function.

This study also considered technical factors that influence management structures and related operations, particularly in their ability to supervise and evaluate performance. These factors include the history of a department; its relationships to other state agencies; federal, state and departmental resource allocations; the degree of regional versus centralized control over performance review and management information systems; the status of traditional research and evaluation endeavors; and the types of hardware and software available to implement and coordinate review systems and support evaluation.

The model performance review system was reviewed by administrators at several departments of corrections, including an advisory group representing several corrections departments, selected in consultation with NIC officials. A draft of the system was presented to the advisory group and sent to over 20 correctional systems that were invited to send representatives to the advisory group meeting in January 1993. Participation by these administrators helped refine the model and enhance its utility to all types of correctional systems.

Presentation of Findings

Chapters I to IV provide definitions of program review, internal audit, and other types of performance review. Chapter II reviews the literature on the use of performance review as a management tool and current internal management and performance controls used in the criminal justice system today. The application of available review systems in the public and private sectors is explored, and the performance review capabilities of a variety of correctional systems are examined. Chapter III defines audit and discusses the importance of internal controls, evaluation, and information systems. Chapter IV describes the framework for evaluation of the various field sites. Chapter V presents a model program review/internal audit system that includes: a list of the elements required for a program review/audit system; suggestions for adapting review mechanisms to different size and different structured organizations; a description of the types of questions that must be asked to help managers analyze their operations; a plan for evaluating performance review systems based on a variety of criteria; a method of assessing risk with which to establish audit priorities; methods for quality control and evaluation; and a discussion of the barriers to implementing the model. Chapter VI raises some of the issues that are relevant to the adoption of program review and internal audit techniques in corrections.

Chapters VII to IX summarize the field work and provide technical information on developing a review/audit capability. Chapter VII describes the findings of project field work. Chapter VIII provides an overview of the evaluation procedures used to monitor the success of the review process in each jurisdiction studied. The types of information needed to examine management review structures and to measure performance are explored. Types of reviews are discussed (e.g., informal, verbal, formal written, administrative, legal, research, and evaluation). A major component of the project is the presentation of methods by which corrections managers can identify and assess risks.

Chapter VIII includes a method for scoring correctional systems and setting priorities that was developed using current experience in program review/internal audit. This system will enable users to design an internal review system that is consistent with their size, structure, and available resources. Organizations that adapt this risk assessment system or a similar one will find that the adjustable format allows them to design and control the performance review themselves. It is a less intrusive approach that allows the user to personally assess and critique departmental policies and procedures. As such, the process is more likely to achieve both acceptance and credibility within the organization, and the user will be more confident in the measures adopted. Corrections administrations should not be mandated to adopt "model" programs designed elsewhere that have components they suspect may not apply to them. Experience has proven the wisdom of involving professionals in the developmental process for any innovative approach to their own work.

Chapter IX documents the management review system of the Federal Bureau of Prisons and the departments of corrections in six states, including their current resources and future needs. Four areas are examined for each jurisdiction: existing performance review systems; the types of resources needed and the methods and tools used to conduct management performance review; the strengths and weaknesses of each system (including the researcher's findings and staff comments); and a comparison of the review methodologies in each system studied, including economy, personnel efficiency, time management, meeting legally mandated or other designated standards, communication of management needs, and accessibility of information. Chapter X provides an overview of advanced auditing applications, to include total quality management, fraud auditing, and the role of automation in the future of performance review.

CHAPTER II

LITERATURE REVIEW

Every government institution, whatever size, must account for how it manages its resources and operations. Accountability methods are usually based on management principles, including classical and behavioral theories, systems approaches, and composite theories. The management techniques that flow from these theories are well-described in the management literature.

Classical theories describe highly structured organizations and are concerned with titles, levels of authority, span of control, chain of command, and grouping of tasks. These are sometimes called "closed" organizational models, because they emphasize the stability of roles within the hierarchy (see Henry, 1980, Chapter III). Typical organizational concerns are summarized in the concepts of planning, organizing, staffing, directing, coordinating, reporting, and budgeting (sometimes shortened to "POSDCORB"), with the last four sometimes simply grouped as "controlling." Performance review in such organizations would be based on clear responsibilities and assigned tasks. Correctional agencies typically take a classical approach, due to their pyramidal, quasi-military structure.

Organizational models based on behavioral theories are "open," goal-oriented, and flatly structured. They stress the application of skills and specialized knowledge toward the completion of goals. This approach is most often found in halfway houses and prerelease centers rather than in institutions where standards of organizational behavior are more clearly defined. In this approach, performance review examines goals or objectives of the program rather than specific tasks related to those goals. The "organization development" (OD) school is a popular version of this management style. It emphasizes the examination and resolution of organizational problems and places a high priority on the values and attitudes that foster positive and constructive relationships. The approach was discussed for use in corrections by the National Advisory Commission on Correctional Standards and Goals (1973). Management by objectives (MBO) is also a popular offshoot of this concept.

The application of evolving management theory into practice has created trends, such as open-door policies, participative management, retreats or "team building," and "walking the unit." A recent example is "total quality management" (TQM), wherein teams of workers from all levels meet to remedy ineffective procedures and trouble spots. Considerable use is made of charts, graphs, reports, and feedback. This approach distrusts the obvious answer and studies other organizations for improvement strategies. Total quality management is initially expensive to implement, but it is directly involved with the quality of performance review. In their book on "reinventing" government, Osborne and Gaebler (1992) place considerable emphasis on TQM in helping organizations realize better results.

It is interesting that the public sector no longer lags behind private industry in the adoption of management innovations. Public service agencies are becoming proactive in developing strategies that meet their needs, instead of accepting the private sector practices.

The History of Performance Review in Corrections

Traditionally, personnel in institutions have been ambivalent about the concept of performance review. Their institutions have operated as autonomous, closed enclaves with little accountability and few written records. There was little monitoring from outside the system and few mechanisms of internal review; as George Beto, former director of the Texas Department of Corrections expressed it, "no other institution has shown a greater reluctance to measure the effectiveness of its varied programs than has corrections" (Jackson, 1971). Self-examination typically resulted from a scandal, riot or notorious change in adminis-tration. Cohen (1987:4) explains that corrections only examines itself "as a result of dramatic events and external pressures rather than as a result of introspection and internal examination."

The 1974 Martinson report generated interest in program evaluation and marked a crossroad in the use of research by correctional agencies (Williams, et al., 1992). Calculating the value of specific programs is a complex process (Palmer, 1993); however, departments have expanded measures of program effectiveness to include cost benefits, time savings, humanistic values, and the traditional concept of recidivism.

Lovell and Kalinich (1992:87) note that internal political factors have discouraged corrections agencies from using information generated from within the system. Their survey of correctional administrators and departmental researchers concluded that program managers were quite critical of the efforts and products of the research department. The comments of the respondents reflected concerns about autonomy, status in the organization, parochial program and organizational political interests, technical problems, and, importantly, the lack of their integration in the internal research process.

Traditionally, there has been scant motivation to develop performance review systems and few employees qualified to design such a program. Furthermore, most departments were entrenched in an historic mistrust of outsiders, educated professionals and non-security personnel. Corrections managers worked their way up from guards to wardens, usually with no formal academic or business training. Until recently respected leaders often earned their promotions with physical strength and "prison sense" (Jacobs, 1977:34). Whatever review mechanisms existed involved internal monitoring and reports filed by supervisors up their chain of command. Records were often haphazardly kept and crudely maintained.

Current efforts to implement performance review systems are still often viewed with skepticism and mistrust. As a corrections researcher explained, "Contact with the program managers is low. Nobody uses the information (at that level). There is protectiveness, suspiciousness" (Lovell & Kalinich, 1992:81). In the McShane et al. study (1990), prison wardens and superintendents rated on a scale of 1-10 how various factors influenced facility management. Managers rated legislative mandates (6.94), court directives (7.39), and state budget constraints (6.55) as far more influential to daily decisionmaking than research findings (3.62) and management information (5.82).

Traditionally, corrections staff undergoing performance review have reacted with everything from indifference to panic, because they don't understand that it is the system and not the employee that is being tested. As noted later, the use of such systems to discipline employees is far less constructive than developing plans of action for remedying deficiencies.

In the past, performance information about the prison system rarely filtered beyond the immediate hierarchy. Performance indicators were carefully guarded and released in limited forms to outsiders, although this information was officially available in the department's annual report. These documents offered important insights into the operations and attitudes of the correctional system and are considered today a type of performance review. Through them administrators may discharge the obligation of disclosure and simultaneously position the department to request future resources in exchange for a positive performance. The published annual report demonstrates accountability to external authorities such as state executives, boards and commissions, and the public. In addition, some report formats ensure accountability from the individual units or facilities to the central headquarters and provide some standardized comparisons of activities and programs.

Annual reports can hide information. Since a department can control the information provided in an annual report, what the document does not state may reveal as much or more than what it does state. Often these reports appear to be showing you everything, but key components—especially if they're not that attractive—may remain hidden. Such reports tend to be positive in tone and rarely mention problems.

Annual reports can reflect changes in the general nature of corrections management, most notably in automated information systems and the widening sphere of public accountability/information needs. One researcher explained that a department prepares many reports in a year's time, each tailored to the information needs of its various constituents. The annual report describes operations; statistical reports on population changes and cost expenditures serve legislative needs, while the media and public service organizations require a diverse assembly of short special issue reports. An annual report addresses the varying demands for information required of the department.

However, many departments do not publish annual reports. Some publish biannual reports while others simply assemble statistical reports on the numbers of inmates, their classification, offense profiles and discharge summaries. Obviously not all states view the report as a public relations tool or even as a motivating force for gathering and analyzing management information. As explained by Idaho officials, ". . . we do not have ample staff to prepare an annual report." It is probable that any state that regularly tracks management information would already have the contents of an annual report at their fingertips.

Although annual reports serve many functions, their lack of consistency makes them unsuitable for meeting accountability demands. The use of inspectors, the advent of accreditation, and the development of internal audit units to supplement external reviews has placed a new emphasis on more precise methods of performance review.

The closed, independent systems of the early twentieth century are gradually yielding to improved performance review procedures, due to four factors:

- larger departments of corrections, with more complex operations and hierarchy.
- increased legal liability for negligence. (Punitive and compensatory damages have been awarded for civil and criminal court actions, including interactions between employees, between prisoners and employees, and between prisoners and third parties outside the criminal justice system. More attention to supervision, training and decisionmaking are solutions to findings of negligence.)
- increased competition for state and federal resources.
- growing pressure for fiscal and operational accountability.

As a result of these forces, many corrections departments have been restructured to allow management greater access to both internal and external information sources to facilitate policymaking. In some cases, restructuring has meant new positions, such as a legislative liaison (e.g., New Jersey, Pennsylvania, Georgia, Washington). This position results from the effect of funding and overcrowding in corrections. While prisons once operated far from the day-to-day workings of the legislature, the State Capitol is now viewed as a direct influence on policy. The passage of bills that affect inmate sentences, treatment, personnel actions, facility construction/siting and the regular struggles over the budget are now critical issues for the modern prison administrator.

Another new position stemming from the current proactive management approach is the "litigation/risk management coordinator," as established in Washington State. Departments recognize that constant monitoring and troubleshooting are necessary functions. The most critical element of this proactive movement is not so much the positions created, but the information flow.

The time is right for the model internal performance review system that will use established principles of audit, scientific investigation, and explanation. While it is understood that every department cannot immediately implement an "ideal" system, the components of a system that will meet minimum requirements will be described. Specific core guidelines and practices must be in place to set up valid program review/internal audit procedures. This may be done economically by departments with limited resources by adjusting the intervals of reviews, to be determined by relative risk, with an understanding of the shortcomings of such reductions of effort.

Standards and Accreditation

An important step in the development of performance review systems has been the gradual development and acceptance of national professional standards (Reimer and Sechrest, 1979; Sechrest and Reimer, 1982) and also national accreditation programs operated by the American Correctional Association (ACA), the National Commission on Correctional Heath Care (NCCHC), which is specific

to the accreditation of medical services in corrections, and others (see Fosen and Sechrest, 1983). This process of peer review,* or review by outside correctional personnel, introduced generally uniform national standards.

Questions have been raised about the integrity of the standards and their ability to create meaningful change in corrections, and whether the correctional facilities and community agencies being certified really meet the highest standards of performance. Judgments of the usefulness of the standards often depend on who is making the assessment. To the corrections practitioner, the standards are generally seen as realistic and challenging; to the reform-minded, they are weak and ineffective, perpetuating poor performance and injustice.

When asked about the credibility of the standards for accreditation audits being done in one state in the early 1980s, ACA staff responded that some prison officials see the standards as too demanding and non-prison sources see them as too lenient. These arguments were further developed in "Accreditation on Trial," an article published in 1982 by *Corrections Magazine* (Gettinger, 1982) and a subsequent "debate" article regarding the resignation of a prominent member of the accrediting body (Bazelon, Charters, and Fosen, 1982). Perhaps the answer is that the standards are about as tough as the field can accept without some assurance that additional resources will become available (see Czajkowski, 1984). The standards appear to be adequate within the framework of what is possible currently; however, they do not reflect the highest standards of performance. The continued development and use of local, state, and national correctional standards can be supported by well-implemented internal program review mechanisms.

Program Review/Internal Auditing

Internal auditing, called program review by some jurisdictions, such as the Federal Bureau of Prisons, has evolved with the notions of standards and accreditation. However, the implementation of program review or internal auditing systems does not require participation in accreditation. Audit criteria that exceed national standards draw on local and federal laws, rules, regulations, policies, and procedures specific to each organization. The development of program review/internal audit in corrections is rooted in the science of internal controls, which has been developing in government, business and industry for many years. The major sources of standards have been the Institute for Internal Auditors, the American Society for Quality Control, and the American Quality Foundation. Some departments of correction have created internal audit units, which will be described in this report. Others still rely on an inspector general, who conducts periodic evaluations of operations.

Internal auditing is different from accreditation. It is not monitoring or inspecting, although followup using the results of program reviews or audits can provide a continuing monitoring function. It is not an investigation, since it is designed as an open process involving all agency personnel in the effort to improve organizational functioning. It is not research or evaluation, although program review can and should be supported by an evaluation component, as outlined in chapter III of this report.

The internal audit is an *internal review*. It differs from the accreditation visit in several ways, principally in its specificity, intensity, and frequency. The internal audit (or program review) is quite specific to the agency in question, particularly the statutes, regulations, and directives specific to the jurisdiction. It can occur more frequently and in greater depth. For example, Bureau of Prisons staff perform program reviews across 14 separate areas, or "disciplines," at different times in various institutions. The Utah Department of Corrections audit unit might review a correctional facility in all areas of performance for periods of up to four weeks or longer.

Accreditation is an *external review*. It occurs at intervals of three years, with some periodic checks in the interim. Internal auditing and accreditation may be both complementary and supportive. Many

*In internal audit "peer review" refers to review of the work of an internal audit team.

correctional agencies are learning how to make them work together to improve the total quality of their operations. Sound program reviews/internal audits using specific jurisdictional criteria (e.g., statutes, regulations, policies, procedures) and encompassing national standards should provide more than adequate information for accreditation visiting committees.

How is program review/internal audit helpful to a system? A study by Etherington and Gordon (1985) demonstrated the value of internal audit for ensuring adequate internal controls. The authors conducted 120 structured interviews with chief executive officers, chief financial officers, internal audit managers, and information processing managers in six of Canada's largest corporations. A survey was mailed to 814 managers with a 43-46% response rate. A major problem for this study was defining internal control. The corporate officers saw audit as including accounting, management, and operating controls, while chief executives were more concerned with efficiency and productivity. Major concerns were expenditures and allocations of capital resources (Etherington and Gordon, 1985:27).

A more acceptable definition of internal control comes from the Financial Executives Institute of Canada. Its definition goes beyond accounting, fiscal, and audit functions to encompass management philosophy, organization structure, quality of personnel, delegation of responsibility commensurate with authority, and effective and efficient management (Etherington and Gordon, 1985:2,113; see also Mautz et al., 1980; Mautz and Winjum, 1981). These areas were generally grouped into accounting (financial) controls and management controls (policies, efficiency, effectiveness, and performance review).

With respect to the relationship between internal control practices and good management, Etherington and Gordon (1985:2) found that internal control was perceived as "important and significant by corporate management, with activities at all managerial levels seen as the domain of internal control." Internal audit was viewed as a major component of internal control by 80% of the respondents, and the role of the external auditor as less important by comparison.

Many executives surveyed were concerned about the need for more formal examination of internal control risks and for cost benefit analysis. Internal control of computerized information systems was seen as "the most pressing internal control problem . . . involving all levels of management" (Etherington and Gordon, 1985:2-3, 122-123).

Regarding the benefits of internal audit, half the companies surveyed had four or fewer staff in internal audit, leading to the conclusion that internal audit was not an expensive operation: "Virtually all executives reported that, in their companies, *the benefits to all levels of the organization substantially exceeded the costs*" (Etherington and Gordon, 1985:122). The report recommends that companies without an internal audit unit establish one. It laments the lack of followup procedures by management, in that delays of up to two years were often experienced by auditors regarding their recommendations.

Other issues addressed in the Etherington and Gordon study (1985:120) include issues of organization and control of internal auditing, risk assessment, computerized information systems, and the role of external auditors. In summary, the authors indicate that U.S. and Canadian internal control practices and problems do not differ substantially, and that many of their conclusions can apply "generically" to any internal control system.

Defining Performance Review

Common Themes

The concept of performance review using recognized audit techniques and other types of evaluation is fairly new to corrections. Many people associate the concept with the fiscal audits that are an accepted part of agency operations. However, performance review is more inclusive and covers audits of fiscal, operational, and program components of the entire agency. Research and evaluation, more traditional forms of review, perform different functions, and as such should be part of any performance review system.

While methods may vary among states and institutions, there are several common themes that pervade performance review. First, performance review is an active process of maintaining control over the planning and operation of a corrections system. It refers to any measure that provides administrators with information about operations that can be used to evaluate their efficiency and effectiveness based on compliance with statutes, regulations, and the goals and objectives generally captured in policy and procedure. The purpose of such a review is to improve the quality of management internally and to meet the information needs of outside authorities.

A second theme of performance review is that the information used by management for the review is accumulated in a cycle of input and evaluation. While there are institutional differences in who gathers, processes and uses the information, the needs and goals of these activities are similar. One of the purposes of this project is to highlight the similarities of these operations across the country.

Finally, the success of performance review hinges on management's recognition of its value. Top administrators must remain committed to improving the quality and timeliness of the information used. Whatever the size of the operation, they all need to continue long-range and short-range planning and related development, to refine the review process, and to allocate resources toward that end. Although the placement of auditors, monitors, and researchers in a system will facilitate the review process, it does not ensure that performance review will take place.

The Purpose of Performance Review

The purpose of performance review systems is to provide reasonable assurance of control and to ensure that accountability is maintained. According to the U.S. General Accounting Office (1992), program performance measurement is the regular collection and reporting of a range of information that may include:

- *inputs,* such as dollars, staff, and materials;
- *workloads or activity levels,* such as the number of applications that are in process, usage rates, or inventory levels;
- *outputs or final products,* such as the number of children vaccinated, number of tax returns processed, or miles of road built;
- *outcomes of products or services,* such as the number of cases of childhood illness prevented or the percentage of taxes collected;
- *efficiency,* such as productivity measures or measures of the unit costs for producing a service (e.g., the staff hours it takes to process a Social Security claim or the cost to build a mile of highway).

Managers may use this information to "account for past activities, to manage current operations, or to assess progress toward planned objectives" (GAO, 1992:2).

Types of Performance Review

There are many terms associated with accountability that are integral to program review/internal audit. These include monitoring, investigation, auditing, evaluation, and accreditation. Program review/ internal audit is not to be confused with accreditation, as conducted by the American Correctional Association's Commission on Accreditation for Corrections, the National Commission on Correctional Health Care for medical services, or other correctional accreditation bodies. It is different from monitoring the

work of agency personnel on an ongoing basis, although the results of program monitoring can and should be used in this process of program review. Monitoring, such as supervisory review, is an internal control; reviewers/auditors assess the adequacy of monitoring efforts.

The functions of monitoring, investigation, program review/audit, evaluation, and accreditation are shown in Table 1. As noted above, program review/internal audit is not an investigation or an inspection, which rarely requires the level of documentation needed for an audit, although some inspections may be performed much like an audit. It is different from research or evaluation, although program review can and should be supported by an evaluation component, as outlined in this report.

Monitoring the work of personnel is a traditional management function. Administrators, managers, and supervisors are required by their roles and training to oversee and direct the work of their subordinates. Monitoring is often used to designate the activity of an outside agency or source with a vested interest in programs and operations. The term "monitor" may designate a representative of the court or other government agency that tracks the use of grants or other financial resources given to the state for operations or programming (e.g., legislative auditors). The term may also refer to one who ensures that the standards of state licenses and health codes and regulations are being properly followed.

Table 1

Monitoring, Investigation, Program Review/Audit, Evaluation, and Accreditation Activities

ACTIVITY	Ongoing Daily Operations	Single Incidents	Functions, Processes, & Entities	Program Outcome, Trends, Patterns, & Projections	Compliance with Standards
Monitoring	X				
Investigation		X			
Program Review/Audit			X		
Evaluation				X	
Accreditation					X

"Monitor" and "special master" are sometimes used interchangeably by the courts to designate a person they employ and place in a correctional setting to insure that judicial orders are carried out. In settling civil rights cases, monitors or "masters" insure that consent decrees are properly in place and activated. Persons in these court-ordered positions report directly to the judge and are given complete access to all information and operations within their area of surveillance.

An **investigation** is an action taken in response to an incident or a complaint. It is a "closed" process involving only the personnel involved in the incident in question. Investigations are often conducted by an office of the inspector general, which can be located in the department of corrections or external to it. They may be part of an internal affairs unit.

Program review or internal audit is generally conducted independently of management but is done internally. It seeks to inform management of areas requiring attention. Auditing is defined in detail in the

following chapter. The major concern of this report is with internal auditing, or program review, which seeks to provide an objective appraisal of operations and controls within an organization. Areas of concern include examining financial and operating information, risk identification and minimization, compliance with external regulations and internal policies and procedures, compliance with standards, and efficient resource utilization (see Sawyer, 1988). Also, reviewers/auditors can assess program results.

Evaluation looks at the quality of agency services and programs using generally accepted research techniques. Research and evaluation are more traditional forms of review that look more closely at *how well* the agency performs its functions. They focus on the outcome of specific activities directed to achieve clearly stated goals. As such, they should be an integral part of any performance review system, as discussed in chapter III. Comparable terminology used in management literature is "quality assurance" within the context of "total quality management" (TQM).

Accreditation and internal auditing are related within the context of the standards promulgated by the American Correctional Association and National Commission on Correctional Health Care. The standards are often used to support or define areas examined in an internal audit. However, in a recent issue of the ACA publication *Corrections Today* (1992) that covered "Accreditation—Three Decades of Evolution," the link between the developing science of internal controls and accreditation is not made. Internal audit as a support for or an adjunct to accreditation is not mentioned. However, this may be changing. The American Correctional Association is now testing a plan to integrate the agency program review/internal audit process with the accreditation process, where appropriate.

Some auditing offices use both national and local or state standards as criteria for internal audits. These standards encompass fiscal and program areas and rely on findings from external audits for fiscal areas, while performance auditing relies on the product of an accreditation team. Several states have developed guidelines based on ACA and NCCHC standards for both fiscal and program audits, such as Illinois, Tennessee, and Florida. Many, such as Georgia, use the U.S. Government Auditing Standards (Comptroller General of the U.S., 1988) for the conduct of these operational audits. However, the ACA, NCCHC, and other national and state standards are simply a suggested framework; they were not developed or written by auditing experts.

For the purposes of this report, performance review will be divided into several areas including program review/internal audit, internal control and risk assessment, management information systems, and program evaluation. Each of these areas is described in some detail.

CHAPTER III

AUDITING AND PROGRAM REVIEW

This chapter has several goals. The first is to define more fully the audit function. The second is to state the importance of internal controls. A third goal is to define risk assessment, including an example of a risk control matrix and an assessment format. A fourth goal is to discuss evaluation and information systems and their relationship to the review process.

Audit Defined

Auditing has been defined by O'Reilly, Hirsch, Defliese, and Jaenicke (1990:4) as:

> a systematic process of objectively obtaining and evaluating evidence regarding assertions about economic actions and events to ascertain the degree of correspondence between those assertions and established criteria and communicating the results to interested users.

Sawyer (1988:7) provides more detail in defining the internal audit as:

> a systematic, objective appraisal by internal auditors of the diverse operations and controls within an organization to determine whether (1) financial and operating information is accurate and reliable, (2) risks to the enterprise are identified and minimized, (3) external regulations and acceptable internal policies and procedures are followed, (4) satisfactory standards are met, (5) resources are used efficiently and economically, and (6) the organization's objectives are effectively achieved—all for the purpose of assisting members of the organization in the effective discharge of their responsibility.

The Institute of Internal Auditors (IIA) is the major international internal auditing body in the world. It sets the standards for internal auditing and certifies internal auditors. The IIA defines internal auditing as ". . . an independent appraisal activity established within an organization as a service to the organization. It is a control which functions by examining and evaluating the adequacy and effectiveness of other controls" (Courtemanche, 1986:17). The objective of internal auditing is to assist management in the effective discharge of their responsibilities. "To this end internal auditing furnishes them with analyses, appraisals, recommendations, counsel, and information concerning the activities reviewed. The audit objective includes promoting effective control at reasonable cost" (Courtemanche, 1987:17).

According to the IIA, internal auditing comprises a review of the following areas:

- the reliability and integrity of financial and operating information and the means used to identify, measure, classify, and report such information;
- the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations that could affect operations and reports, and determining if the organization is in compliance;
- the efficacious use of resources;
- assessment of management, including safety;

- implementation and results of programs leading to compliance with established goals (Courtemanche, 1986:17).

The Comptroller General of the U.S. (1988) characterizes two types of government audits as financial and performance. Financial audits find out whether an entity is operating according to generally accepted accounting principles and whether the information presented in its financial reports conforms to established criteria. Performance audits encompass economy-efficiency audits and program audits, both of which assess compliance, among other issues. Economy-efficiency audits assess how resources are used and identify causes of inefficiencies and uneconomical practices. Program audits evaluate the extent to which legislative or legally mandated requirements are achieved and the effectiveness of operations.

Auditing may be regularly scheduled or done at a specifically designated time. A disadvantage of the single period audit is that an agency may exhibit uncharacteristically "good" behavior for the audit period. Scheduling should anticipate which areas will generate the most problems if they are not functioning well; this involves risk assessment, discussed later in the report. Increased fiscal austerity means that more agencies will be responsible for conducting and reporting their own auditing analyses. The institutions surveyed in this study regularly conduct program reviews/internal audits. However, political forces also affect auditing procedures. In Georgia, for example, a new governor's budget cuts caused the auditing function to be removed from the corrections central office and decentralized throughout various facilities. In Illinois (surveyed in this report), the performance auditing unit was eliminated and its functions reassigned to the fiscal audit unit mandated by statute. There are varying ways in which program reviews/internal audits are placed in organizations with respect to the reporting authority's responsibilities.

The Importance of Internal Controls

Internal control activities are not superfluous "red tape"; they are essential to any organization concerned with achieving objectives, safeguarding assets, and complying with laws, regulations, standards, and policies that govern them. Internal controls exist as part of the overall controls established at the highest levels within the organization. Internal control procedures are put in place by a Board of Directors or other management entity "designed to provide reasonable assurance regarding the achievement of . . . effectiveness and efficiency of operations, reliability of financial reporting [and] compliance with applicable laws, rules, and regulations" (Treadway Commission, 1992:9). It is essential for managers to develop of a strong system of internal controls, for reasons stated above, and because these controls are designed to reduce risk. Management concern for developing a strong system of internal controls is reaffirmed by Dittenhoffer (1991: 30):

> Internal controls include the plan of organization and methods and procedures adopted by management to ensure that its goals and objectives are met; that resources are used consistent with laws, regulations, and policies; that resources are safeguarded against waste, loss, and misuse; and that reliable data are obtained, maintained, and fairly disclosed in reports.

Furthermore, Arthur Andersen & Company (1986:3) explains that recent concerns about government operations have triggered considerable interest in the subject of internal control. These include continued public concern about fraud, waste and abuse, and budgetary cutbacks. In many instances Inspectors General and the U.S. General Accounting Office have documented evidence of poor internal controls within the management of the Federal government.

Brink and Witt (1982:78) stress that the "importance of the control function comes from the fact that the examination and appraisal of control are normally a part—directly or indirectly—of every type of internal auditing assignment." The AICPA's standards (320.09) agree that internal control comprises the plan of organization and all of the coordinate methods and measures adopted within a business to

safeguard assets, check the accuracy and reliability of its accounting data, promote operational efficiency, and encourage adherence to prescribed managerial policies (Brink and Witt, 1982:81). Further, the IIA Research Foundation (1991:2-2) defines a system of internal control as ". . . a set of processes, functions, activities, subsystems, and people who are grouped together or consciously segregated to ensure the effective achievement of objectives and goals." Internal control techniques may include documented procedures, segregation of duties, supervision, security of property and records, internal audit, and competent personnel (Arthur Andersen & Company 1986:14).

Internal controls generally fall into the financial-accounting or administrative category. According to Brink and Witt (1982:81), "Financial or accounting controls comprise the plan of the organization and the procedures and records that are concerned with the safeguarding of assets and the reliability of financial records . . ." Sawyer (1988:88) agrees that accounting control includes the plan of the organization, the procedures and records that safeguard the assets, and the reliability of financial records. Administrative controls are broader and may include: 1) organizational controls, consisting of the table of organization, chain-of-command, and reporting responsibilities; 2) planning controls, such as short and long-term planning efforts, program proposals, and budget proposals; 3) operating controls that refer to policies and procedures, supervision methods, documented supervisory review, and staff training; and 4) informational controls such as automated and manual reports generated to monitor operations. These controls are discussed in greater detail in chapter VIII.

Public Officials' Responsibility

The Comptroller General (1988:1-4) has said that: "Public officials are responsible for establishing and maintaining an effective internal control system to ensure that appropriate goals and objectives are met; resources are safeguarded; laws and regulations are followed; and reliable data are obtained, maintained and fairly disclosed."

Part of implementing systems of internal control includes developing financial and performance auditing capabilities. **Financial auditing** is important to accountability, since it provides an independent opinion on how accurately an organization's financial statements present its financial operations. It also determines whether other financial information is presented in conformity with established or stated criteria. **Performance auditing** is also important to accountability because it provides an independent view on the extent to which government officials are "faithfully, efficiently, and effectively carrying out their responsibilities" (Comptroller General, 1988:1-5).

The IIA Research Foundation (1991:2-2) notes while management has the ultimate responsibility for ensuring the adequacy of internal controls the internal auditor must evaluate whether the appropriate controls are in place and functioning as designed. OMB Circular A-123, initially issued October 28, 1981 (and subsequent revisions), mandate the preparation of a five year management control plan for all Federal agencies. Its purpose is to plan and direct the process for reviewing risk and identifying and correcting material weaknesses in internal control systems.

According to Arthur Andersen and Company (1986:3-4):

> In an era of inflationary costs, budget cutbacks and reductions in personnel, management must eliminate fraud, waste and abuse, improve debt collections, plan and execute programs more effectively, respond to increased oversight by auditors and inspectors general, and, at the same time deal with the normal operation and management of large and diversified organizations.

Public officials are responsible for providing reasonable assurance that objectives and goals of the organization are achieved in an efficient, effective, and economical manner. Government operations must comply with laws and their intent language as promulgated by legislatures and other governing bodies. Proactive managers develop objectives and goals based on these legislatively mandated requirements.

Managers within the BOP, IDOC, UDC and NJ DOC operate review and internal audit systems. Professional standards have been adopted by these review/audit units for use in conducting financial and performance audits. The primary scope of these audits is to assess the control environment within the organization and to test specific internal controls developed and operated by management.

Internal controls are implemented to reduce risk. Internal auditors are concerned with potential risks and are trained to look for the safeguards that will help prevent losses. However, another purpose of a comprehensive internal audit function is to assist management. As a key management tool, the review/ audit function should assist in management's duty to govern. The duty to govern is described by DiIulio (1987, page 263):

> It is easy to think of alternatives to imprisonment and to pursue magic cures for the ills of America's correctional complex. It is much harder to get down to the nitty-gritty business of finding and implementing ways to improve conditions for the hundreds of thousands of people who live and work in prisons. The former is an exciting enterprise that is in vogue; the latter is a tremendous undertaking that seems hopeless. The first stimulates general ideas and frees us to look ahead; the second immerses us in the particulars of prison management and forces us to learn from our mistakes. The former enables us to theorize about how well we will employ new or additional resources; the latter constrains us to discover and apply practical ways of doing better with what is at hand.

DiIulio (1987:263) expands upon the concept of governing prisons as a public trust:

> The government's responsibility to govern does not end at the prison gates; nor, for that matter, does its ability. Whether government can or should run cost-effective railroads, engineer economic prosperity, or negotiate us to international bliss may all be open to questions. But government can and should run safe, humane, productive prisons at a reasonable cost to the taxpayers. No self-respecting government would abdicate or excuse itself from so central a duty. Prisons are a public trust to be administered in the name of civility and justice. Governing prisons is a public management task that we can learn to perform much better.

Using all resources within the organization, including legal, research, and audit, it is management's responsibility to know the law, regulations, and standards applicable to the organization; develop written, comprehensive policies and procedures based upon the law, regulations, and standards; implement staff training regarding organizational policies and procedures; provide supervision of staff in the context of policies and procedures; and document all staff training and supervision. Management is responsible for controlling and directing operations and for assuring that compliance with organizational goals, objectives, policies, and procedures is maintained.

Generally Accepted Government Audit Standards

The BOP Program Review Division, IDOC Fiscal Internal Audit unit, UDC Bureau of Internal Audit, and NJ DOC Internal Audit Unit subscribe to Generally Accepted Government Audit Standards (GAGAS) as promulgated by the Comptroller General of the United States in a U.S. General Accounting Office (GAO) publication entitled *Government Audit Standards*, 1988 Revision. According to the Comptroller General (1988:1-1), federal law mandates that federal inspectors generally comply with these standards when performing audits. In addition, audit work conducted by nonfederal auditors of federal organizations, programs, activities, and functions must also comply with these standards.

Broader applicability of the standards is recommended by the Comptroller General (1988:1-2), who advocates their adoption by state and local government auditors and public accountants. The IIA and the American Evaluation Association (AEA) have also issued related standards. The American Institute of

Certified Public Accountants (AICPA) has issued standards that are applicable to and generally accepted for financial audits. The AICPA standards for field work and reporting have been incorporated into the standards promulgated by the Comptroller General.

The standards promulgated by the Comptroller General define the types of government audits conducted. These include financial and performance audits. According to the Comptroller General (1988), financial audits include financial statement audits and financial related audits. Financial statement audits assess whether an entity is operating in accordance with generally accepted accounting principles. Financial related audits determine whether financial reports are fairly presented, if financial information is presented in accordance with established or stated criteria, and whether the entity has adhered to specific financial compliance requirements.

Performance audits include economy, efficiency, and program audits. Economy and efficiency audits ascertain whether economical and efficient use is made of resources. They identify causes of inefficiencies and uneconomical practices and measure the degree of compliance with laws and regulations governing economy and efficiency. Program audits include evaluating the extent to which the desired results of legislative or legally mandated requirements are achieved, the effectiveness of operations, and whether there is compliance with laws and regulations applicable to the program (Comptroller General, 1988).

The Comptroller General (1988) has established general standards pertaining to auditor qualifications, independence, due professional care, and quality control. Specific standards address financial audit field work and reporting, and performance audit field work and reporting. The IIA standards are meant to serve the entire profession of internal audit in all types of organizations. They address independence, professional proficiency, scope of work, performance of audit work, and management of the internal auditing department. These standards are periodically modified by the issuance of Statements on Internal Auditing Standards.

Risk Assessment

An organization's use of internal controls is one method by which it can identify and minimize risks. Sawyer (1988:164) says that often organizational operations are not "mishandled" because of dishonesty or malice, but because personnel do not follow the rules, do not understand instructions, or are not properly monitored. Internal auditors are trained to look for the safeguards that will help prevent losses, whatever their cause. Hyde (*Internal Auditor,* 1986:36) describes risk as "the probability of significant loss of assets or disruption of a program caused by poor performance of a critical activity." It is the exposure remaining after efforts at management control. Risk is defined as follows:

RISK = EXPOSURE *less* CONTROL

The IIA Statement on Internal Auditing Standards (The Institute of Internal Auditors, 1992b:61) defines risk as the probability that an event or action may adversely affect the organization. The effects of risk can involve:

- An erroneous decision from using incorrect, untimely, incomplete, or otherwise unreliable information.
- Erroneous record keeping, inappropriate accounting, fraudulent financial reporting, financial loss and exposure.
- Failure to adequately safeguard assets.

- Customer dissatisfaction, negative publicity, and damage to the organization's reputation.
- Failure to comply with laws, policies, plans, and procedures.
- Acquiring resources uneconomically or using them inefficiently or ineffectively.
- Failure to accomplish established objectives and goals for operations and programs.

Program reviewers/internal auditors test internal controls to identify risk. The extent to which a particular operational objective can be achieved depends upon the answers to four basic questions:

- What could go wrong? Would the technique used prevent it from happening?
- If it happened, would it normally be detected? When?
- If not detected promptly, how would it impact the entity/program/account balance?
- If undetected material errors or irregularities could occur, what changes should be made to prevent or detect them? (Arthur Andersen and Company, 1986:53).

Dittenhoffer (1991:5-5) describes three categories of risk:

(1) *Inherent risk* describes the basic hazards—for example, fraud, supply interruptions, and accounting errors—that auditees face in the normal course of business.

(2) *Control risk* represents the danger that the internal controls designed to protect the auditee from inherent risk may not have been installed or will break down.

(3) *Detection risk* addresses the possibility that the auditor will fail to detect a breakdown in internal controls and express an incorrect opinion.

The risk control matrix shown in Table 2 illustrates the relationship of the control objective to operational risk with reference to an inmate medical screening. Program review units use various methods to identify important audit areas. The first step in determining operational risk, vulnerability, or exposure is to segment the organization into assessable units. The Utah Bureau of Internal Audit (BIA) staff uses a formalized risk assessment tool to establish audit priorities department-wide and specifically within the institutions. This tool is based upon a model developed by the Institute of Internal Auditors (IIA). All institutional functions and processes were first identified based on identified objectives, as shown in Table 2. Risk factor criteria were established and were used to prioritize all entities and functions within the audit universe, using the form shown in Table 3. A similar tool was developed to prioritize all entities and functions within the Utah Department of Corrections. A completed risk assessment results in a listing of entities and functions from highest to lowest risk. High risk entities are scheduled for comprehensive audit, while moderate and low risk entities and functions are addressed with less frequency and intensity.

Table 2

Risk Control Matrix: Inmate Medical Screen

OBJECTIVE	CONTROL	RISK	AUDIT TEST
To ensure new inmates arriving at Reception and Orientation undergo a Medical Screening conducted by appropriate staff within 24 hours of arrival.	1. Comprehensive written policies and procedures addressing Medical Screening.	1. Lack of policies and procedures provides no standards for measuring staff performance.	1. Determine if policies and procedures have been reviewed and approved by the Medical Authority and are in accordance with law, regulation, standards, consent decrees, etc.
	2. Forms and related documentation requirements.	2. Various methods of documentation may occur. Possible lack of documentation.	2. Find out if standardized forms based on policies and procedures have been developed, made available to staff and properly prepared.
	3. Staff training.	3. Without staff training, various unwanted practices may occur.	3. Evaluate whether all staff providing services to inmates have adequate training regarding Medical Screening.
	4. Supervisory review.	4. Without continuous review, problems may go undetected.	4. Review supervisory practices to find out if inadequate Medical Screening practices are detected and corrected.

Table 3

Utah Department of Corrections Risk Assessment

RISK ASSESSMENT

DIVISION:_____ LOCATION/FUNCTION: _____

DATE:_____ ASSESSED BY: _____

STAFF INTERVIEWED (Name/Title):_____

SEGMENTATION SCHEME REFERENCE:_____

RISK GRADING:_____ FISCAL YEAR TO AUDIT: _____

AUDIT BY:_____

****

SUM OF "VALUES":_____ *DIVIDED BY* SUM OF "PRIORITIES":_____ =

RISK FACTOR:_____

			Priority	Value
1. MANAGEMENT PLANNING: The degree of formalized planning conducted by management pertaining to operations. This includes documented short and long-term plans that clearly state objectives, include timelines for completion, affix responsibility for accomplishment, and are effectively communicated throughout the organization and external to the organization, where appropriate.	INADEQUATE MINIMAL PARTIAL COMPLETE N/A	4 3 2 1 0		
2. ORGANIZATIONAL CONTROLS: Includes organizational charts, chain-of-command, reporting responsibilities, and adequate organizational control methods including effective communication lines and the ability to affix responsibility.	MINIMAL INFORMAL AVERAGE OUTSTANDING N/A	4 3 2 1 0		

3. POLICIES AND PROCEDURES: Refers to the adequacy, completeness and applicability of policies and procedures that guide operations. This includes internal technical manuals, post orders, special orders, general orders and manual chapters. Of great importance is the degree to which these guidelines reflect the legal and professional principles in constitutional law, statutory law, case law, regulation and professional standards.	NONE INCOMPLETE MARGINAL COMPLETE MODEL	4 3 2 1 0		
4. MANAGEMENT/STAFF TRAINING: The adequacy, completeness, and applicability of documented preservice and inservice training based on the legal and professional requirements for the organization.	NONE INCOMPLETE MINIMAL COMPLETE MODEL	4 3 2 1 0		
5. OPERATIONAL VULNERABILITY: An estimation of the exposure to legislative scrutiny, public examination, etc. The potential for such exposure and also the degree to which exposure has already occurred should be considered.	LITIGATION VULNERABLE AVERAGE SECURE N/A	4 3 2 1 0		
6. OPERATIONAL COMPLEXITY AND INTERRELATEDNESS: Refers to the degree to which complex operations occur and the level of interrelatedness or interface existing with other components within the facility/division and also outside the organization.	VERY COMPLEX COMPLEX MEDIUM NORMAL N/A	4 3 2 1 0		
7. STAFFING/CHANGES IN OPERATIONS: Staff scheduling, rostering, chain-of-command, span of control and the recency and degree of any change within the organization are important factors.	PROBLEMS CHANGES MANAGEABLE EXCELLENT N/A	4 3 2 1 0		
8. SUPERVISION AND DOCUMENTATION: The degree to which operations are controlled and essential activities documented. The effectiveness of staff and volunteer supervision should be assessed and a judgment made about whether appropriate documentation is maintained.	NONE POOR AVERAGE EXCELLENT N/A	4 3 2 1 0		

9. COMPLIANCE WITH POLICIES AND PROCEDURES: An opinion as to the level of staff compliance with policies and procedures with emphasis on critical operations.	NONE MINIMAL AVERAGE FULL N/A	4 3 2 1 0		
10. FACILITY RISK MANAGEMENT: With respect to facility use and the level of security, an assessment should be made of the significance and adequacy of risk management efforts (i.e., written disaster plan, fire, safety and health inspections, and related management responsiveness to reported deficiencies).	HIGH RISK MEDIUM MODERATE LOW N/A	4 3 2 1 0		
11. MANUAL SYSTEMS CONTROL: This area includes such internal controls as access to, and physical control of assets, key control, supervisory review, proper segregation of duties, etc.	POOR WEAK AVERAGE EXCELLENT N/A	4 3 2 1 0		
12. AUTOMATED SYSTEMS CONTROL: Refers to procurement and use of computer hardware and software, integrity of data input, use and relevance of related reports, system security, data backup, etc.	NONE WEAK ADEQUATE EXCELLENT N/A	4 3 2 1 0		
13. OPERATIONAL REVIEWS: Refers to the level of internal and independent reviews of operational performance. This may include assessments by management, local internal audits and department audits, and external audits and inspections.	NONE MINIMAL ACCEPTABLE MODEL N/A	4 3 2 1 0		
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Evaluation

Purposes and Types of Evaluation

Evaluation seeks to determine how well a function is being performed. It may also contribute to the development of new or revised organizational goals and objectives (i.e., new audit criteria). There are four categories of evaluation:

- those that assess the implementation or initiation phase; how effectively the program was phased in;
- those that monitor the actual program operations to see if the program is operating correctly;
- outcome evaluations that determine whether the program has met its goals (i.e., was a program successful?);
- cost evaluations that determine just how much a program cost in relation to its benefits, or a cost-benefit analysis. Was the program worth the money?

By definition, evaluation uses "systematic, standardized methods of social science" to assess the various interventions for their effectiveness (Smith, 1990:25). A key element of an evaluation is the measurement of how successfully a program has met its goals. This measurement is often called *outcome evaluation.*

According to Lewis and Greene (1978), a program's early phase or implementation period should be evaluated. This *formative evaluation* can give program officials valuable insight to be used in the initial development of a treatment or process. This form of research is also called *implementation* or *process evaluation.* Lewis and Greene (1978:175) caution, "no matter how well thought out a project may be, there are always problems that have not been anticipated but that may influence the success or failure of the project." For example, an implementation evaluation conducted after the start-up of a drug treatment program might assess whether the original staffing ratios are adequate to cover the actual operational needs, whether the participants are receiving the treatment services as planned, and whether the schedule of treatment is going to be able to move along at the rate initially planned. The evaluation may also look at actual versus planned costs and whether the characteristics of selected participants match the population originally targeted.

Evaluations will indicate whether programs should be continued, altered or terminated. *Replication* of treatment studies is also an important mechanism for justifying the widespread application of initially successful treatments (Lempert and Visher, 1988). Because of an evaluation, as with an internal audit, programs may be initiated, personnel may be changed, procedures may be revised and other solutions to accomplishing a goal may be attempted.

Today, more competition is found for the limited funding available to criminal justice agencies. Evaluation research can indicate where available resources can be best used. Thus, the motivation for conducting evaluation research is practical as well as economical. J. Michael Quinlan, former Director of the Federal Bureau of Prisons, endorses the evaluation process, noting that it "must become a part of every Bureau activity, not just because it improves our efficiency, but because it ensures a wiser use of public resources" (Lebowitz, 1991:15).

While evaluation research should help in the formulation of policy, it should not be the sole basis for it. Some programs may be continued in spite of unfavorable findings. Even when expressed goals are not met (i.e., recidivism is not reduced), a program may be retained for its other values, such as providing education and work skills, cost savings, or other organizational goals. The decision to continue

a program is not solely a scientific or numerical judgment. However, with good evaluations, it can be an informed decision.

The use of evaluation has been limited and controversial, with little planned effort to evaluate or develop the best programming. As a defense mechanism against the charges that "nothing works" in correctional programming some corrections administrators may have shied away from evaluating their activities in favor of more "harmless" research efforts. A tendency is found in corrections to hire researchers and not allow them to conduct research. Most research departments manage databases and/or provide management information, statistical reports, surveys, literature reviews, and surveys of policies and procedures. As Lovell and Kalinich (1992:90) argue:

> Top administrators have done little to clarify the role of the research department. Top administrators have actually given little forethought to the role for research information or to the use and potential use of research information to achieve desired outcomes.

For example, an Arizona warden wrote of a multifaceted therapeutic community operating within the system, concluding that the inmates in the program were calmer, less angry, related better to staff, received fewer disciplinary reports, filed fewer grievances, and were more involved in work and school programs than other inmates in the same institution. However, there were no formal evaluations done on this program nor were there any independent studies showing that the program guaranteed a successful adjustment to society.

One reason for the lack of evaluation is that records were seldom or inaccurately kept. Without meaningful and reliable information, it is difficult to gauge the success of programs or to compare prior results with current performance. It is only in the last decade that this problem has been remedied, with the development of quantitative databases. In part, the current availability of aggregate data files is a product of the automated recordkeeping components of most management information systems. Lewis and Greene (1978) demonstrate that improved data sources and data collection can yield improved evaluation, collation, and analysis, provide useful information for various programs, and improve information dissemination.

Another problem that has hindered the evaluation process is that some programs ran out of funding and were closed before evaluations could be done. Some programs eliminated the evaluation components to allow the program itself to survive. Ironically, the evaluation was not viewed as essential to the future survival of the program. Administrators are only now beginning to realize how essential evaluations of prior programming are in qualifying for outside grant funding to continue these programs.

In other cases, programs ended before enough "treatment" had taken place to make assessment meaningful. Because of changes in political administration, programs funded under one party may be abandoned by the other. Even where good evaluations have been done, politics may dictate program funding decisions. However, the existence of meaningful evaluations offers the opportunity to make policy decisions based on empirical evidence. For example, the California Youth Authority developed a program to increase the number of female recruits who passed the physical agility test. A one-day, preparatory course was held before the test to assist women in developing and practicing the skills necessary to meet the basic physical requirements. Special "FIT for CYA" sweatbands were given out with the instruction and plenty of encouragement was offered. Unfortunately, there was no followup evaluation of this effort to find out if benefits were realized; that is, to see if course participants did better in the exam than a control or nonparticipant group.

There are two major forces presently driving evaluation. One is that initial funding is often tied to a program's evaluation component or continued funding is linked to the presentation of periodic evaluation reports. The second force driving evaluation is that in many agencies it is required by law.

A significant amount of correctional program literature is available in the form of reviews or reports. Program reviews supply data on the numbers and types of participants, outcomes of treatment, and costs associated with various activities. Reviews are statistical and are designed to simply provide

facts and figures. They are atheoretical in that they do not test a hypothesis about how and why a program might work or what expected outcomes may be.

Evaluations or evaluation research, on the other hand, may be done by social scientists from inside or outside a program. Research is theoretical and involves the prediction of program outcomes. Evaluation research is the scientific test of a series of assumptions or hypotheses about a given treatment. Evaluation research is best carried out with an experimental group that receives the new program or "treatment" and a control group that does not. The ability to replicate or reproduce research findings is important in substantiating a study's findings. As research findings are replicated in additional studies, we gain confidence in the ability of that program to produce the same results with similar populations. As Lundman (1984:43) explains:

> The gain in confidence is greatest when replications do not repeat in exact detail all of the elements of a previous project. The question to be answered by searching for replicative studies is whether a treatment hypothesis implemented under a variety of circumstances is effective, not whether a project precisely repeated would have the same results. Diversity along dimensions such as location, dates and subjects are important in assessing the general effectiveness of a particular approach . . .

An evaluator may do either a report or a research study, depending on the type of information sought and its intended use. If the purpose of the evaluation is simply to see if a program is meeting its goals, for example to have clients complete the training or treatment, then a report may suffice. However, if the goal is to compare treatments or to measure the effects of a treatment over time, then a research study would be proper.

Inside and Outside Evaluation

In determining the "best" persons to evaluate a program, administrators distinguish between those who are *inside* or *outside* the organization. Inside evaluators may be agency researchers, board members, the director, supervisors or program staff. In some cases, inmates are surveyed or interviewed as part of the evaluation. Outside evaluators are experts in the type of program being evaluated. They are often administrators from similar programs in the state or from other states, scholars, or consultants in specialty areas. When expertise is not essential, community leaders may be selected for this role.

Several factors affect the decision to use inside or outside evaluators. The first issue is the administrator's *confidence*. It is important that the evaluator is competent and inspires trust. The second consideration is *objectivity*. It may be difficult for insiders to be objective about the material they review, to see facts clearly without prejudice. (For a discussion of objectivity, see Roberg, 1981.) A third aspect of this decision is the evaluator's *understanding* of a program or an operation. In many cases insiders have the advantage of really knowing what a program is about; they know how goals have been translated into projects and relationships. Outsiders may miss some nuances because they lack the working knowledge of a program and its relationship to the agency. However, this can be redressed with some extra preparation and access to pertinent details.

The final consideration in deciding to use inside or outside evaluators is the *plan the agency has for using the results*. Reports that are not going to be widely circulated or published may not require the neutral authority often associated with outside evaluations. When little money is available and strong pressure exists to conduct a full-scale evaluation, an in-house evaluator may suffice. Some agencies regularly conduct inside evaluations and undergo outside review every three to five years. One realistic compromise in the quest for meaningful evaluation is for studies to be conducted by the research office of the state or state department of corrections. Program staff may supply those data that can be analyzed by researchers not directly connected with the project. An even better solution is to consult with the

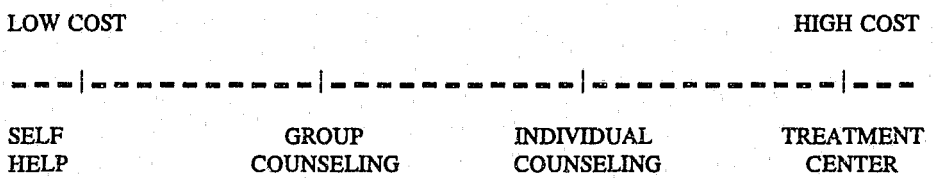
research office in the initial program development and implementation stages so that the appropriate data are tracked and available for analysis throughout the project.

There are several types of evaluations depending on the questions being asked of a program. One type is cost evaluation that provides a cost-benefit analysis of a particular program. It may also be able to determine if program alternatives, either more or less costly, can provide similar rates of success at meeting program goals.

Cost Evaluation

Cost evaluation is important, but it is not a substitute for a program review. Not all cost evaluations are inherently meaningful. The value of court-mandated or humanistically necessary programs cannot be measured by a cost evaluation. It is possible to assess required programs in terms of manpower and resource expenditures to find out if they are efficiently managed. Such comparative cost assessments between programs are becoming common, perhaps because little theoretical or practical agreement can be found on the assessment of "benefits." Also, there is little disagreement that certain types of programs such as education and drug treatment should exist. Thus, given similar outcomes, such as recidivism rates, programming decisions are more likely to be made along the lines of relative cost.

An assumed distinction is often found in comparing the cost of certain categories of treatment programs. As diagramed below, for example, self-help programs like AA will be much less costly to operate than programs using professional counselors. In fact, the number of professional employees, equipment, supplies, and support services necessary to operate a program will distinguish it in terms of the expenditures necessary for its support. These can be illustrated along a continuum of cost.



It is unrealistic to compare the costs of programs from two different service levels unless goals and treatment differences are also considered.

The Role of Information Systems

Applications

Computerized information management systems have revolutionized traditional management review. They generate those data used in the review/audit process as well as the new audit trails. This has been true in fiscal auditing since the advent of the computer. The IIA's Certified Internal Auditor (CIA) program addresses this issue in their certification criteria. Gleim (1991:148) acknowledges the computer as a common audit tool, noting that it is used daily for data management and comparisons, statistical analysis, and extracting information for audit test purposes. Experience with such systems is viewed as fundamental to the work of the auditor.

The IIA has included a module on auditing and information technology in its series on "systems auditability and control." The IIA says (1991:3-2) that "The use of information technology to support the internal audit function is no longer optional; it is imperative." Reviewers/auditors must discover and understand the audit trails left by automated systems. These systems may eliminate hard copy or "paper trails," forcing reviewers to directly access the system.

In the 1970s, automated systems were used in a few select departments. Use of information systems in corrections grew during the eighties, due to innovations in personal and mainframe computers.

Telecommunications and office systems technologies were also part of the new resources for managing information (Caudle, 1990). The application of these technologies to the performance review process has been limited and uneven across correctional agencies. However, these systems now provide new audit trails for use in performance review, and in some agencies the information derived is being integrated into the program review and planning processes.

The Hart and Moore study (1980:15) of information demand shows the following breakdown of requests for management information:

Government Agencies	25%
Executive	8%
Legislative	4%
Judicial	3%
Federal	4%
Social Service Agencies	6%
Correctional Agencies	24%
Universities	12%
Institutes and Councils	13%
Individual Citizens	15%
Private Firms	7%
Press	4%

Before a quality automated management information system is implemented, corrections departments must first accomplish their primary objective of automated recordkeeping. According to Alleman (1990:8), "America's jails and prisons lag woefully behind most other organizations in the use of computers. It is still more true than not that most prisons, despite size, rely primarily on antiquated, clerically based record keeping systems." Alleman stresses that good information management systems should allow those data to be recorded, reported, monitored, communicated, and analyzed. Systems that simply record or communicate information, and do not analyze, will not allow managers to effectively solve problems. Interactive systems alert users to important deadlines and possible errors in procedures. The most useful systems will handle large amounts of information and make it available in different formats. Simulation programs will allow managers to quickly understand the possible effects of proposed changes in one area on other related operations.

The automation revolution has not been painless or even efficient. A recent Government Accounting Office (GAO) report discusses problems in computerizing complex government agencies; these include introducing technology without proper needs assessment and staff training. The issue of secrecy also arises, along with an unwillingness to integrate these data, which means valuable information may not be disseminated. As one consultant explained to *Newsweek,* (DeSilva, 1992:70) there is a

> generational conflict between the Stone Age managers intimidated by scary computer jargon and young whizzes who can infiltrate enemy military systems with their laptops but aren't experienced enough to understand how government agencies work. The managers end up delegating computerization to the "techies" who in turn recommend complicated systems that may have little relation to the agency's needs. The government tends to let technology direct them and not direct the technology themselves.

In 1990-1991, the Robert Presley Institute for Corrections Research and Training and California State University-San Bernardino sponsored several workshops on managing computer resources. Participants included top managers (primarily wardens and superintendents) who were uncomfortable with how automation could enhance administrative effectiveness. Demonstration and hands-on sessions allowed them to directly experience some personal computer techniques, including spreadsheets and electronic mail.

Discussion topics included handling large data sets, computerized operations such as identification and commissary, and the need for security in access areas.

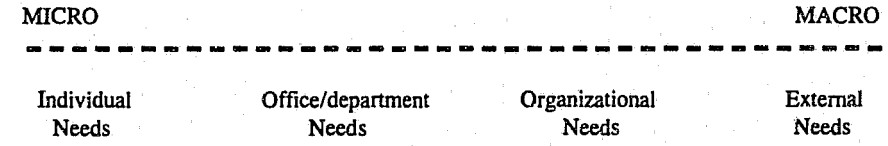
As managers have recognized, computers, particularly information management systems, have myriad applications. Functions range from managing employee records to scheduling maintenance, assigning shifts, controlling overtime, tracking disciplinary cases, classifying inmates and ordering food. The obvious benefits of such systems are the increased availability of information that permits greater efficiency in performing daily operations. Other benefits include shifts in resource allocations, as requests can be justified with facts and figures.

A disadvantage of computerized information management is that results are not immediate. Initially, a learning curve is found which reflects differing abilities. Also, many areas that profit from automation, including clerical and data processing, may not have a high profile or priority in the organization (Northrop et al., 1990). Automation did not result in many staff reductions, according to recent surveys of public sector administrators; however, cost savings did occur (Northrop et al.). Although computer support staff was hired, no increases were made to existing jobs despite increases in prison populations.

Use of Information

A management information system (MIS) can encompass the informal reports of staff, the inmate "rumor mill," and complex networks of inside and outside databases. However, most people associate management information systems with electronic data processing (EDP) systems developed to support internal operations. Internal data needs include all those administrative functions that support the structure of the system, such as fiscal activities, personnel management, inmate data maintenance, security, and physical plant operations. An effective information system not only processes those data, it also allows managers to respond to information demands from external entities by generating specifically formatted reports. Outside requests may come from governmental agencies, politicians, the press, or private citizens. A breakdown of the uses or need for management information may be viewed on a continuum from individual (micro) to organizational and extra-organizational (macro) needs.

LEVELS OF NEED FOR MIS



Management information should not be mistaken for or replace actual research. Although it addresses the frequency and trends of events, its use in decisionmaking should be guarded. Only more sophisticated research models using multivariate analysis (controlling for the effects of different related variables) can give us meaningful information about cause and effect relationships as well as the probability of certain predicted outcomes. Williams et al. (1992) outline some dangers of substituting MIS raw data for research.

- Raw data may be misinterpreted by persons without statistical training or without a sense of error related to the relative size of differences. If these data in a small sample show large differences it is easy to conclude that a real difference exists when the difference is, in fact, a fluctuation due to chance.

- When attempting to relate raw numbers with different bases, the accompanying percentages may be complementary or even the sole form of those data. Percentages based on small numbers may seem to indicate large differences when the movement (or addition) of only a few cases is really involved. Again, the differences may be the result of mere chance.

- Raw numbers and percentages provided to managers are not controlled and may be misleading if compared to raw data for another area. Differences in raw data exist for various reasons, the most common of which is that the two areas are different entities with different functions. Comparisons must be based on similar elements. For example, five apples are not necessarily better tasting, more expensive, more nourishing, or harder to digest than four pears; the number reveals only that there is one more piece of fruit in the apple group than in the pear group.

- Raw data are generally out of context. Easy access tempts the manager to bypass the research unit that explains differences, controls for important variables, and is based on appropriate statistical analysis. Managers must understand how data are interpreted to avoid drawing poor and incorrect conclusions.

- Finally, it is possible that aggregated data, rather than individually based raw data, may be the basis of the management information system. If this is the case, the database would appear to contain valuable information, while in reality all of the above problems apply. Further, nothing can be done to make aggregate data more useful without an understanding of those original raw data. The entry of individually based raw data is preferable to those data aggregated at input.

This study examined how information systems are used in corrections to support performance evaluation. Issues included the degree to which MIS results (reports, etc.) are integrated with performance review and the auditing functions. In some cases performance review, management information, and short and long-range planning were linked in the same system. Integration of these functions met organizational needs far beyond those of managers, auditors, or specific organizational units.

Information systems in correctional agencies focus on three areas: operations support, direct service, and population summary information. For purposes of the study, these categories were used to look at information systems in the jurisdictions and the topics in each can be summarized as follows.

ORGANIZATION OF INFORMATION SYSTEMS

OPERATIONS SUPPORT	DIRECT SERVICE	POPULATION SUMMARY
Finances	Inmate Accounts	Population Trends
Personnel	Canteen/Commissary	Racial Balances
Training	Classification	Admission
Scheduling	Discipline	Assignments
Staff/Inmate ratios	Grievances	Housing
Vacancies	Health	Work
Fixed Assets	Pharmacy	Charge/Sentencing
Inventory	Vistor Control	Calendar/Scheduling
Vehicle Management	Property Inventory	Detainer/Warrants
Key Control		Discharge
		Move Orders

Shugoll and Dempsey (1983) distinguished between *operational data*, the case information used in daily decisionmaking, and *statistical data*, the aggregate data compiled for reports and statistical summaries. Many corrections departments (New Jersey, Georgia) now publish statistical reports in addition to or instead of traditional annual reports (Nevada, North Carolina).

Operational data have become "friendlier" to management needs, and systems can now measure staff and inmate conditions. The Moos Correctional Institution Environment Scale is a 90-item true-false instrument that can be administered to personnel or inmates. The social climate scale measures three dimensions of institutions: people-to-people relationships, institutional programs, and institutional function. Specific variables include whether inmates are encouraged to develop autonomy, whether programs are oriented toward release and jobs, and whether program rules are clear (Houston, Gibbons and Jones, 1988). Such an instrument can track attitudes over time to compare attitudes between institutions.

Another example of operational information designed for managing prison environments is the *Prison Social Climate Survey*, used by the Federal Bureau of Prisons (BOP) since 1988. It surveys randomly selected staff and inmates and assesses living and working conditions in the BOP. It provides valuable information on personal safety, security, quality of life, and personal well-being within the work environment. Another project of the Office of Research and Evaluation is the Key Indicators/Strategic Support System (KI/SSS) that is discussed in greater detail in chapter VII. The automated system provides information on inmates, staff, financial management, and institutional operations and was developed to support performance review and planning capability (see Saylor, 1983, 1988a, 1988b, 1989). The Program Review Division integrates information from various sources into a system that supports goal setting, evaluation, and future planning (Lebowitz, 1991:13). In addition, the Office of Research and Evaluation (ORE) was moved to a new Information, Policy, and Public Affairs Division. ORE also conducts various studies on BOP programs and services that are part of a strategic planning effort.

Data Entry and Security

A controversial aspect of automated data systems is centralized versus decentralized data entry. **Centralized** entry systems offer uniform methods and specificity in job function, whereas **decentralized** entry allows those most familiar with each type of information to file that information. For example, medical services personnel would code and enter medical data. Similarly persons in classification, discipline and education would code and enter their data on inmates and operations. The advantage here is a level of quality control, presuming that data processors better understand and could therefore adjust information variables. This method prevents personnel unfamiliar with a discipline from incorrectly categorizing entries. Data processors familiar with an area may be more likely to rectify errors or missing information; such accuracy and thoroughness can only enhance quality.

Information security is an important issue. In 1987 the Federal Government passed the Computer Security Act, legislation that established minimum security practices to protect sensitive information in Federal computer systems. It also requested that computer systems with sensitive information be identified and that agencies submit plans for their security to the National Institute of Standards and Technology, the National Security Agency and the Office of Management and Budget (OMB) for review. Areas of security concern include personnel screening, risk assessment, audit and variance detection, security awareness and training measures, and controls for authorization/access, hardware/software maintenance, data integrity/validation, physical environment, confidentiality, and emergency backup and contingency planning.

While Federal agencies continue to implement these controls, a recent Government Accounting Office report noted that many Federal agencies have yet to meet the goals and deadlines outlined in the 1987 legislation (GAO, 1992:1). Some officials had bad experiences in developing a computer security plan, learning that data entry and security controls must be in place to ensure that the "data trails" left by automated systems are timely, accurate, and useful.

The ***integrity*** of a management information system depends on the accuracy of those data entered. Most data processing software automatically detects wrongly coded entries and flag errors for resolution by the entry operator. MIS ***security*** refers to protection against intentionally introduced error and unauthorized access to sensitive databases (Waldron et al., 1987). Depending on the particular database, the extent of possible damage from unauthorized access will vary.

Designating information as "sensitive" or "vulnerable" is controversial, and the practice has inhibited the widespread use of databases. Evidence shows user resistance to the system, due to the possibilities for exploiting sensitive information and cumbersome security systems. For example, the California Department of Corrections has a 48-page manual on computer security that is based on the Federal Bureau of Prisons' Task Force on Inmate Access to PCs report. Its recommendations include:

- the prohibition of inmate writing of programs used to conduct the work of the institution;
- the designation of a full-time computer security specialist at every institution;
- the establishment of a computer security committee to develop system-wide plans and policies;
- limiting inmate access to PCs and software, and the controlled release of diskettes to prevent tampering with files;
- consider locking devices on disks or drive units when appropriate;
- identifying computer-literate inmates and those known for computer fraud/abuse and excluding them from computer-related assignments.

Other recommendations are regularly scheduled training sessions on virus control, use of passwords, and optimal use of backup procedures.

It is likely that concerns about computer security and potential abuse of automated systems have hindered the use of sophisticated management information systems. It is also possible that some managers use security as an excuse for not developing such systems. However, the value of aggregate data to anyone except managers and researchers is debatable, and the potential for abuse seems minimal.

CHAPTER IV

THE STRUCTURE OF PERFORMANCE REVIEW

Since an agency's performance review system reflects its organizational structure, it is no wonder that little uniformity is found in the application of such systems in the United States. A recent analysis of organization charts of several U.S. correctional agencies shows how they vary in structure. The Federal Bureau of Prisons (BOP) takes a regional approach, which brings management support closer to field locations and enables each region to conduct its own audits and management reviews. It is held that "regionalization has enabled timely and effective guidance to local institutions through streamlined administrative procedures" (Quinlan, 1988). BOP's Occupational Safety and Environmental Health Program ensure a safe and healthy physical environment by having Safety Managers at each site to inspect food service operations, living units, vehicles, and hospital operations. A major concern is proper use of equipment, especially in activities carried out by Federal Prison Industries (UNICOR).

Our examination of organizational charts also revealed the placement of performance review offices. Many departments lack a research office, believing their management information systems are sufficient; they tend not to develop more sophisticated research/evaluation capabilities. One state DOC's research office is so low on the organizational chart it appears to lack direct access to senior management. However, some organizations are modifying their performance review functions, if only with relabeling. A recent change in another state has planning and research report directly to the commissioner, rather than to an assistant commissioner.

As noted earlier, significant restructuring took place in the Federal Bureau of Prisons to maximize information gathering and use. A new division was created to better promote the use of management information and review, and the Office of Research and Evaluation was moved within the Federal Bureau of Prisons to a new Information, Policy, and Public Affairs Division. The Office of Research and Evaluation conducts studies of treatment programs, recidivism, and other areas, and surveys the staff's perception of the work climate; this information is used in strategic planning within the Bureau.

A Framework for Evaluation of Performance Review Systems

While the development of management-directed performance review systems has varied over the years, the basic components include internal and external review on both continuous and intermittent schedules, with different systems for ensuring operations and program controls. Most agencies can identify their external and internal review units within this framework. Many functions, such as annual fiscal audits, can be clearly identified as external, intermittent activities. State or Federal (OSHA) safety inspections are similarly external and intermittent, although regularly scheduled. Investigations might occur any time, as can court orders requiring oversight. Evaluation of a program can be continuous but usually for a specific period of time only.

Functions such as program review and internal audit are ambiguous. They are not specific to a given time frame, and, depending on the location of the activity in the organization, may be viewed as external or internal in nature. A warden may consider a review initiated by central office as external, while central sees it as internal. Many activities, such as fiscal controls and database maintenance, have built-in controls that operate continuously. These controls are also reviewed intermittently, especially with respect to their application.

Conduct of the Study

This study highlights the Federal Bureau of Prisons and six state program review/audit systems. It includes information on the system used by the Correctional Service of Canada. The intent was to identify

those aspects of performance review/internal audit that would contribute to a model attainable at some level by all correctional jurisdictions. The draft reports were reviewed by directors and representatives of several correctional systems for their feasibility.

Project staff studied the Program Review Division (PRD), the internal audit arm of the Bureau of Prisons created in 1988. The division assumes that program review is linked to overall agency performance as well as the planning function, information systems, and research and evaluation needs. We involved as many correctional agency personnel as possible during the study. It is hard to "sell" management on the idea of adopting "model" programs designed elsewhere which they feel may not apply to them. However, it is imperative that field personnel participate in any process that will affect their jobs (Reimer & Sechrest, 1979; Sechrest & Reimer, 1982).

The model internal program review/audit system presented in this report identifies the structural components that lead to better management control. No perfect system exists for program review/audit of organizational activities. Agencies with the most comprehensive review/audit functions have an administrative commitment to such systems and also to sufficient funding.

Generally, the automated information systems examined were not linked specifically to the internal audit process, although they were a component of the management review process in most jurisdictions. The BOP and the Correctional Service of Canada have linked technology to performance review and planning, and hence to organizational outcomes. Both systems refer to "strategic plan goals" or "corporate objectives." The use of these information systems in internal auditing is now being explored. As with other technologies, the proper management of information systems is important to both performance review and internal audit.

Summary of the Field Visit Process

An open-ended, 21-item questionnaire was used to determine the present condition of the program review/internal audit function in our sample group. This format is based on the definition of administrative controls discussed above. It is reproduced here (as revised) as a reference for agencies that wish to assess current program review and internal audit capabilities or plan a program review and internal audit function.

Table 4

Analysis of Program Review/Internal Audit System
Onsite Survey Questions

I. ORGANIZATIONAL ISSUES (Controls):

A. Legislation: Does enabling legislation/federal regulation exist to guide the program review process? Are copies available?

B. Policies and Procedures: Does your agency have comprehensive, written internal policies and procedures for the review/audit process? Are copies available?

C. Operational Standards: Is the program review/internal audit function guided by policies and procedures?

D. Organization: Does your agency have an organizational chart, job descriptions, post orders or other documents that show staff involved in the internal review process?

E. Staff: How are staff assigned? How many staff are involved? Do the reviewers report to an individual who is placed at a sufficient level within your agency to insure objectivity and independence of the review process?

II. PLANNING ISSUES (Controls):

A. Are written audit plans and schedules prepared?
If **YES,** obtain copies and determine who prepares these documents and how they are distributed.

B. Find out if relevant training is provided reviewers. Obtain copies of lesson plans or other documentation. Determine if reviewers are associated with professional audit associations or organizations and obtain related certifications.

C. Determine how your agency identifies facilities and entities to be audited. What is the audit universe? Is the audit universe prioritized for reviews based on any process of formalized risk factoring? Is related documentation available?

D. Is the time scheduled for onsite visits adequate to address the scope of the review?
If **NOT**, determine disadvantages of short time frames.

III. OPERATIONAL ISSUES (Controls):

A. Are facility and agency staff sufficiently familiar with the review process and the policies, procedures, and other guidelines that will be used in their review/audit? Are they generally well prepared for the review? Is a review announcement prepared? Is an entrance conference conducted?

B. Are written instructions prepared for/by the reviewers for the onsite verification phase (i.e., an audit/review program)? Are uniform instructions given as to sample size? What types of documents are to be reviewed? Is there consistency in review testing procedures from facility to facility and unit to unit?

C. Are the reviewers provided the information needed to conduct appropriate audit/review tests (i.e., documents, staff schedules, opportunities to observe practices)? Does the review occur in a generally cooperative environment?

D. Is sufficient audit/review evidence gathered and are appropriate evaluations made (i.e., are working papers sufficient and are logical assessments and conclusions made by the reviewers)?
Review a sample of working papers (refer to relevant criteria).

E. Do the reviewers provide management immediate verbal response at the end of the onsite phase? If not, should they? Does an exit conference occur? Does management provide a response to an audited unit? Are there opportunities for management to seek clarification from the reviewers?

F. Do the reviewers possess adequate professional proficiency to conduct the reviews? If **NOT**, what additional training, education, experience, etc., is needed?

G. Are the policies and procedures or standards used as review/audit criteria sufficiently comprehensive? If not what is missing. What operational areas do wardens and managers find important or troublesome that are typically not included within the scope of the reviews? Are life, safety and health issues adequately addressed for example?

IV. INFORMATIONAL ISSUES (Controls):

A. Are written review reports provided regularly? Does policy and procedure require report preparation within specified time frames?

B. Do the audit review reports present an accurate portrayal of existing conditions and offer sound recommendations?
If **NOT**, is there a workable method in place to address the accuracy of the report and seek clarification from the reviewers when necessary? Obtain and review sample reports?

C. Are audit/review reports useful tools in developing action plans to remedy deficiencies? For example, has your agency successfully used reports for purposes of capital requests, for assigning responsibility for systems development or writing policies and procedures?

D. Are followup reviews conducted?
If **NOT,** is there a mechanism to ascertain the degree of resolution of issues identified in the review reports?

E. Are written action plans generally developed in your agency to address deficiencies identified by both **managers** (management review system) and **reviewers?**
Please explain or define the current management review system that exists within your agency including methods of documentation. (It would be useful to obtain samples of written action plans).

F. What role do external auditors/reviewers play in influencing the management review system within your agency? Please be specific as to state, legislative, fiscal or ACA auditors, OSHA inspectors, fire marshal, etc.

Criteria for Measurement

Standards for a program review/internal audit system were derived from the *Government Audit Standards,* Comptroller General of the United States (1988), the *Codification of Standards for the Professional Practice of Internal Auditing,* (The Institute of Internal Auditors, 1989), *A Common Body of Knowledge for the Practice of Internal Auditing* (The Institute of Internal Auditors, 1992a), and the actual practice of internal audit. These criteria should be used by organizations who wish to develop a program review/internal audit capability.

CHAPTER V

MODEL PROGRAM REVIEW/ INTERNAL AUDIT SYSTEM

This chapter presents a model that can be the basis for an activity plan to implement program review or internal audit procedures in a department of corrections, prison, jail, or other correctional organization. The steps necessary to developing a model are outlined and examples are given. The model draws on the field work presented in detail in chapters VII and VIII for program review/internal audit procedures used by the Federal Bureau of Prisons and departments of corrections in Illinois, New Jersey, Utah, Idaho, Oregon, and Washington State.

The steps or activities presented in this chapter will not apply in the same way to every agency considering implementation of program review. However, the developing art of internal review suggests that a specific body of techniques are required for its successful implementation. Any model, such as that presented here, is a depiction of an issue under study. Whether quantitative (using numbers) or descriptive (discussing how a manager might respond to a union demand), a model should lead to better decision-making. Models reduce one's reliance on intuition. They are based on facts and, therefore, provide objective information as well as clues to the consequences of a particular action. They are integral to the planning process.

Model development has three stages: 1) describing the current system or activity in terms of its goals, objectives, and strategies for attainment; 2) defining the improvements that would facilitate meeting goals; and 3) designing a blueprint based on the first two steps that would allow the achievement of these goals. Thus, a model must describe present conditions, desired goals, and a method by which to achieve them. The model exists for guidance, to provide a standard; it will not be immediately realized by every agency. Its value to each correctional system should be weighed in terms of existing resources and potential benefits.

Our model addresses how program review systems should operate and their future direction. More detail is provided in later chapters. This chapter summarizes the basic concepts and steps of program review to guide agencies in developing their own review capability. To the extent possible, these elements are designed to show how they can be adapted to organizations of different sizes and structures. This section includes:

- a listing of elements essential to good program review/internal audit and evaluation systems;
- a format for managers to use in analyzing their existing operations;
- the organizational requirements necessary to establish a program review or internal audit capability;
- an outline of an actual program review, including a risk assessment procedure;
- a plan for evaluating the program review system used based on a variety of performance criteria;
- a description of information system requirements and software that can support program review/internal audit and evaluation activities;
- a description of the barriers to effective implementation of program review/internal auditing and program evaluation.

Organizational Steps for Program Review/Internal Audit

The way in which the program review is organized and conducted is critical to its usefulness to the agency. Our model outlines the general procedure, but each entity (state, county and local correctional agency) and department must establish initiatives that reflect its needs. The agency must make commitments in these areas before implementing the review process, details of which follow. Organizational steps include:

- enacting enabling legislation or charter;
- establishing agency policy or an internal directive;
- identifying the disciplines or functional areas to be reviewed;
- identifying areas of greatest risk;
- establishing measurement criteria and a reporting system for results;
- a method for making the system relevant to personnel performance;
- making the system part of the planning and decisionmaking process;
- establishing the internal audit function;
- developing information sytem support;
- developing a strategic management capability;
- conduct training and marketing.

Enact Enabling Legislation

The auditing function should be authorized either through enabling legislation, a charter, or both. An example of model internal audit legislation has been drafted by The Institute of Internal Auditors and is included as Appendix A.

Federal agencies—in accordance with 31 U.S.C. 3512 (b)(1), which refers to executive accounting systems, and the Office of Management and Budget (OMB) Circular A-123, which addresses internal control systems—are required to establish a continuous process for the evaluation and improvement of the organization's system of internal controls. Several states studied have already enacted audit legislation.

The IIA standards establish the importance of an audit charter for an organization operating an internal audit function. These standards (Institute of Internal Auditors, 1989:10) state that the purpose, authority, and responsibility of the internal auditing department should be defined in a formal written charter, and that "the charter should a) establish the department's position within the organization; b) authorize access to records, personnel, and physical properties relevant to the performance of audits; and c) define the scope of internal auditing activities."

A charter may require the organization to provide an annual statement assuring compliance with applicable laws and adequate systems of internal control. Such a statement should comprise a report of material weaknesses and corrective actions taken or planned and should consider internal and external reports. The charter and law should grant auditors access to records and information, delineate reporting

responsibilities, and specify lines of authority. It may also specify educational, experience, and certification requirements for auditors.

Establish Organization Policy or Internal Directive

The Chief Executive Officer (CEO) must officially state in an agency directive that managers are responsible for the development and application of internal controls. The program review/audit function, however, must be established independent of management. Unit administrators will be held accountable for the program review/audit findings and any corrective action required. The organization policy or internal directive is the foundation of the program review process.

Identify Primary Disciplines for Review

The organization should identify the primary disciplines or major program areas that are to be measured. These areas should be further grouped into "indicators," specific functions and related processes, that are directly linked to the organization's goals and objectives.

Identify Areas of Greatest Risk

Audit areas deemed "at risk" should be identified by staff, who should also assess critical factors or indicators within these areas. Areas where actual practice significantly deviates from goals, objectives, policies, procedures, laws, regulations, and standards may have serious ramifications for the organization.

Establish Measurement Criteria and a Reporting System

The organization should establish standardized audit criteria to measure the performance of the areas under review. It should also establish a uniform method for reporting program audit findings. In an audit of an agency's compliance with standards, the consistency of audit testing procedures and the completeness of evidence are major concerns.

Make the Review System Relevant to Personnel Performance

The organization should establish a procedure to incorporate audit findings and recommended corrective action(s) into the performance plans for the managers responsible. Executive management must demonstrate the significance of the internal control process by using audit results as a management indicator in evaluating personnel performance.

Make the Review System Part of the Decisionmaking Process

Managers at all levels must be trained to interpret information relevant to their areas and to make decisions based on their analyses. The following are specific to this area:

- The CEO and executive staff will consider budget requests and appropriation transfers only if they are accompanied by quantifiable data and supporting information.
- Modifications in mission, program, or function must be supported by objective data. Changes should be monitored over time to see if desired results are achieved.

- Proposals for new initiatives, services, or programs should include a cost benefit analysis supported by objective and quantifiable data. They should include the "key" or critical indicators that will be measured during future audits and program reviews.

- The organization should incorporate the results of the review/audit process into the annual budget cycle. Results should also be used to identify the goals and objectives of the organization for the next year.

Establish the Internal Audit Function

Generally accepted government and internal audit standards address the impact of the program review/internal audit function. This function should be determined by the following controls:

- Organizational—the organizational status of the program review/audit function as indicated in enabling legislation and charter;

- Planning—identification of important review areas, establishing priorities (risk assessment);

- Operational—program review/internal audit policies and procedures, planning and initiating a program review (the preliminary survey), conducting and managing onsite verification, local operational reviews, follow up reviews, quality assurance;

- Informational—reporting review results to management and developing action plans to correct deficiencies.

A crucial step in the auditing process includes examining the documentation that accompanies the report findings. The quality, validity, relevance and thoroughness of audit *tests* and *evidence* directly affect how useful the resulting audit report will be. During the *evaluation phase* of the audit, examiners find the degree of compliance with laws, rules, policies, and regulations; the level of economy and efficiency; whether the program results are achieved; and they recommend corrective action when actual practices and standards differ.

Integrate Review with Information System

Modern management practices require an information system that can support many functions, including program review. Existing data collection systems, both automated (mainframe, minicomputer or PC-based) and manual, should be assessed to determine the availability and accessibility of needed information. Findings from the assessment should:

- include a management information system (MIS) model, a user feasibility study, and a cost proposal; the model should integrate existing data collection operations in order to support the internal control/audit review process;

- provide executive management feedback on the internal control/audit review capability.

Develop a Strategic Management Capability

An internal control program that monitors and measures institutional performance must be part of a comprehensive strategic management plan. Information collected from the internal control process must

be fed back to executive staff and policy makers to develop long term plans and establish organizational goals. Staff must be trained and oriented to the strategic management cycle and the relationship that the internal controls program has in providing responses to management. The following are specific to this area:

- Each organization should identify and publish its goals and objectives.
- Each organization should determine the existence of long term planning or strategic management capability and/or a formal annual planning cycle.
- If a strategic planning cycle exists, it should include input from each level of management and the information needed to monitor workload performance.
- The strategic planning capability should provide a feedback mechanism for each level of management in order to assess the performance of their respective areas of responsibility.

Conduct Training and Marketing

Executive management must educate managers about the value of the program review/internal audit process to the organization. The orientation should be presented to others who are interested, including staff and inmates.

The Program Review/Internal Audit Model

Implementation of the program review/internal audit process requires that four areas be addressed, at a minimum: enabling authority, organizational controls, internal controls, and operational controls. The need for enabling legislation and/or a charter has been discussed above. The following procedures are likewise fundamental to the attainment of a program review/internal audit process.

Organizational Controls

The status of the review program within the organization is addressed in government and internal audit standards. *Government Audit Standards* (Comptroller General of the U.S., 1988:3-8) state that "the audit organization should report the results of their audits and be accountable to the head or deputy head of the government entity and should be organizationally located outside the staff or line management of the unit under audit."

Standards of The Institute of Internal Auditors (1989:9) also indicate that "the director of the internal auditing department should be responsible to an individual with sufficient authority to promote independence and to ensure broad audit coverage, adequate consideration of the audit reports, and appropriate action on audit recommendations."

Internal Controls

An internal control system includes risk assessment and auditing, functions that define the audit universe and set priorities. Important audit areas are suggested in several ways: by agencies internal and external to the department, by surveys, by management concerns including known problem areas, and by state or national correctional standards.

The risk assessment tools presented in this report use quantitative techniques that help determine and prioritize high risk areas, an essential preliminary process. Because resources required by the review process can be hard to find, Sawyer (1988) sees risk assessments as a type of analytical review procedure

which is linked directly to the effectiveness and value of the audit unit to the organization. Important or high risk areas must be identified in order to better direct resources. Sawyer (1988:447) makes it clear that "Risk analysis is perhaps one of the greatest challenges to auditors. It requires skill, experience, knowledge of operations, personal contacts, awareness of the operating climate, and an understanding of the firm's objectives and operating philosophy."

Defining the Organization

The first step in determining operational risk is to assess units according to their vulnerability. No one method applies to all agencies. Organizations vary in structure and activities performed. However, agencies often define themselves according to their information system needs, and these divisions may be suitable for auditing purposes. "The important thing to remember is that the inventory should encompass the entire organization, and the individual assessable units should be of an appropriate nature and size to facilitate the conduct of a meaningful vulnerability assessment" (Arthur Andersen and Company, 1986:9).

Identifying Areas of Risk

Program review staff should focus on issues which represent material risk. Sawyer (1988:203) indicates, "The professional internal auditor should be able to identify the objectives of an operation, the risks that lie in the path leading to the objectives, and the key controls in effect, or needed, to help achieve the operation's objectives." The IIA *Standards* (1989) also address establishing the audit universe and developing priorities for planning and conducting the audit.

Of the jurisdictions studied, most had formalized methods based on quantifiable measures for identifying the audit universe and for scheduling activities. The BOP assessment process examines each component of a discipline or program to determine:

1) the vulnerability of the program to fraud, waste, abuse, and mismanagement;

2) the potential for serious problems if policy and regulations are not followed, or systems of internal control are not adequate;

3) the degree to which resources are being used efficiently;

4) program review priorities;

5) management indicators by which program operations are to be evaluated.

Management meetings offer a structured forum for assessing risk and needed changes. Discussions should 1) identify an objective for operational activities, 2) assess the level of risk, 3) articulate procedures or control techniques that ensure that operational objectives will be met and problems avoided, 4) identify the perceived adequacy of these controls and safeguards, 5) anticipate the significance of actual risk to the program's mission, 6) distinguish methods of reviewing the activity to ensure controls are adequately tested, and 7) index specific program review objectives and steps to carry out testing. The central office program administrator is responsible for maintaining documentation about the assessment process.

A risk assessment tool was described earlier in this report. This tool, developed in Utah and based on an IIA model, identifies institutional functions and processes outlined for 13 areas of possible risk, shows the factor criteria established, and identifies the review/audit priorities established. Management control plans should identify the level of risk associated with program areas and present corrective

measures for problems that do not require additional review. Any special studies, surveys or task force efforts to examine problems in detail should include a firm schedule.

The review/audit plan or schedule developed in this process should include the number of planned audit hours, the risk factor, the institution or unit to be audited, a summary of previous internal and external audit findings, the number of repeated findings, and the percent of audit hours versus the percent of expenditures for each institution. In establishing audit priorities, key assumptions and judgmental risk assessments should be based on prior external and internal audit results.

Operational Controls

The demands of maintaining a comprehensive program review/internal audit function require operational guidelines for internal audit staff. IIA *Standard* 530 (1989:48-49) addresses this issue, calling for policies and procedures "appropriate to the size and structure of the internal auditing department and the complexity of work." Formal procedures and technical manuals may not be necessary in smaller units, although they are advisable in larger organizations. Greater detail is provided in chapter VIII.

Policies and Procedures

Comprehensive written policies and procedures must guide the review process from its development through implementation. Appendix B provides a Summary of General and Specific Standards for the Practice of Internal Auditing. Similar guidelines are found in BOP *Program Statement 1210.12*, found in Appendix C. The policy should include:

1) a declaration regarding the purpose and scope of the review process;

2) a listing of all affected directives and standards that are rescinded or referenced;

3) a catalog of terms used;

4) a description of how the program statement is organized;

5) background information, including laws and regulations that necessitated the development of the program statement;

6) the overall policy regarding program reviews;

7) a summary of management responsibilities;

8) a series of statements concerning executive and administrative staff responsibilities for the program review process;

9) a description of the role and function of each unit and how it relates to the program review process.

The policy must identify vulnerable areas, classify the types of reviews required (routine or special), and include the availability of resources (see Haefeli, 1989). It must cover planning, verification and evaluation, and reporting results. The examination phase (data collection, interviewing, observing) is essential to the audit, and the policy must emphasize its structure and accomplishment. The policy should define acceptable audit evidence and include guidelines for obtaining it. Other guidelines include those for situations where auditors must redirect or stop the review due to unforeseen problems. In addition,

working papers, invaluable assets to the audit process, must be addressed, including forms, general sampling methodology, and documenting reviewer evaluations (judgments made by reviewers based upon the evidence gathered).

An audit liaison (the facility/organization representative) should be assigned. This person plays a vital role in the audit. The liaison insures the timely progress of the audit, according to the planned scope and schedule. Duties include overseeing the verification phase, development of a draft report, and obtaining an evaluation of the program review team from the chief administrative officer of the facility audited.

Another policy issue, important for closure of the review process, is the presentation of material findings, which should include the elements of a finding (condition, criteria, effect, cause, and recommendation). Also of concern is the fairness, accuracy, clarity, persuasiveness, and timeliness of the report. Review/audit report distribution, retention, and release provisions should be incorporated in policy as well as procedures for review/audit followup.

In summary, policies and procedures must guide all aspects of program review/internal audit, including 1) department risk assessments to establish review priorities, 2) review/audit schedules, 3) review/audit programs, 4) the onsite verification and evaluation phases, 5) reporting results, 6) review/audit followup, and 7) local program reviews/internal audits. These guidelines should be part of an administrative manual issued department-wide, with more detailed information available in technical manuals for the review/audit staff.

Planning and Initiating the Program Review/Internal Audit

The first stage in conducting a review involves the *preliminary survey* (see Sawyer, 1988:129-130), which provides information on managing finances and operations and for evaluating and reporting performance. It "will also provide information about the size and scope of the entity's activities as well as areas in which there may be internal control weaknesses, uneconomical or inefficient operations, lack of effective goal achievement, or lack of compliance with laws and regulations. However, tests to determine the significance of such matters are generally conducted in the detailed audit work as specified in the audit program" (Comptroller General of the U.S., 1988:6-2).

An *audit program* must be developed upon completion of the preliminary survey. The elements of an audit work program, addressed by the IIA (1989, Standard 410), include:

- establishing the audit objectives and scope of work;
- obtaining background information about activities to be audited;
- determining the resources necessary to perform the audit;
- communicating with those affected by the audit;
- performing an onsite survey in order to become familiar with the activities and controls to be audited, identify areas for audit emphasis, and invite auditee comments and suggestions;
- writing an audit program;
- determining how, when, and to whom audit results will be communicated;
- obtaining approval for the audit work plan.

Sawyer (1988:193-194) notes that these steps "provide for the gathering of evidence and permit internal auditors to express opinions on the efficiency, economy, and effectiveness of the activities under review." The program lists directions for the examination and evaluation of the information needed to meet the review/audit objectives, within the scope of the audit work.

BOP *Program Statement 1210.12* requires a written site plan that includes the review site, program area (discipline), scope, dates of review, suggested team members, estimated budget in dollars and reviewer days, date of last review, status of last review, a summary of indicators (previous review findings and other data, potential problems, and any anticipated adjustments to the Program Review Objectives). Appropriate approvals are obtained. The reviewer-in-charge then implements the plan, which includes arranging for the services of team members and onsite logistics.

At this point, a review/audit program should be prepared by the reviewer-in-charge, usually after the pre-audit survey phase and before the onsite verification phase of the review/audit. The review/audit program identifies general areas to be audited and explains what was found during the pre-audit survey. A series of audit objectives and required audit tests are developed, followed by standards and criteria that will enable reviewers to concentrate on priority areas. These can include areas highly vulnerable to risk, those having the potential for savings, and those where there have been problems. Checklists and other forms are developed as required by the audit program. A list of review steps follows the objective, background statement, and policy steps. These steps describe the work required to meet the program review objectives, and they represent the minimum acceptable testing that must occur to obtain the evidence necessary to meet the program review objective. Management indicators that may be contained in program review steps reflect the expected outcomes of programs. They result in information allowing the monitoring of goal attainment.*

The reviewer-in-charge should become thoroughly familiar with the audit area by reviewing all applicable laws, regulations and policies and procedures; obtaining and analyzing organization charts, job descriptions, and post orders; examining past audits, reviews, and investigations; conducting an inspection of the entity and interviewing staff; and interviewing executive, legal and other staff to identify relevant issues. Management is responsible for identifying weaknesses in internal controls and reporting these weaknesses to the auditors.

Conducting the Field Work

The field work is the heart of the program review/internal audit process. It must be conducted and managed in a way that evaluates performance according to accepted standards. It is a systematic process of objectively gathering evidence about the organization's operations, evaluating it, and finding out whether those operations meet acceptable standards. As Sawyer (1988:227-228) notes, "The term 'systematic process' implies planned audit steps that are designed to meet audit objectives. It also implies that the internal auditor will employ professional discipline in the audit, as well as scientific method, while gathering, arraying, recording, and evaluating evidence."

Verification of Assumptions. Field work verifies the assumptions made during the preliminary survey. That is, the scope, methodology, tests and procedures used must provide reasonable assurance that review/audit objectives are accomplished. This may involve statistical sampling, standardized data

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*The steps outline the work to be done during the review, specific documents to be examined, sampling techniques to be used, span of time to be reviewed, processes to be observed, persons to be interviewed, and purpose of the program review step. Appropriate references to policy, regulation, standards, etc., may be included, which will reduce the amount of time required by reviewers to become familiar with review criteria from these sources.

collection, statistical inference, quantitative techniques and other aspects of quantitative analysis (Comptroller General of the U.S., 1988:3-11).

Records. Complete records are essential to the review/audit process, because they substantiate the reviewer's conclusions. These are the "working papers," which may include tapes, films, and disks.

Testing. Review/audit findings are tested to ascertain how well they support an audit opinion. The test process examines all or part of the documentation, including transactions, records, activities, functions, and opinion. Sawyer (1988:240) has identified the steps to be taken in testing, which are included in chapter VIII.

Evaluation. After taking their measurements, the auditors evaluate their findings to arrive at professional judgments. It is also useful for them to evaluate the standards they are applying during the audit, since even established performance criteria can be improved upon (Sawyer, 1988:232).

Sufficient Evidence. The verification and evaluation efforts that result from conducting audit tests, assembling working papers, and making judgments must be of high quality. Findings and conclusions in reports must be fully supported by "sufficient, competent, and relevant evidence obtained or developed during the audit" (Comptroller General, 1988:3-11). The working papers serve as evidence in the event program review conclusions are challenged. Physical evidence is most dependable, followed by documentary or analytical evidence. Testimonial evidence, or interviews, may be the least reliable.

Due Professional Care. Program review staff must be proficient and exercise due professional care. A growing body of audit knowledge is available, covering types, tests, procedures, and methodology. Auditors should be familiar with this information and apply it to the review/audit being undertaken.

Working Paper Review. The audit itself, once completed, must be reviewed to ensure that procedures were followed and that supporting documentation exists. The audit director may designate members of the program review/internal auditing department to do the review. This review should be conducted at a level of responsibility higher than that of the preparer of the audit working papers (IIA standards, 1989:39).

BOP *Program Statement 1210.12* provides an overview of the program review process. The examination phase of the review involves all the data collection, interviewing, and observations conducted at the review site. In this phase, the reviewer-in-charge holds a meeting with team members and briefs them on the plan, including division of labor, time frames, objectives, and sampling techniques. The department head and staff are informed that all comments that might alter findings and recommendations, or that provide information concerning the cause of deficiencies, will be fully reviewed and considered, and that the reviewers will work with the department head and staff to find causes and solutions.

Management should be regularly briefed via the review/audit liaison, to clarify preliminary review/audit results. Should urgent issues arise (e.g., security, health, or safety deficiencies), auditors must immediately report them verbally and in writing. This should be done through the reviewer-in-charge or through the local program review/audit director, and these issues should be included in the final report. A briefing on the final day should be conducted with management in which the reviewer-in-charge states when the draft report will be provided to management.

All review/audit tests must be thoroughly documented, whether these tests are done on a computerized spreadsheet or through other means. Working paper summaries must be prepared for each audit work program area and objective or series of objectives. The content of these papers is discussed in chapter VIII. All working paper summaries and supporting documents, such as records of discussion, checklists, and spreadsheets, should be coded to a referencing system developed for the audit program. The work

of the reviewers/auditors should be evaluated also and a written report provided the program review/audit director.

Local Followup Operational Reviews/Internal Audits

There are three types of followup procedures: followup reviews/audits (by central office staff), local reviews/audits, and local followup on recommendations. Followup audits may be done by central office auditors or conducted locally. Local followup operational reviews/audits should be performed by management within all agencies surveyed. These types of reviews reflect the purpose and importance of followup to the formal reviews/audits. Many benefits can be derived from this process. Using central office program reviews, management may ensure that operations are in order. Management may assign content experts to examine operational areas, which may result in training and cross-training of staff. Often, ownership for action plans to correct deficiencies is enhanced, and, especially in larger organizations such as the Bureau of Prisons, local or regional program reviews/internal audits are more cost effective than central office reviews.

Operational reviews within the BOP must occur within ten to fourteen months from the week the previous program review was conducted. It is the responsibility of the facility CEO to ensure this occurs. These reviews include the five phases of Program Review Division review—preparation, verification/examination, evaluation, reporting, and followup.

In Utah, local internal audits are conducted by facility staff who have been trained by the audit unit, which oversees these local internal audits. The local internal auditors are generally more familiar with the intricacies of operations than central office auditors. However, oversight from central office auditors lends a degree of objectivity to the process.

The responsibility for the conduct of followup reviews is with a facility administrator or may come through central office. They should be prioritized based upon the dates agreed upon in the exit conference for completion of action plans. Specific audit findings that warrant followup should be identified and progress made toward eliminating these findings should be documented.

Quality Assurance/Peer Reviews

An organization must establish an ongoing process of quality improvement that is essential in maintaining its program review function. Both the Comptroller General (1988:3-17 to 3-18) and the IIA (Sawyer, 1988:910-911) have promulgated standards for continued quality improvement. This external quality control review of the audit function should ensure that the program review system is in place and that audit standards are being followed. Also, the director of internal audits should establish and maintain a system within the unit for evaluating the operations of the internal audit department.

BOP *Program Statement 1210.123* requires that the reviewer-in-charge establish and maintain a program that assures that program review work conforms with GAO auditing standards and with the requirements of the program statement. This includes the requirement that the reviewer-in-charge conduct a Quality Assurance Review (QAR) for each review report. The QAR includes 1) assurance that review findings are fully supported by sufficient, reliable, and relevant evidence, 2) an indication that the program review objectives have been met, 3) statements showing review team members were properly supervised and their work was adequately reviewed, 4) verification that review findings can be traced to working papers and that supporting documentation is accurate, and 5) an indication that interim meetings were regularly conducted with institution management. The review authority examines the report to ensure compliance with the provisions of the program statement and standards of auditing.

Utah DOC accomplishes the objective of quality improvement in several ways. Audit staff request comments from division directors whose units have undergone audits. Audit staff establish short and long-term goals for the coming year, review the progress of the previous year goals, and submit a written

report to the department director. External peer reviewers do a comprehensive review of the review/audit process using audit peer review standards established by The Institute of Internal Auditors.

Management Information

The development, implementation, and maintenance of a sound internal control system is totally dependent on accurate, timely and relevant management information or "indicators," which monitor and measure performance against clearly defined and quantifiable goals. The use of information technology to support the internal audit function is no longer optional. It is imperative. "Not only is much of the data that the auditor must obtain in electronic format, but data volume and complexity preclude effective review through manual techniques. Furthermore, the overall information systems (IS) environment is rapidly changing" (IIA Research Foundation, 1991:3-2).

Internal auditing departments are integrating internal audit and information skills, obtaining assistance from consultants and staff with IS skills, and focusing on training and certification of internal audit staff. Program review/internal auditors should also play a key role in IS development. According to the IIA Research Foundation (1991:1-21):

> Internal auditors should review the systems planning process to ensure the integration of organization and IS objectives. In addition, they should address the process and procedures used to develop and maintain the organization's systems and data. Auditor involvement in the system development process helps to assure that appropriate controls and security requirements are incorporated during development; that data integrity is maintained throughout the implementation process; and that the resulting system meets management's objectives.

The Bureau of Prisons (BOP) has developed a comprehensive and integrated internal control system, which includes the development of a computerized strategic support system. This system, along with the system developed by the Correctional Service of Canada and elements of the New Jersey and Illinois systems, represent the basis of a model information system for use in both traditional management tasks and performance reviews of all types. It is becoming increasingly clear that "paper trails" are becoming "computer trails." Program review/internal audit staff must understand these systems, what they generate, and their capabilities for internal control.

The history and mechanics of the BOP Key Indicators System (KI/SSS) are described fully in chapter IX. The purpose here is to outline KI/SSS capabilities and to add those elements of the New Jersey, Illinois, and Canadian systems that are most useful in developing a MIS capability that supports performance review. It is important to understand that the BOP is a very large and geographically dispersed system and, as such, the use of information is even more critical in understanding and integrating system operations. While size was not as great a concern for the Correctional Service of Canada, the geographic dispersion of its units also made its Executive Information System a necessity.

Federal Bureau of Prisons

The Program Review Division (PRD) is responsible for the ongoing and systematic review and evaluation of all programs and operations in the BOP (U.S. Department of Justice, 1992). There are 93 employees in the Program Review Division; approximately 68 are Program Review Examiners who complete onsite reviews at the institutions. Other than the central office division review staff, institutional field staff from within a specific discipline assist in the program review process at institutions other than their own. The PRD, with input from the executive staff, regional directors, central and regional office administrators, and institutional staff, has established formal criteria and guidelines for reviewing each of the Bureau's 15 major programs or disciplines at the institutional, regional and central office levels. These disciplines are divided into the Operations Branch and the Program Branch. The *Operations Branch*

has 1) Correctional Programs, 2) Correctional Services, 3) Community Corrections, 4) Human Resources, 5) Medical Services, 6) Religious Services, 7) Financial, and 8) Computer Services. The *Program Branch* has 1) UNICOR, 2) Psychological Services, 3) Educational Services, 4) Food Service, 5) Inmate Systems Management, 6) Safety, and 7) Facilities.

Onsite program reviews of each discipline are completed at each institution once every two years, and each discipline is rated according to a Bureau-wide rating system of superior, good, acceptable, deficient, at risk. The PRD works with the executive staff and the director to prepare the annual assurance statement and management control plan that identifies the goals of the Bureau for the upcoming year. To this end, the group has developed a strategic management cycle that incorporates the continuous monitoring, review, and feedback of each institution, region, and division into the planning process. There are 10 elements to this process:

- strategic plan goals,
- operational review,
- social climate survey,
- other information sources,
- policy development,
- management assessment,
- program review,
- institution character profile,
- information synthesis,
- key indicators.

The development of the strategic management cycle in the BOP was the result of the director's interest in an objective review or process and the creation of the PRD. In turn, the PRD established a comprehensive internal control process that has been integrated into daily management and the annual planning process. Also, the director's interest in an information-based management approach convinced all levels of BOP management to rely on sound data.

This new approach required an information support system that would provide Bureau management with meaningful information with which to run daily operations and also to monitor performance and measure it against generally established criteria. The combination of these factors in the BOP, coupled with advances in computer technology, led to the development of the KI/SSS.

Development of the Key Indicators System

The Key Indicators/Strategic Support System was developed to support virtually every component of the Strategic Management Cycle. KI/SSS is a PC-based management information tool developed by the Bureau's Office of Research and Evaluation, in concert with Bureau administrators. It provides access to a range of BOP information on inmates, staff and financial operations (Saylor, 1988a, 1988b). It was developed to extract data from several direct service systems and provide a vehicle for aggregating, formatting and disseminating meaningful information to Bureau managers. The mainframe applications are still the primary support.

KI/SSS provides comprehensive, historical and current data vital to decision-making at institutional, regional and executive levels. This information is used for managing institutional operations, for comparative analysis and resource allocation at the regional level, and for monitoring performance and internal control purposes at the national level. The director and executive staff use the Executive Staff Module of KI/SSS for periodic reviews of institutional and divisional performance and for planning, management, and policy development purposes. The Bureau's long term goal is to incorporate KI/SSS and the Executive Staff Module into the annual budget cycle.

Like any management information system, KI/SSS provides current information on a specific area or discipline. However, a strategic support system also provides longitudinal or trend statistics for comparative analysis. Strategic Support Systems can integrate a wide array of data elements and allow for a systematic assessment among them at a single point in time or through continuous time. Moreover, strategic systems are designed to provide support on demand (Saylor, 1988). Key Indicators is accessible directly from a personal computer whereby managers can select the information for the time period they want, format it, and extract it.

KI/SSS contains extensive information on each BOP institution, region, security level and the Bureau nationally, in such areas as rated capacities, admissions and discharges, average daily population, inmate demographics, security designation, custody classification, urine surveillance, assaults, escapes, disciplinary hearings, and the like (Saylor, 1989). Up to 95% of the information in the system comes from mainframe databases maintained by the Department of Justice or the BOP. Local databases provide input in various areas of institutional performance (e.g., assaults, use of force, urinalyses). Other Bureau units, such as UNICOR, provide information for the system, and there is a self-reporting data capacity in which semiannual summaries of information are placed in the system. Due to the large amount of information available, an "executive staff module" is produced as part of the system.

Several other special data collection efforts are included in KI/SSS. These include the social climate surveys (staff perception of personal safety and security, work environment, quality of life and personal well-being).

Data Flow/Data Production

Each month data from mainframe computer systems are combined with data from the Bureau's local PC-based and institutional self-reporting applications. The results are formatted on a compact disk (CD-ROM, read-only memory) and distributed to 120 institutional wardens, regional directors, members of the Bureau's executive staff, and selected branch chiefs as an update of the previous month's data. The CD updates are self-contained; they include all current and historical data and also the report generator software and menu devices used to interface, produce reports, and respond to requests for information. The software is proprietary and, as a result, each KI/SSS CD site must procure a one-time license for its use. The entire data flow and data production process is described in chapter IX.

System Benefits

KI/SSS was designed to support strategic information delivery, assist Bureau managers in their ongoing operations, and to monitor performance. Some of its benefits are the immediate access to information; user friendly (nontechnical) interface; flexibility in data use; timeliness (i.e., data less than two months old); operational data entry; and wide use of the system (e.g., at all levels of management, in strategic planning, public affairs, monitoring and comparing institutional performance by regions). The system also captures offender characteristics trends, provides institutional profiles, and allows wardens to monitor institutional performance.

KI/SSS data are used by staff in its annual risk assessment process. Each BOP discipline annually conducts a management/risk assessment, in which it assigns risk levels to components of its programs based on an assessment of the previous year's program reviews and other relevant information (Rausch, 1991). This risk assessment process indicates whether sufficient control techniques exist in the discipline and whether they should be implemented.

Future KI/SSS applications are discussed in chapter IX. A major concern is the increasing costs of onsite visits by PRD staff as the number of Bureau institutions grows. It is anticipated that in the future the KI/SSS database will help support "long distance reviews" of operations and reduce the need for onsite activity. The scope of the review process can also be narrowed. Another enhancement to KI/SSS is the development of additional modules with which Bureau managers may monitor performance on an

institutional or department level. The Executive Management Module, begun in 1991, is an example of this. The Warden's Quick Menu Module, which groups together those items identified by wardens as important factors to monitor on one menu, is another example of a group-specific enhancement. Modules for institutional staff at the departmental level and by program discipline are now being considered.

Other Systems

Correctional Service of Canada

Correctional Service of Canada (CSC) representatives demonstrated the various parts of their "management of information" services to project staff. The CSC has taken initiatives similar to those of the Bureau of Prisons in the development of its strategic information network. This three-system network consists of the Executive Information System (EIS), the Offender Management System (OMS), and the Offender Population Profile System (OPPS).

The EIS, the core of the system, was "developed to respond to the needs of management in order to assess performance, monitor progress on priority projects, raise awareness of the political...agenda and advise of newsworthy items inside and outside CSC" (Correctional Service of Canada, c. 1992a). The system contains financial data as well as information on security incidents, corporate projects, briefing notes, and legal decisions. Standard reports can be derived, as can various types of follow-through activities. Redi-Mail offers communication between system users.

A major system goal is to measure the status of various "corporate objectives" established by senior management staff. In this sense, the CSC system is similar to the BOP's, upon which it was modeled. Both take a "business systems approach," linking technology to planning and organizational outcomes. While the BOP refers to "strategic plan goals" based on "key indicators," the Canadian system refers to "corporate objectives" based on "corporate performance indicators," which have a somewhat different meaning. As with the BOP system, accountability was the main concern. Accountability is measured against published goals/corporate objectives. The system is operationally based and designed principally for use by managers.

CSC senior management created their mission statement and statement of eight "corporate objectives," upon which the system is based. During this period, "key indicators" were identified. These indicators are not to be confused with the BOP's key indicators, which refer to categories of variables. CSC key indicators denote *performance* and are statements of specific goals, or targets, to be obtained. These performance indicators *must* specifically relate to the corporate objectives that appear in the agency's mission statement. There are 52 performance indicators, which represent 52 types of questions. Performance targets might be to keep institutional population growth at a constant rate of no more than 2.5% per year, or that inmates be released on their stated release dates. Using output from the Executive Information System, it is easy to see if these targets have been met. In this sense, the system supports both management and audit functions.

An example is provided in a paper done by the Research and Statistics Branch (Porporino & Robinson, 1991). Corporate objective #1 is:

> ENHANCE THE SERVICE'S CONTRIBUTION TO THE PROTECTION OF SOCIETY BY SAFELY REINTEGRATING A SIGNIFICANTLY LARGE NUMBER OF OFFENDERS AS LAW-ABIDING CITIZENS WHILE REDUCING THE RELATIVE USE OF INCARCERATION AS A MAJOR CORRECTIONAL INTERVENTION.

Various methods for achieving this objective are given, such as changing the distribution of offender populations with respect to prison or community supervision. However, the authors point out the problems of measurement that can lead to a false impression of real performance changes over time. This

concern supports the conclusions of this report that raw data must be subjected to careful analysis by trained staff.

Almost all information in the EIS comes from existing databases. The source agency is responsible for supplying the relevant information, which it may not do for any number of reasons. Also, not all information suggested for the system is put in it. An "overseer" screens the various data sources in relation to stated corporate objectives and the CSC mission statement. In this way system managers control the information coming into the system. The system is centralized, which is seen as critical to its success. It does not "stand-alone" like KI/SSS. Everything is "online" (i.e., institutional personnel can download daily at will, and the information is very current). Measurement against objectives is done quite regularly. There are mechanisms to perform internal measurements.

The Offender Management System is used by the CSC and by the National Parole Board. The system automates information on penitentiary placement, case management, sentence administration, security, programs, and medical records (Correctional Service of Canada and the National Parole Board, c. 1992b:1). User input during the first application phase resulted in several improvements and enhancements to subsequent editions. It is presently unclear how this system will be used by review/audit staff. The availability of this information has expedited the processing of offenders.

The Offender Population Profile System (OPPS) provides statistical profiles of offender populations. It is designed "to 1) standardize, 2) streamline and 3) enhance the reporting of monthly institutional and community offender population information" [and meets the] CSC . . . requirement for the standardization of offender data and statistics (Motiuk and Boe, c. 1992c). The system includes "key indicator reports," population summaries, and "time plots." These reports, tables, and graphs represent the current inmate population total, by region (province), and particular population group.

Special data files are extracted (downloaded) each month from CSC's automated Offender Information System and Parole Supervision System. These data are entered from the field and formatted for the OPPS system. The OPPS system operates in SAS software (i.e., BASE, STAT, GRAPH, AF, FSP), version 7.06 in a VMS or OS/2 environment.

In summary, the Correctional Service of Canada and the National Parole Board have a system in place that supports the measurement of compliance with specified objectives, or internal controls. Although the system is still being developed, it does provide for future improvements in the measurement of organizational performance.

Illinois, New Jersey, and Utah

The State of Illinois' Fiscal Control and Internal Auditing Act requires internal auditors to conduct pre-implementation reviews of new or extensively revised electronic data processing (EDP) systems. Reviews must find out if the systems provide for adequate audit trails and accountability. Illinois Department of Corrections (IDOC) Fiscal Internal Audit (FIA) staff perform these reviews.

The Illinois DOC management information system uses 15 components to track operations. These MIS operations are not specifically linked to audit functions at this time. Discussions with fiscal audit personnel did not reveal an intensive linkage to the EDP system, although audit personnel did have input into the design phase of their Budgetary Accounting Reporting System (BARS). Also, audit staff have the same access to the system as others in the department and have begun to develop an audit point tracking system. EDP personnel indicate that audit staff are always invited to give input into system development as it occurs. The EDP system was designed to supply information for management purposes. While most of the system is based on the use of a mainframe computer operated by Central Management Services (CMS), some aspects of it are restricted to personal computers.

Within the New Jersey Department of Corrections (NJ DOC), EDP audits are conducted by staff of the Division of Policy and Planning, MIS Bureau. These audit efforts address NJ DOC training, inmate classification, and management information systems. The MIS Bureau conducts audits of the S/36 CMIS

system at each institution to insure that the system is being used efficiently and that the proper security precautions meet DOC guidelines.

Staff of the Utah Department of Corrections (UDC) Bureau of Internal Audit (BIA) have been involved in several information system (IS) audits. These have included audits of system installations and audits of the IS function department-wide. These audits have included: 1) short and long-term planning, 2) data processing product purchasing, 3) EDP training, 4) mainframe security, 5) operating logs, 6) tape libraries, 7) disaster recovery planning, 8) software documentation standards, 9) hardware and software inventory procedures, and 10) surplus practices.

Information system review involving internal control issues can be aided by using audit criteria available in the IIA Research Foundation's *Systems Auditability and Control* publication. The review program code requires the use of a consultant or an Illinois DOC data processing employee not associated with the system. While the latter option would not guarantee total objectivity it may be the only economical option. The FIA Chief Internal Auditor felt that all financial and compliance auditors need to develop an understanding of systems auditability and control concepts. No auditor can function effectively in an automated environment without a basic understanding of how internal controls are implemented in a PC, LAN, or mainframe application.

Costs of Implementation

Program Review/Audit Costs

The most detailed information on audit costs was available from the Utah Department of Corrections. It is as follows:

(a) **Staff of 7**: director, 5 auditors, 1 secretary

(b) Available audit days -

Work days in year (52 x 5)		260
Less average: off duty days		
vacation	10	
sick days	3	
holidays	11	
emergency days	2	
training	7	
		-33
Net Audit Days Available		**227**

(c) 227 x 7 staff = **1589 actual work days per year**

(d) Average of 25 **full** audits, follow-up audits, and special projects annually, and oversight of local internal audits.

(e) Total budget for bureau: **$335,000** (includes salary, benefits, and current expenses)

(f) Average working days per activity annually:
1,589 working days per year = **64 days average per year per activity** (25 audits, etc.)

(g) Audit cost per day:
$335,000 (budget) = **$211 per audit day** (1,589 working days)

(h) Total average cost per audit/activity:
64 days per audit/activity x $211 per day = **$13,504 per audit/activity**

The Bureau of Prisons has not broken out its audit costs to the same degree as Utah; however, efforts are being made to better track audit costs. These costs vary widely and depend on the number of examiners that are required to complete a program review. Since the Bureau is widely spread geographically, the distance to review sites is a significant cost factor. On the average, for fiscal year 1991-92, it cost about $800 to $1,000 to fund one reviewer per review site per day.

The number of reviewers required per site is determined by the number of guidelines to be reviewed and the complexity of the review site. Different "disciplines" require different size teams. For example, the chaplain or psychology review teams may need only two examiners, while UNICOR or correctional services may require up to 12 reviewers. Some disciplines, such as human resources or financial management, will have the same number of guidelines at each site. UNICOR teams vary depending on the number of factories at a given review location.

Thus, it appears that a team of five reviewers, working at a site for five days at an average cost of $921 per examiner per audit, could cost $4,605 for a total of 25 auditor days. The $921 per audit is not inconsistent with $1,055 per auditor per week found in Utah, based on $211 per day for five days, although Utah audits lasted much longer, on average. However, neither the BOP nor Utah factored in all organizational overhead costs, which could be as much as 20% more than the costs shown. If this were the case, an average audit/program review could cost from about $1,100 to $1,250 per auditor per week.

Management Information Support System

Bureau of Prisons

Intensive design and development efforts for KI/SSS began in late 1986, with the first prototype distributed to a limited number of users at eight locations during 1988. Four staff members were involved in the initial phases of the project on a half-to-three-quarter time basis. Currently, four personnel work on the project on a nearly full time basis, with five others assigned to it about 20% of the time. KI/SSS is currently available at all BOP locations.

IBM-compatible personal computers (PC's) are used to develop and maintain KI/SSS and are also needed by the end users, who had to purchase them and CD-ROM readers for use with KI/SSS applications; however, the equipment is used for other applications. A local area network (LAN) application produces maximum results at the institutional level.

Two costs specifically attributable to the development of KI/SSS are the CD-ROM Publisher, which cost $30,000 in 1990 and is used to master (create) the image of KI/SSS that is transferred to compact disk, and the actual production of CD's. The latter is contracted out to a compact disk pressing plant; the cost in 1992 was $14,000. BOP staff note that these expenditures resulted from the decision to distribute this application in the CD-ROM format. A strategic support system could be distributed on other types of media.

One of the responsibilities of the ORE is to respond to information requests. Before the development of KI/SSS, responding to these requests required a large portion of ORE staff time and considerable mainframe computer resources. In assessing the development costs for a strategic support system, one must offset the expenditures listed above by the subsequent reduction in the resources required to provide information on an ad hoc basis. Since the implementation of KI/SSS, the ORE has experienced a decrease of about 80% in the number of ad hoc requests received. As a consequence, staff now devote their time to continued KI/SSS development and to the central mission of the office, which is basic research and program evaluation.

Illinois Department of Corrections

The Illinois management information system was implemented over a 6-year period at a cost of $7 to $8 million. MIS applications exist in the three major areas of concern: operations support, direct service, and population summaries. There were no data on the cost of the development of the audit capability.

New Jersey Department of Corrections

New Jersey's original plan called for the installation of minicomputers at each institution, a goal that has been achieved. The goal was to establish an Inmate Trust Fund Accounting system (basically for commissary purchases and business remits). The OBSCIS is part of the system, but is serviced independently. The long-term goal of the department, as indicated in the 1989-1994 Data Processing Master Plan, was to integrate these two systems.

The cost of the original 5-year plan was estimated to be almost $8 million for hardware, software, maintenance, training, staff, and consumables (New Jersey Department of Corrections, 1984:1-4). Actual costs were much less, about $5.6 million (detailed in chapter IX). Staffing requirements included two staff positions at each institution to carry out additional applications. These were to be a computer operator and a senior data entry operator. Nine of 20 sites (45%) have a full time, trained computer operator. These positions became available through the reassignment of work resulting from the automation effort. Data entry operators were not provided.

Seven positions were recommended for central office, which appears to have been exceeded based on information presented below. The pre-CMIS system consisted of six separate, nonintegrated systems for classification/sentencing tracking, trust fund accounting, food service, preventive maintenance, health/pharmacy, corrections officer scheduling, and central office microcomputer applications.

New Jersey DOC contracted with an outside firm to design the 5-year plan. The contractor spent over six months soliciting information on system needs from prison and central office staff, visiting institutions, and interviewing key staff and "interfacing agency" personnel. DOC staff also researched available software packages and visited vendors who would provide system software and hardware. Automation guidelines and system goals were formulated. The principal monitoring function was to be able to "monitor, on a year-by-year basis, costs associated with each identified task" (New Jersey, 1984:1-9), such as inmate information, inmate banking, etc. Information was to be used to "operate and manage the institutions and provide greater coordination at the departmental level" (New Jersey, 1984:1-9). The use of the system to monitor or audit performance beyond fiscal applications was not stated as a goal, and, as noted elsewhere, is not a current goal or function of the system.

Program Review/Internal Audit Training

The BOP's *Program Review and Strategic Management Course*, part of the Institutional Cross Development Series, is offered to all PRD and institutional staff involved in operational reviews. The course covers 1) management assessments and how to use these data; 2) performance monitoring, which discusses operational reviews (an annual review conducted under the jurisdiction of the installation CEO), and program review (comprehensive reviews conducted at the direction of the Review Authority), which includes preparing for and conducting a program review, and gathering other data; 3) strategic planning that discusses the planning process and implementation; and 4) the KI/SSS. Some of the BOP training (e.g., interview techniques) for program reviewers is done onsite during the audit. One program review team member at the site visited had received no training specific to audit techniques before the review.

In Illinois, inservice audit training was provided to new OPA hires and local internal auditors by the OPA Audit Manager. Specialized audit training for FIA staff is obtained through the Springfield Chapter of The Institute of Internal Auditors; this allows the audit staff to participate in professional

development seminars. Also, new auditors participate in on-the-job training for six to 12 months to develop professional internal auditing skills.

In Utah, auditors receive up to 40 hours a year of specialized audit training from local and national sources; this is funded by the UDC. The BIA Bureau Director provides initial training to all new staff; its audit training package has been used by the National Institute of Corrections and other agencies (Haefeli, 1992). This training manual contains ten sections, including examples, which define and detail all areas of the internal auditing function.

In New Jersey, new auditors assigned to the Internal Audit Unit receive on-the-job training with supplemental training available from an interagency audit forum in New Jersey. Since there is no centralized division or organizational unit within the NJ DOC responsible for the internal audit process department-wide, all audits and programmatic reviews are local efforts. Also, the Deputy Director of the Division of Policy and Planning provides training on various aspects of the 20 IBM S/36 that make up the CMIS system.

Program reviewers require more than onsite instructions. Program review training should be a continuing process, best given in special training sessions lasting at least two days (16 hours). Training for staff of the information system units should be required also, especially for the EDP audit staff. Highly specialized training is required for electronic data processing auditors, and outside specialists may be required for this function. In any case, *these data entered by staff must be accurate and reliable if they are to be used in the audit process*. Thus, both the operating systems themselves and the data entry function must be reviewed.

Reviews become a problem when training funds are reduced during budget crises, which was occurring at some project sites. Training at one site had not occurred on a major scale for MIS personnel for almost five years. Most training was done internally, much of it "on the job." With such limitations on training, it is difficult to envision either operational staff or reviewer/auditor receiving adequate training in basic review techniques, much less quality assurance or total quality management concepts in the future, although training in these areas is recommended.

Advancements in audit technology and management techniques that should be reviewed and considered in training are covered in chapter VI. These include quality assurance and total quality management techniques, or continued quality improvement, construction auditing, and fraud auditing.

Conducting Program Evaluations

Choosing Evaluation Criteria

A few traditional rules apply to choosing evaluation criteria. In the long run, it is better to choose multiple criteria rather than single variables to test the success of a program. In fact, it may be preferable to choose as many outcome criteria as possible. In better evaluation scenarios, variables related to the study were determined early in the planning stages of a program. Data not already available in management information systems were designated and tracked right from the start by program operators. In some cases, existing agency data in the computer system were not in a format conducive to the intended research. Plans were made as soon as possible to obtain all necessary data in the correct format to allow proper analysis to be conducted. This meant that evaluators were able to obtain a clear understanding of how variables were to be defined, how secondary data were collected, and for comparison purposes, how to adopt variable categories and classifications used in previous research.

Although it may be easier and more convenient to monitor just one outcome, such a method does not allow for the possibility that there are many different success indicators. Staff and clients may see many different goals as central to the program. For example, in evaluating a drug treatment program the criteria measured may include:

- number of arrests during and following treatment,

- number of positive drug tests following treatment,
- participation in drug treatment sessions,
- participant's self-esteem or changes in attitudes towards drugs,
- number of days without further criminal justice system contact,
- length of time employed and income earned.

Accurate measurements require quantifiable criteria (i.e., criteria that can be assigned a numerical value or judged upon a numerical scale). For example, it is easier to measure how many months a person maintained continuous employment rather than how they now feel about themselves. Feelings, attitudes and impressions are difficult to quantify and it is difficult to obtain consensus on their meaning even between two or three persons. For this reason evaluators should select measurement variables for which considerable agreement is found as to their meaning or value. For example, arrest is a concrete event the occurrence of which is indisputable. It is also assumed by a large segment of society that arrests are important followup measures in studies of correctional treatment. This does not mean that self-assessment and attitude changes cannot be measured. There are several standardized psychological tests that reliably measure these concepts. Thus it is possible to quantify feelings and attitudes by saying a person went from a pre-treatment life outlook satisfaction score of 12 to a post-treatment score of 26, and to determine the statistical significance of such an improvement.

Assessing the Reliability of Measurement Instruments

One of the most common tasks for research and evaluation studies is to determine the reliability of the tests or instruments used in daily corrections programming. Instruments may be scales or surveys used in needs assessment, classification, and data gathering. These may also be used in program research to profile the types of offenders being serviced or to create comparable groups for an experimental study.

A test is reliable if it will produce similar results over time, regardless of subtle changes such as who administers or scores it. For example, a program director may interview each inmate-client with an alcohol dependency questionnaire. The answers may then be interpreted differently by each counselor depending on their own personal orientation toward drinking. Each counselor might also lead clients toward certain types of answers.

Reliability is an essential feature of classification instruments or risk assessment surveys. Reliability of a classification instrument is measured as the frequency with which the same classification occurs when several different officers score the same offender. The reliability of a testing device is greatly reduced when administrators do not trust the instrument. Then, individuals may change the score of one or more variables to raise or lower the total.

Measures of test instrument reliability are usually conducted in controlled settings. For example, several test administrators come into a room and listen to a taped interview. Based upon what they hear, each scores the offender on the instrument provided. The researcher then determines how frequently the scores match. Studies of this type have produced reliability measures better than 85% (Baird, 1979). This means that 85% of the scores were close enough to be considered "the same."

In reality, however, we know that the everyday scoring of classification instruments or psychological tests does not take place in a controlled environment. Further, the process for reviewing an employee's scoring may be minimal. It is possible that the manipulation of scores occurs more frequently than anyone would care to admit. In one California study, over one hundred classifications were re-scored by a committee after it reviewed all the materials available to the officer who originally classified the cases. The committee came up with the same score on only 16% of the cases. Researchers estimated that at least

25% of the cases were being assigned to an inappropriate level of supervision. While exact scoring is not necessary to assure that offenders are placed into the correct supervisory level, broad discrepancies may have serious consequences.

With diminishing resources, departments can provide high levels of service to only a small portion of the clientele. If reliability in classification is a problem, it may be the case that some offenders receiving a high level of service may not need it. In addition, many who do need it may be kept out by lack of space in the program.

Common Problems in Program Evaluation

A program's design may cause problems during an evaluation, particularly if it has not been planned so that one can empirically measure its effects. Evaluation is often only an "afterthought" and rarely an influence on the original design of a program.

When evaluation strategies are tagged on after a program is already underway, it is difficult to initiate a good evaluation methodology. This means that conditions surrounding the delivery of services have not been controlled enough to allow program operators to say that it is the treatment itself that has led to a client's success or failure. Instead, other "intervening" factors in the participants' environment may have altered their performance. Some of the problems of program design and operation are now discussed.

Random Assignment

Even if it were possible to accurately measure a program's accomplishments, the problem remains of determining whether the program itself made any difference. If a program group is evaluated without being compared to a similar group, reviewers cannot discover whether those treated would have achieved the same results without the program. If a program to decrease drug use among female inmates succeeds, how can we be sure that those same individuals would not have stopped using drugs even without the program. In fact, while not likely, it is possible that they may have reduced their uses even more without the program. That is, the program may have actually *increased* their drug use beyond the level they would be taking had they been left alone. These types of problems make interpretation of results very difficult. The valid interpretation of a program's results is assured by use of a control group at the onset of the program. The best way to create identical treatment and control groups is to randomly assign individuals to the two groups. However, random assignment does not work with small groups; enough people are needed to produce the balance of characteristics such as age, race and sex. One cannot assign participants to each group, even if various demographic characteristics such as age, race, sex, and income are known in advance and people with each of those characteristics are assigned equally between the two groups. Other characteristics might affect the results. Even if the two groups were identical at first, changes in the control group over time might still confound the comparison.

Finally, individuals cannot be partially assigned in a random process; they must *all* be assigned that way. It is not uncommon for programs to make erroneous claims of randomized assignment when, in fact, they purposefully assigned some individuals to either the control or treatment group (for various reasons they thought were good at the time). In these cases, an evaluator does not know if the different assignment process created differences in the two groups or, perhaps, kept the program from working. To remedy this problem, evaluators have begun taking over random assignment procedures from the program workers. The researchers can simply flip a coin and assign each potential client into either the control or treatment group right from the start. By doing so, they can make sure that group assignments are truly random.

Although random assignment assures the validity of an evaluation outcome and the process has court approval, many corrections administrators oppose its use. This results because they do not understand the significance of randomization in assuring meaningful research, but there are other reasons for their

resistance. Program administrators do not like to relinquish their authority to assign clients to treatment groups. Further, many feel the need to control intake to the program believing that releasing control may jeopardize the program or deny an eligible client needed services. Ironically, randomization is the fairest way of assuring that eligible clients receive the services of an experimental program.

A meaningful experimental evaluation cannot be conducted unless more eligible clients can be found than the program can accommodate. Program participants must be compared to similar individuals who have completed other forms of programming or no programming at all. If enough room is available in a program to accommodate all who need the service, then there will be no one to attend alternative programs and, therefore, no comparison results. In addition, random assignment assures that all eligible persons will have an equal opportunity for selection without the biases that may be introduced by an intake person or committee. If the program administrator has carefully identified the personal characteristics and criminal history of the program participants, these criteria may be applied to an initial screening before random selection. This assures that all participants who enter the program are right for it. Random assignment will not introduce a population that would be disruptive to program goals. In this way the administrator is assured both fairness in selection of participants and the appropriateness of the participants.

Once administrators understand and accept randomization, the next obstacle to overcome is the courts. In many jurisdictions, the courts have authority to order defendants into specific programs. As with the program administrator, the courts are reluctant to give up this authority to random assignment. In these cases, judges are hesitant to allow researchers to put some offenders in a "control" group when the judge believes that the treatment would be most helpful. Again, the appellate courts have held that the random assignment procedure does not deprive a person of his rights or of due process. Nevertheless, convincing judges and criminal justice administrators to accept the methodology of a good experiment is sometimes the most difficult obstacle to overcome.

When Random Assignment is Not Possible

The institutional researcher or reviewer has less flexibility in evaluation design than do those in community treatment programs. However, there are also more natural environmental controls in this setting. Within the prison, the possibility of external influences contaminating treatment effects is greatly reduced.

There are many instances in institutional programming when random assignment will be neither practical nor possible. In these situations, quasi-experimental designs are applied. According to Cook and Campbell (1979), quasi-experiments have treatments, outcome measures, and experimental units, but:

> . . . do not use random assignment to create the comparisons from which treatment-caused change is inferred. Instead, the comparisons depend on nonequivalent groups that differ from each other in many ways other than the presence of a treatment whose effects are being tested. The task confronting persons who try to interpret the results from quasi-experiments is basically one of separating the effects of a treatment from those due to the initial non-comparability . . . the researcher has to explicate the specific threats to valid causal inference that random assignment rules out and then in some way deal with these threats.

For example, some states require all sex offenders to enter treatment; this reduces the possibility for a non-treated control group. In such instances, comparisons may be made between two different types of treatment or in varying lengths of treatment. Laws may also require that treatment occur at a certain time in the incarceration period (i.e., not until two years or one-half of the sentence is served). This may reduce the possibility of measuring the amenability to treatment at different points in time and create treatment groups that are more alike (in prison experience) than under other circumstances.

Multiple Treatments

One of the problems surrounding evaluation is the ability to distinguish between the effects of simultaneous or overlapping treatments. For research purposes, it is preferable for clients to receive only one treatment. With this, comparisons between the different treatments and persons getting no treatment could be made. In reality, however, programs exist to provide the maximum amount of benefits affordable and not for the ease of research. Therefore, in many cases, clients are often involved in multiple programs, such as drug treatment, counseling, education programs and vocational training. It is difficult under these conditions to determine which component is responsible for the client's success. Neither could it be determined whether all elements would be necessary in order for someone to be successful.

Selection Bias

The concept of selection bias generally refers to choosing participants with the highest likelihood of success. While a high success rate is important to a program's continued funding, deceptive selection procedures make it difficult to compare the results of similar programs. Working with offenders means servicing relatively high risk groups of people compared to the general population. In any program a level of failure will be found that is expected and accepted particularly as the group becomes younger and more seriously involved in crime. Because the serious young offender group is very large and in need of programming, it should not be overlooked simply to make programs appear more successful. Care should also be taken not to compare the results of programs that target clients of different risk groups.

As critics have noted, most research on the outcome of corrections does not control for the different criminal potentials of offenders when sentenced. That is, most persons sent to prison are a relatively high risk group compared to probationers or those given community service sentences. Therefore, studies that track probationers over time and compare their performance to parolees or those under intensive supervision may contain biased samples.

The Problem of Participant Drop-Outs

The frequency of participant drop-out from corrections programs is another evaluation problem. In any given program, a large number of clients will be rearrested or revoked or will abscond. This was the case in the early boot camp studies where approximately 50% of participants never completed the program (Sechrest, 1989:16). As a result, those who remain are statistically "more likely to succeed" simply *because* they remain. The higher probability for success from those who "stick-it-out" may artificially elevate program outcomes. The best resolution of this situation is to account for lost participants by explaining the ratio of participants who began to those who completed the program. It would also be helpful to profile the type of participant who leaves a program.

Organization Resistance to Research

There are many reasons that staff may resist efforts to conduct program research. A lack of understanding of the research goals may lead some workers to fear or suspect the investigation. Some employees may believe that negative findings would jeopardize their jobs or reflect poorly on their abilities. In these instances, workers may get defensive or even try to manipulate the data gathering.

Another potential problem is that the evaluation process may appear to present additional work for employees. Unless they understand the value of the research being conducted, they will likely resist and resent the extra burden of reports and data collection. In one study, researchers were met with objections from the union representing the organization workers. It was alleged that "the list and forms requested by Program Services was an appreciable additional task for already overworked probation officers, and

the union contract stipulated that no substantial work increases were to be made without union approval" (Watts & Glaser, 1990:14).

There are several preliminary steps that can be taken within an agency before conducting evaluation research that will help decrease resistance. First, evaluators should meet with program staff before the conduct of an evaluation. The goals of the research should be carefully explained. It is also important for personnel to see that the top program administrators are supportive and cooperative in the research effort. Efforts should be made to eliminate fears and rumors about the use of the evaluation results. Researchers should solicit input from employees in areas that concern their functions and time. Evaluation results should be shared with employees and explained to them. The evaluation process can then be a meaningful and "painless" experience for all.

Recidivism as an Outcome Variable

By far the most common measure of a program's success is the participants' rate of recidivism. However, recidivism is a concept with many connotations. The most general is the act of committing a new crime by a person already processed through the criminal justice system. It may also mean that an ex-offender has been arrested or charged with a new offense, or that a person on parole has committed a technical violation and has been revoked.

Recidivism is often viewed as a product of law enforcement or supervision effort. The fact of no new arrests for a defendant doesn't necessarily mean that no new crimes have been committed, it simply indicates that no new crimes have been detected. Recidivism rates then will vary by the quality of law enforcement impacting the group of persons being studied. Two individuals living in different communities may commit the same type and number of offenses, but they will be subject to different probabilities of arrest. The chance of detection will vary by the level of law enforcement in each community.

For example, research suggests that offenders on intensive parole receive more technical violations than offenders on regular supervision (Turner et al., 1992). In addition, even if the level of detection of new offenses or technical violations is the same, the subsequent handling of cases may be different in each area. One jurisdiction may pursue each new offense with a complaint filed in the prosecutor's office while another may pursue only felony offenses or serious misdemeanors. If recidivism is defined as a new conviction, the person living in a jurisdiction that does not pursue prosecution would be deemed a "success." At the same time, the person living in a more prosecution-oriented community would be deemed a "failure."

Selecting a Time Period Recidivism Measurement

One particularly confusing aspect of recidivism is the question, "When does a person put enough time between a prior offense and a new offense to avoid being considered a recidivist?" Ever? Take, for example, the 14-year-old boy who steals a car with a group of older, rowdy friends. As a first-time offender, he is put on probation. After 25 years of crime-free life, this man is now convicted of tax evasion. Is he a recidivist?

Recidivism is a more confusing concept than other terms like chronic offender or habitual offender. The labels of chronic or habitual most often represent a legal status where specific offense and time-frame criteria are established. For example, one state may define a habitual offender as someone who is convicted of three similarly patterned offenses over a period of 10 years. Furthermore, it is difficult to compare recidivism rates of different study groups. One reason is that recidivism has been defined many different ways. Another is that recidivism rates in one report may be incorrectly compared to revocation figures in another. A person may have been revoked on technical grounds such as failure to make payments or meetings with the probation officer, but this should not be compared to committing a new crime. In most cases, revocation rates will be much higher than recidivism rates. This is because not

everyone who is revoked has committed a new crime, but most of those who have committed a new crime have been revoked.

There may also be confusion in interpreting program success results when studies use different time frames for measuring recidivism. For example, one department of corrections boasted that its boot camp graduates had lower recidivism rates than regular parolees. However, the followup period on those who had completed boot camp was only six to eight months while parolees were tracked for up to two years (Pearlman, 1990).

Degrees of Recidivism

Glaser (1964) explained that recidivism may come in different degrees and that success may mean different things. To demonstrate this, four different categories were used to describe the possible results of community supervision. The first is *clear reformation,* defined as being on parole for one year with steady work, committing no new crimes and not spending time around other criminals. This contrasts with *marginal reformation,* which is the status of a group that is less successful in the community. These clients have not returned to prison, but they have failed to keep a job and to stop associating with bad influences. The third category is the *marginal failure,* those who have returned to prison with violations of parole or probation or some petty offense. Although this is a failure group, it is distinguished from the *clear recidivist,* an individual who has committed a new major crime for which he or she is sent to prison.

Although one must be careful in using the concept of recidivism in evaluation research, it is an important part of a program evaluation. The public has realistic concerns that programs designed to "correct" offenders still provide for a safe community. Citizens and their elected representatives are constantly expressing the need to know if programs really do what they set out to do. Research results that provide meaningful and clear information about recidivism are a valuable public service.

Another advantage of reporting recidivism rates is that they can be applied as a relatively concrete measure. When using arrests, it is easy to determine whether someone was arrested or not. When clearly defined and consistently applied, recidivism rates are clear. You were either charged with a crime or not, convicted or not, revoked or not; there is little confusion in these types of data.

Employment as a Measure of Success

Using employment as a measure of a program's success presents many theoretical problems. One problem is that studies often fail to differentiate between the various levels of employment—full time, part time, and intermittent. Some studies do not include those who are working part time in their employed category while others include this group without distinguishing their status. Both procedures misrepresent the true employment picture. In fact, some may argue that employment status is relative to each client's history. For those who have no significant work history, steady part time work may be a great improvement and a sign of treatment success. On the other hand, those who have held permanent, high-paying jobs who engage in part time or low-paying positions may not have benefitted from treatment at all.

Another problem found in work statistics is the inability of these data to discriminate between finding a job and keeping a job. Often reports simply indicate that a certain number or percentage of participants had found work upon completion of the program. However, the length of employment or job stability is an important aspect that may provide more useful information about a program's effect than simply employment alone. Some data on clients is only gathered at one point in time, for example on a certain date each year. When this occurs, the intermittent employee may be misrepresented. These data show that this person is actually employed on that date. However, they do not reflect that he or she has been unemployed the six months before or for six months after that date.

While job changes are often treated as an indicator of instability, one should carefully examine the changes for meaning. If each change brings higher pay and more responsibility, then these may be very

positive steps. It is also a positive step if one changes jobs in the direction of a desired career or position. Also one would want to examine the reasons for termination. Being fired is qualitatively different from being laid off during a recession. A thorough evaluation of employment would certainly want to address the quality of employment of each participant.

Studies that go into detail about employment may consider the wages earned and the status of the position held. Menial labor jobs may be considered as "underemployment" if the person is skilled in some particular trade or profession. Changes in the availability of work and the wages earned may be a result of the local economy and beyond the control of the client. It would be inappropriate to compare the results of programs from different economic areas. It is unlikely that simply not having a job would be the cause of revocation of community supervision. However, unemployment may be linked to other revocation-producing behaviors such as drinking, fighting, and committing property offenses.

One of the most misleading aspects of employment statistics in evaluation research is the projection of employment rates over time. Some reports may say that anyone who ever held a job for any length of time has been employed while others may set an arbitrary length of time as adequate for success in employment. In cases like this, six months or a year may be used as an indicator of stable employment; the reader must then determine whether this is adequate. One way to combat this is to look for the number of program participants employed at a certain point in the program or study or on some particular date. Another way is to determine the average number of those employed at any given time during the study period.

Other Measures of Program Success

While traditional outcome variables for program success generally include recidivism and job-holding, there are others to be considered. For those incarcerated, success may be measured by completion of therapy, consistent attendance or participation in treatment, reduction in disciplinary action, positive staff evaluations, promotions in classification, and involvement in other self-enhancement programs. For those released from prison, measures may include school enrollment, degree completion, reduction in drinking or drug taking, reduced reports of truancy (for juveniles), control of anger, positive involvements in the community, ability to get along with family members, self-reported changes in attitudes and perceptions, ability to make payments on fines and restitution orders.

Collecting Data for Evaluations

There are many different sources of information to be tapped during an evaluation. Once the program goals have been matched to measures of success, it will be time to learn how to best collect those measurements. Data sources include interviews, questionnaires, observations, program records, and files as well as clinical examinations, official documents, and tests.

Interviews

The conduct of interviews will give the most accurate descriptions of how programs are operating according to the people involved. While descriptions can be detailed in interviews, it is often difficult to conduct statistical analyses because interview sample sizes are usually small. Also, it is difficult to compile the results and make sense out of the aggregate data, since not all participants will describe things in the same way. In addition, if clients are allowed to discuss issues in a rambling, conversational way, it will be difficult to compare the content of one interview to another.

One solution to the problem of different answers is to use *structured interviews* with "forced choice" questions. The advantage of interviews over questionnaires is that they allow the interviewer to have personal contact with the subjects, explain questions, and ensure that he or she understands specifically what the respondents mean by their answers. Any unclear point may be elaborated upon to improve the

integrity of the answers. However, interviews may subject respondents to more stress and a tendency to "perform" for the interviewer. Also, potential bias exists for interviewers who may hear things they would "like to hear" from the interview.

Questionnaires

An advantage of using questionnaires is that they provide anonymity. Respondents tend to answer questions truthfully when they believe they will not be identified by name. One way to control the answers to questionnaires, especially when building a large computerized data set, is to give the participant closed-ended questions. This type of question makes it easy to tabulate and analyze those data. However, this method does not always allow the respondent to give additional valuable information that may fall outside the given choices. Also, it does not allow for qualification or elaboration of the information given that may change the nature of the answer. Thus, some important descriptive information may be unacknowledged.

Observations

When evaluators come in to observe programs, an artificial atmosphere often takes over the program. People are nervous and on their "best" behavior or often behave in non-ordinary ways that might confuse those gathering information. One solution is to make the observers less obvious and obtrusive. Another way to lessen the effects of evaluator interference is to extend the evaluation period or number of visits. By doing so the evaluators become a "known" and a "common" occurrence around the data gathering site. To increase the reliability of observational data, Weiss (1972) suggests that observations be recorded as they are made.

Program Records

Logbooks, charts, intake records, and progress notes are a valuable part of the daily operation of any treatment or supervision program. However, these records may not always be in a form that is meaningful for research or which transforms into aggregate data files. For example, the type of family history data needed for a study may only be found in a rambling narrative case file. Thus, it would be very time consuming to read each complete case history in order to extract the necessary information (Weiss, 1972). The initial design or a redesign of existing organization records could ease research and evaluation efforts.

Another serious challenge to the use of program records is their accuracy. Record accuracy is affected by any number of changes that may occur over time in a program. This is especially true when the designated staff member tracking the information is sick or leaves the job. Record accuracy may also be threatened by changes in measurement methods. For example, if a halfway house changes its drug test the result may be better detection. If researchers were not aware of the test change, they might erroneously conclude that drug use among residents had increased. Additionally, there may be changes in the value of certain criteria for the program such as minor violations or levels of employment.

Clinical Examinations

Clinical examinations are often conducted or reviewed to determine the medical or psychological gains that may have been realized by program participants. Important considerations for the use of clinical examinations are who conducts these investigations and under what circumstances. Also the type of medical or psychological characteristics noted should be clearly defined using professionally accepted standards and measurements. The credentials of those providing treatment results should be included, particularly when drug and alcohol treatment programs use paraprofessional facilitators. Evaluators should

be careful to explain the limitations of such examinations or any other circumstances that may have colored the findings.

Tests

A variety of tests may be given to measure client performance following some treatment. Psychological tests may characterize personality patterns or look for emotional or thinking disturbances. Vocational tests will look for career interests, aptitudes or measurements of specific skills. Academic achievement tests will assess the grade level at which a person is functioning. It is important to know and explain the validity and reliability factors of any test used.

When a test is valid, it measures those values that you proposed to measure. When a test is reliable, it provides the same results over time and with different groups of similar test takers. However, it is important to look for any elements in the environment that may be influencing those taking the test. This might be noise, stress or perceptions about the purpose of the test. The results of tests are more significant when pre- and post-treatment tests are given and then compared. This means that the same test is given before and then after the treatment period. By doing so, improvements or changes in scores will be relative to a predetermined or base score.

Government Documents

These include official criminal records and police records. They can include revocation paperwork, which is an important source of evaluation data for recidivism studies. However, such records only measure behaviors reported to authorities. Evaluators most often use government documents as a secondary data source, meaning that they do not actually gather this information themselves. There is, therefore, a higher degree of error assumed in data that are gathered by someone else. This is especially true when it is someone who does not have a vested interest in the accuracy or "integrity" of these data.

Interpreting Program Results

There are a number of problems involved in interpreting program results. Many events that occur during a program's operation are beyond the control of the treatment provider. Since treatment does not take place in a controlled laboratory or a vacuum, it may be difficult to credit the program alone for a client's behavioral changes.

Another problem affecting interpretation is the impact of socio-historical events. This refers to the current events in a country, community, or family that may have a profound impact upon the offender. Researchers and evaluators must recognize, measure and control for these events as they may affect program results. Wars, economic recessions and changes in laws or probation criteria may not affect program participants equally.

It is also necessary to consider the effect of *maturation* when evaluating program results. That is, the client may no longer be interested in criminal activity, a common tendency in juveniles more so than in adults. It may be difficult to determine whether a program contributed to the youth's "outgrowing" of delinquent behavior or whether this change would have occurred without intervention.

Evaluating Program Evaluations

Program outcomes refer to the results of a completed goal or treatment term and may be expressed numerically, as the number of graduates from a program or parolees who don't get arrested. Impact, on the other hand, is the significance of an outcome, perhaps over time. Whereas outcomes are fairly concrete in observation, impacts may be more difficult to assess. Counseling may improve an offender's self-concept, but if he or she lacks the skills to get a job, then lifestyle may not be improved at all.

Impact is probably the most important but least measured aspect of program evaluation. It tells us if those who have completed parole or some institutional treatment program will be successful over a continued period. There are many who believe that this is the truest measure of rehabilitation (Cowen, 1978).

A major problem in comparing evaluation reports is that programs differ in scope. Some are national, some are state (system-wide) and others run at individual units. The larger a program's support base, the more resources the developers may have at their disposal. It is unfair to compare programs that come from significantly different levels of operation. Likewise, the size and type of the population served in each program may vary. Programs with a large applicant pool available may be able to more carefully "select" candidates, those viewed as more likely to succeed. Differences in the inmate profiles between institutions also make program outcome comparisons difficult. Inmates at Federal prisons, for example, differ significantly (in terms of age, race, education, and income) from those at most state prisons, and one could not expect similar results from similar programs operated in each. The duration of the program may also be an important variable affecting client behaviors. The longer and more intensive some treatments are, the more likely they may be to produce success.

Programs also vary in their approach to treatment. When reviewing a program, one should identify its strategy as traditional or innovative. When programs are built on traditional concepts, the designers and evaluators should be aware of the previous findings of similar programs. These findings should be an important part of the evaluation of each subsequent program built on the same philosophy. The outcomes of each new effort will be gauged against previous results, and similar findings or improvements would be expected.

Another factor to consider when comparing programs is their different goals. Short-term and remedial goals may be more easily addressed than those that cover long-range improvements. For example, it is easier to find jobs for offenders than to engage them in meaningful and economically rewarding careers. One would have a greater likelihood of success in graduating a person from an alcohol treatment program than insuring that the person remains alcohol-free for two or three years. The way goals are worded and measured may make it difficult to compare programs and to determine if they have met their goals.

When initial differences in program constructs are present, it will be difficult to compare even similar treatment methods. This is especially true when examining differing offender definitions or eligibility criteria. For example, two institutions run programs for violent offenders or sex offenders or even drug offenders. Depending on how each category of offender is defined, the two programs may draw different population participants and thus maintain differing potentials for success.

CHAPTER VI

ISSUES IN PROGRAM REVIEW/INTERNAL AUDIT

Some areas are of special concern to both the units being audited and the internal audit teams. Foremost is the issue of the credibility of the findings of the program review/internal audit. As noted elsewhere, comprehensive working papers must be developed and maintained for each review. The reviewer-in-charge must ensure the proper development of working papers; this review-related evidence must be accurate and complete, understandable, legible, neat, and relevant. Working papers (including appropriate attachments) must be organized so that an independent reader will draw the same conclusions as the reviewers. The working papers serve as evidence in the event that program review conclusions are challenged. Physical evidence is most dependable, followed by documentary or analytical evidence. Testimonial evidence, or interviews, may be the least reliable.

A successful internal audit depends on accurate and convincing documentation. The use of faulty evidence in presenting a finding could affect the credibility of the entire internal audit. For this reason, evidence discrepancies should be resolved each day of the audit or at the final debriefing session. Auditing is an open process in which findings are communicated; it is not an investigation in which findings are kept from the subject(s). Continuous involvement with staff of the audited unit ensures openness and can prevent problems of faulty findings.

A related issue is the method by which findings are presented. Administrators and staff often prefer overall compliance scores (like those for accreditation) that can be compared with other facilities, and some review/audit units provide them. This may be appropriate in specific areas where compliance tallies are required, but is not the preferred approach for program review/internal audit activities. Total compliance scores may mask material (i.e., significant) deficiencies. Internal reviews/audits should focus on deficiencies and their potential correction rather than providing a total compliance "score." In this approach the seriousness of specific deficiencies is weighed against the risk of not correcting them.

An issue related to the presentation of audit findings how personnel of the audited agencies receive audit findings. In some of the agencies contacted during the study, it was clear that past audit findings had been used to punish or discipline staff who had responsibility for areas with deficiencies. This is not a recommended approach. Deficiencies exist for many reasons, and many have been documented in the past. A more constructive approach is to view the program review as an effort to maintain high levels of performance in the system and its processes. This does not preclude normal management concerns over staff performance. Problems of staff performance should be addressed within that context and not within the context of the review/audit effort.

Another credibility issue concerns the "professional" nature of the audit team: the reviewers' qualifications, how they present themselves to the unit being audited, and how they interact with staff under review conditions. It is important throughout the review that the team maintain a professional demeanor and practice "due professional care," as discussed in chapter VIII. The review is a scheduled activity and not necessarily an invited activity. Attempts to lighten the situation with humor, for example, may be misunderstood.

Reviewers must be aware of and sensitive to the impact of their findings, especially deficiencies, which are of two general types: cost-related and those requiring changes in policy and/or procedures. The review team is not responsible for developing plans for correcting deficiencies; however, they may respond to inquiries regarding resolution of these areas.

Wardens and superintendents should not feel threatened by the review or audit. The result of this concern is sometimes an effort to control audit activities. It is understandable that administrators and other staff want to personally "show off" the facility, and they usually offer pertinent information during the process. However, the audit team should anticipate this behavior and intervene at some point in order to maintain the review schedule.

Most reviewers meet with line supervisors of the units in question at the onset of the review process. Similar defensive behavior may occur at these meetings, but with the opposite attitude. Some staff may suggest (by word or demeanor) that there are deficiencies in their area that are not being addressed. Auditors should be attuned to obviously disaffected staff and plan to talk with them to identify the nature of the problem.

Another issue is how the audited unit presents documentation to the audit team. When accreditation methods were developed in the 1980s, corrections departments often complained about the preparatory paperwork required for the audit and the degree of personnel and other resources required, often over periods of months. This problem became especially acute when there were staff shortages. The question of efficiency is raised. Should various units being audited prepare separate documents for review by the auditors at a central location, or should auditors go to the units and find documentation where it is available to and accessible by personnel operating the unit?

The issue of personnel and resource usage was discussed with project staff by the review/audit team at one site. The review team had heard complaints regarding the use of supervisors' time to compile documents. (Sometimes, document compilation is required for analysis, as when records such as work orders are being sampled and analyzed.) Organization policies and procedures, administrative directives, and the like should be available to auditors with limited help from facility staff. Local policies, procedures, guidelines, documentation of activities, and minutes of meetings can also be compiled in advance, although it may be more appropriate for auditors to go to the units and have staff locate these documents there. Documents such as shift logs and inmate files should be viewed on the unit. Being on the unit is advantageous because it allows a visual inspection, and this practice may promote interaction with personnel on that unit. In any case, it creates less work for staff and probably yields comparable results. It is preferred that the members of the review team initiate requests for records and review them personally at their location in the unit.

A related issue is the relationship between internal audit and accreditation. As noted, a 1992 issue of *Corrections Today* was devoted to "Accreditation—Three Decades of Evolution." This issue did not explore the linkages between accreditation methods and the developing science of internal controls. It is time to formally explore such linkages for several reasons. One is to ensure greater efficiency in evaluating operations by reducing duplication of effort. Internal audit provides more depth than accreditation, because it probes more deeply into substantive areas. Accreditation provides a yardstick against which to measure overall performance against national norms. Both are necessary and complementary goals. It appears that such a marriage is being explored by the ACA.

A more comprehensive issue arises regarding the overall value of the review/audit process. The question can be asked, what value is an internal audit if the reviewers are in the same organization? Won't the team members tend to "understand" the problems they find in their own organization? Might there be a reluctance to check on a problem when facility staff reported that it was resolved after the last audit? Questions may be raised about the politics of individuals temporarily assigned to an audit team (for the week) who know they might be later assigned to the unit they have audited. What are the concerns of individuals who are assigned to the review/audit unit who may later be reassigned to an operational unit?

A related concern is that organizations will accept the least difficult set of criteria in assessing their performance. Constitutional minimums stated by the courts are hardly the best guidelines for ensuring professional operations. National standards may rise above legal minimums, but by virtue of their national application they simply cannot and do not define every area of correctional practice. Such standards rely on local policy and procedures for compliance. Program review looks at the details of compliance with local or jurisdictional criteria—laws, rules, regulations, and policies. Strong program reviews should yield compliance levels quite consistent with both legal norms and national standards. Many correctional organizations have integrated the most important national standards into their review systems.

Standards for internal audit, as promulgated by the Institute of Internal Auditors and the Comptroller General of the United States, are designed to ensure the independence and objectivity of the process, and

especially the independence of the auditors in carrying out their duties. Support from the top levels of the organization—based on legislation and/or other type of authorization, policies and procedures, and local guidelines—is critical. However, individual auditors are part of organizations and may not view these protections as sufficient to ensure freedom from outside influences. Support for the process from the top levels of the organization is the only way to defeat this problem.

The Future of Program Review/Internal Audit in Corrections

The future of program review in corrections is as good as the administrators who embrace it. Corrections cannot operate on intuition or experience alone, which became apparent in the era of court intervention. The national standards and accreditation program requires an agency to complete a self-evaluation before the external audit, which has caused many departments of correction to initiate systematic internal reviews. Accreditation was and still is an excellent starting point for internal review; however, better techniques are becoming available.

Program review/internal audit is a technique that developed in business and industry and is relevant to all organizations concerned with quality assurance. It has already proven effective in the corrections profession and warrants further evaluation. The Bureau of Prisons has the best potential for evaluating the usefulness of its program review process. The key indicators system (KI/SSS) provides management with access to a great deal of information on organizational operations; it is an outstanding tool for strategic planning and the application of quality control principles. These data "serve as 'indicators' in the sense that they let the user observe and analyze system changes such as levels of crowding, the distribution of inmates with regard to security and custody requirements . . ." (Saylor, 1989:40).

Can performance review predict future events related to performance measures and correction of deficiencies? Does the review adequately identify the types of prevention techniques required to improve operations? Could the system prevent a disturbance or a riot? It is understood that this would be difficult to know because the disturbance might not occur, which is desirable, but could a relationship between past problems and future reductions based on the performance review function be established? Perhaps this type of information will be determined from an analysis of existing institution profile data. When a problem such as a disturbance does occur, it is investigated to the extent possible in terms of prior efforts at identification.

Bureau staff state that concern always exists about the cause and effect of a problem, and that the program review information is useful in evaluating the programs, components, and activities that may lead to risk. They can clearly see the strengths and weaknesses of all BOP programs, and that is not in doubt. However, no hard data support these observations. Such data would be most useful in convincing other jurisdictions of the value of the process in controlling possible problems. It is hoped that the Bureau will support or even undertake a study of this process to see how effective it is in actually preventing potential problems in the organization.

CHAPTER VII

FIELD VISITS

This chapter contains the analysis of program review/internal audit systems for the Federal Bureau of Prisons and several state departments of corrections across the country. Included are: 1) a detailed explanation of the organization of existing performance review systems in the jurisdiction studied, 2) the types of resources needed and the methods and tools used to conduct management performance review in each jurisdiction, 3) an analysis of the strengths and weaknesses of each system, including the findings of the researchers and the concerns of the staff using these procedures every day, and 4) a comparison of the six states and the Federal Bureau of Prisons on the methods and procedures used in management review. These include economy, efficiency of personnel, efficiency of time, meeting legally mandated or other designated standards, communication of management needs, and availability and utility of the information used. An overview of evaluation procedures, which are used to monitor the success of the review process by jurisdiction, is given. Potential users of this information should find it useful in designing a program review or internal audit system.

Conduct of the Study

The study examined six different program review/audit systems to compare their strengths and weaknesses. The intent was to identify and document aspects of program review/internal audit that would contribute to a model attainable at some level by all correctional jurisdictions. Directors and representatives of several correctional systems reviewed draft reports for their feasibility.

Six states and the Federal Bureau of Prisons Program Review Division were evaluated. At the founding of the PRD in 1988, staff recognized that program review is linked to total agency performance and to the planning function, information systems, and research and evaluation needs. The process involved as many correctional agency personnel as possible. It is often difficult to "sell" administrators and managers on adopting "model" programs designed elsewhere that they may feel do not apply to them. Involving the field in the developmental process for any innovative approach to improving corrections has proven beneficial (Reimer & Sechrest, 1979; Sechrest & Reimer, 1982).

A key element of the model audit system(s) developed was the identification of the structural components that lead to better management control. There is no perfect system for program review and auditing of organizational activities. Correctional systems with the most comprehensive program review and auditing functions have an administrative commitment and funding sufficient to allow them to work at full capacity.

Automated information systems were not generally linked specifically to the internal audit process, although they are a component of the management review process in most jurisdictions. The U.S. Federal Bureau of Prisons and the Correctional Service of Canada have managed to link technology to performance review, planning, and organizational outcomes. Both systems refer to "strategic plan goals," or "corporate objectives" in the Canadian system, which are based on "key indicators" or "corporate performance indicators." The use of these information systems in internal auditing is just beginning to be explored. Again, use of technology is important to performance review/internal audit only if it is properly managed.

Summary of the Field Visit Process

To establish the present state of the program review/internal auditing function in the six states and the Federal Bureau of Prisons, an open-ended questionnaire format was used. This format is based on the definition of administrative controls discussed earlier. It provides agencies a tool with which to

assess current program review/internal audit capabilities.

Criteria for Measurement

The primary sources of criteria used in comparing the actual practices of program review/internal audit were the *Government Audit Standards* of the Comptroller General of the United States (1988), the *Codification of Standards for the Professional Practice of Internal Auditing*, prepared by the Institute of Internal Auditors (1989), and the practice of internal audit. These criteria should be used by organizations that wish to develop a program review/internal audit capability. Examples of audit policies and procedures are provided in Appendix C, including Federal Bureau of Prisons Program Statement 1210.12 and policies for the Utah and Illinois Departments of Corrections, respectively. Appendix A provides examples of statutes governing internal audit. Standards for the audit of governmental organizations, programs, and activities are found in Appendix B. Examples of audit programs and audit objectives are shown in Appendix D.

Developing Operational Definitions

Within the Federal Bureau of Prisons (BOP), the Program Review Division (PRD) has responsibility for all centralized BOP program reviews. The Illinois Department of Corrections (IDOC) Fiscal Internal Audit Unit (FIA) is charged with conducting financial audits; an Operations and Program Audit Unit (OPA) was responsible for performance audits until it was dissolved in 1992 (after 10 years) and its duties assumed by the FIA. The Bureau of Internal Audit of the Utah Department of Corrections (UDC) completes performance and financial audits of all department operations. The multi-state audit (MSA) system operating between Washington, Oregon, and Idaho results in audits of institutions to assess compliance with mutually agreed-upon standards. These standards have been adapted from American Correctional Association (ACA) standards. The New Jersey Department of Corrections (NJ DOC) has various audit units, with no centralized office performing this function.

A method of examining and analyzing the review/audit systems for these organizations was developed based upon Generally Accepted Government Audit Standards (or "GAGAS") and the practice of internal audit. Definitions were developed for each review/audit operational category. These definitions, which are given below, were prepared to explain the informational matrices for each organization included in this chapter.

1. *Organization*: the general structure of the agency based on the most current organizational chart or table available.

2. *Number of Employees*: the number of persons employed within the organization, including institutional, support and field staff.

3. *Number of Institutions*: the number of institutions under the authority of the organization by security level and/or type.

4. *Number of Inmates*: the total number of inmates under the jurisdiction of the organization.

5. *Legislation*: whether enabling legislation authorizes and guides the review or audit function within the organization, including a description of key elements of the legislation.

6. *Charter*: a published document within the organization that authorizes and guides the review or audit function, including reporting relationships, scope of work, etc.

7. *Audit Committee*: whether an audit committee has been established to provide oversight of organizational internal control, reviews or auditing, and financial reporting, and whether the committee is made up of individuals from outside the organization.

8. *Organizational Status*: the position within the organization of the review or audit function and the related degree of independence.

9. *Categories*: the types of reviews or audits conducted as described by the organization.

10. *Policies and Procedures*: whether the organization has written, comprehensive policies and procedures regarding the review or audit function, including a summary of the general content of these policies and procedures.

11. *Review/Audit Staff*: the personnel assigned to the review/audit function and staff qualifications as described within applicable job specifications.

12. *Certification*: the emphasis the organization places upon professional certification of review or audit staff.

13. *Training*: the types and sources of any specialized training provided the reviewers or auditors.

14. *Affiliation*: any review or audit-related professional affiliations maintained by the organization's reviewers or auditors.

15. *Standards*: whether the organization's review or audit group has adopted professional audit standards as promulgated by the Comptroller General of the United States, the American Institute of Certified Public Accountants, the Institute of Internal Auditors, American Evaluation Association, etc.

16. *Automation*: the level of electronic data processing employed as it relates to the review/audit process, including planning, testing procedures, working paper preparation, evaluation methods, communication etc.

17. *Universe*: all organizational entities and functions reviewed or audited.

18. *Priorities*: methods used by the organization to develop priorities for the review/audit process, e.g., risk assessment and management assessment methodologies.

19. *Cycle*: the recurrence of reviews or audits as required by enabling legislation, policies and procedures, executive mandate, etc.

20. *Schedules*: the process by which audit schedules are developed and implemented.

21. *Scope*: those areas generally examined during reviews or audits, including performance and financial related issues.

22. *Survey*: the degree and extent of formalized planning for each review or audit and the level of related documentation.

23. *Work Program*: how preliminary assumptions are made by the reviewers or auditors before conducting the review/audit, and how review/audit objectives and anticipated testing procedures are summarized.

24. *Notification*: how and when those being reviewed or audited are informed and prepared; may include written notification, an entrance conference, ongoing liaison efforts, etc.

25. *Onsite Verification*: the nature of the review or audit phase where tests are conducted, evidence gathered, and evaluations made to support reported results. This includes supervision of review/audit staff, oversight of working paper preparation, liaison with reviewed or audited staff, interim reporting of results, and closure.

26. *Working Papers*: methods used by review or audit staff to document the verification and evaluation process or evidence supporting judgments and conclusions.

27. *Reporting Results*: the manner in which draft and final review or audit reports are prepared, including timeframes, style, content, response from those reviewed or audited, action plan development, and whether an exit conference is conducted.

28. *Local Reviews or Audits*: review or audit by operations staff that supplements the efforts of the reviewers or auditors.

29. *Safekeeping and Accessibility*: how working papers and review or audit reports are stored and the right of access to these documents.

30. *Follow Up*: how the organization ensures that action occurs subsequent to review or audit issues or findings.

31. *Continuing Quality Improvement and Peer Review*: the degree and nature of internal and external scrutiny of the organization's review or audit process by individuals familiar with the organization.

32. *External Review or Audit*: reviews conducted by agencies outside the organization.

Review/Audit Procedures by Organization

A master matrix of review/audit operational categories appears at the end of this chapter. It is designed to guide the reader to review/audit operational categories by organization. There are also several appendices containing sample policies, job descriptions, risk assessment forms, audit programs, audit working papers, and other information.

Federal Bureau of Prisons Program Review Division (PRD)

1. **ORGANIZATION:** The PRD is one of the nine divisions of the BOP. The assistant director reports to the Director of the BOP. The nine assistant directors and the six regional directors constitute the Director's executive staff.

2. **NUMBER OF EMPLOYEES:** Approximately 24,000 employees are employed by the BOP. However, 1995 projections reach almost 40,000 employees.

3. **NUMBER OF INSTITUTIONS:** Nationally, there are 70 institutions in six geographic regions. There are 47 additional facilities planned and 16 existing facilities will be expanded by 1995. The six geographic regions include Northeast (Regional Office in Philadelphia, PA), Mid-Atlantic (Regional Office in Annapolis Junction, MD), Southeast (Regional Office in Atlanta, GA), North Central (Regional Office in Kansas City, MO), South Central (Regional Office in Dallas, TX), and the Western (Regional Office in Dublin, CA). The regional offices have responsibility over institutional and community activities. Bureau coordination and program development are the responsibility of the Washington, DC Central Office.

According to a publication entitled *Bureau of Prisons Goals for 1992*, an objective of the BOP is to adequately manage the inmate population and to meet projected space requirements. Strategies include obtaining sufficient resources to reduce crowding to 104% of rated capacity by fiscal year 1995, increasing the use of alternate methods such as home confinement, exploring options for development of new alternatives such as restitution centers and day prisons, adding a total of approximately 8,500 beds at existing institutions, construction of new institutions, and contracting for beds. Maximum security institutions are designed to house persons serving long sentences, except Atlanta, an Administrative institution with several levels of security. Satellite camps are minimum security.

4. **NUMBER OF INMATES:** More than 90,000 inmates are in the custody of the BOP.

5. **LEGISLATION:** Following 31 U.S.C. 3512 (b)(1), which refers to executive accounting systems, and the Office of Management and Budget (OMB) Circular A-123, which addresses internal control systems, each Federal Government agency is required to establish a continuous process for the evaluation and improvement of the agency's system of internal controls.

The PRD Assistant Director has responsibility for coordinating the agency-wide effort to comply with the Integrity Act (P.L. 97-255). The act also requires the official to ensure that the agency's methods of assessing the adequacy of internal controls comply with this act. The BOP has published *Program Statement 1210.12* that addresses Management Control and Program Review. This document cites various Directives, Department of Justice (DOJ) Orders, OMB Materials, General Accounting Office (GAO) Standards and American Correctional Association (ACA) Standards.

6. **CHARTER:** The BOP *Program Statement 1210.12* includes a detailed description of the authority of the PRD. Program reviews of all program areas are conducted by reviewers under the authority of the Assistant Director, PRD. Also included in *Program Statement 1210.12* are the following: 1) implementation of the Management Control and Program Review systems in compliance with generally accepted government audit standards and policy, 2) development of annual review schedules and related budgets, 3) selection criteria for program reviewers, 4) a statement that the review process is to be independent, 5) appropriate training for review staff, 6) program reviews to be conducted in a timely, economical, and professional manner, 7) review reports to be timely and prepared in a professional manner, 8) reports are to be reviewed to ensure review objectives were met, 9) exemplary program findings are to be validated, 10) an evaluation is to be made of the adequacy of response to review findings, 11) followup reviews are to be conducted to ensure all required corrective actions are taken, and 12) program reviews do not come to closure until corrective actions have been taken and internal controls are in place to prevent recurrence.

The responsibilities of the Wardens/Superintendents directly affect program reviews. Concerns include providing full support and cooperation to the reviewers, providing prompt consideration to findings, ensuring freedom of access to all property, records, employees and inmates, and providing timely initiation and completion of appropriate corrective action to enable closure of the program review within specified time frames. The BOP *Program Statement 1210.12* systematically defines the responsibility of all key managers and executives in assisting the director, who is required to submit an assurance statement to the Attorney General at the end of each fiscal year certifying that BOP programs are operating

effectively and in accordance with applicable law, and that the systems of internal control are adequate to protect resources. Material weaknesses and significant concerns in the Bureau's systems of controls are to be identified and a plan for correcting them included. The PRD Assistant Director is the designated BOP Internal Control Officer.

In addition to oversight of the program review process, the PRD Assistant Director: 1) serves as Program Review Authority for all centralized BOP program reviews, 2) issues an annual review schedule and has ultimate responsibility for ensuring timeliness in carrying out the review schedule, 3) develops and updates review policies and procedures, 4) provides training to program reviewers, 5) monitors all reviews and related materials to ensure reviews are conducted in accordance with policies and procedures, 6) reviews program review objectives and guidelines for completeness and adherence to accepted formats, 7) provides analysis and response to all levels of the agency concerning program reviews, 8) assesses effectiveness of the review program, and 9) makes recommendations to the Director for improvements in management control and program review. Regional directors have responsibility for: 1) ensuring that Wardens and Superintendents in their regions are fully responsive to program review findings and that program reviews are closed by the institution in a timely manner, 2) determining the need for special reviews or studies and ensuring they are conducted, 3) analyzing the results of program reviews, management assessments and other studies to determine if there is a pattern of noncompliance or lack of controls in regional programs, and 4) annually preparing a certification letter to the Director attesting to the adequacy of internal controls in regional programs, summarizing major findings and identifying major concerns requiring corrective action. Central/Regional Office administrators complete Management Control Plans and Year-End Assurance Statements for their respective disciplines.

7. **REVIEW OR AUDIT COMMITTEE:** Reviews are planned, scheduled and conducted within the context of the BOP Strategic Management Cycle. This cycle embodies information from 1) strategic plans and goals, 2) management assessments, 3) program reviews, 4) operational reviews, 5) prison social climate surveys, 6) institution character profiles, 7) management indicators, 8) policy development, and 9) other information sources (external agency reviews, etc.) All of these areas are interdependent and collectively form what is known as a "strategic management cycle."

8. **ORGANIZATIONAL STATUS:** An assistant director is responsible for the functional units or branches of the PRD. These include the Program Review Branch (PRB), Strategic Management Branch, and Program Analysis Branch. A deputy assistant director administers the PRB.

9. **CATEGORIES:** The PRB is divided into two parts: 1) Operations and 2) Programs. Staff of PRB conduct financial and program reviews as specified in *Program Statement 1210.12.* Financial reviews are conducted to assess compliance with laws, regulations, policies, and generally accepted accounting principles, and to determine whether financial statements of the reviewed entity fairly present the financial position (also referred to as financial and compliance reviews). Program reviews determine compliance with applicable regulations and policies, adequacy of internal controls or safeguards, and the effectiveness, efficiency, and quality of the programs and operations (also referred to as management, centralized, operational, or expanded scope reviews).

10. **POLICIES AND PROCEDURES:** Comprehensive, written policies and procedures guide the PRD. The components of the BOP program review process are addressed in Program Statement 1210.12. The statement includes 1) a declaration regarding the purpose and scope, 2) a listing of all affected directives and standards that are rescinded or referenced, 3) a catalog of terms used, 4) an account as to how the statement is organized, 5) background information, including laws and regulations that necessitated the development of the statement, 6) the overall policy regarding program reviews, 7) a summary of management's responsibilities, 8) a series of statements about executive and administrative staff's responsibilities for the program review process, and 9) a catalog of the role and function of the various

branches of the PRD as they relate to the program review process. The BOP *Program Statement 1210.12* addresses 1) developing a program review program, or plan, and 2) conducting a program review program. Included in appendices are 1) standards for audit that consist of a summary of *Standards for Audit of Government Organizations, Programs, Activities and Function,* 1988 Revision, GAO, and 2) program review process examples.

Developing a Review Program. These programs, or plans for program review, are based upon an identification of vulnerable areas, the classification of the types of reviews required (routine program reviews or special reviews), the availability of resources, and the sites to be included. The details of the management assessment process and followup activities that are the responsibility of the central office program administrator are documented. Policy addresses the necessity for updating program review guidelines, the development of review objectives, and the specific components of a review. Emphasis is placed upon organization and supervision of the verification or examination phase. These topics include planning, verification and evaluation, and reporting results (data collection, interviewing and observing). Types of review or audit evidence are enumerated along with the standards associated with obtaining evidence (sufficiency, competence/reliability, and relevance).

Procedures are listed when reviewers encounter serious or unusual problems that may dictate halting or redirecting the review work. Development of working papers is discussed in detail, including development and use of forms, general sampling methodology, and documenting reviewer evaluations (i.e., judgments that are made by reviewers based upon the evidence gathered). Development of material program review findings is discussed, including the elements of a finding, *i.e., condition, criteria, effect, cause, and overall rating*. Reporting results of the program review is dealt with in detail, including the characteristics of the report (fairness and accuracy, clarity, persuasiveness, and timeliness). Review report distribution, retention, and release provisions are discussed. The statement specifies that reporting on results of a program review is governed by the principle of "reviewing by exception." This principle is used throughout the auditing profession and means that if an area, component, or issue is not mentioned in the report, the reader may assume that no serious or significant deficiencies or need for improvement were identified. The program review report format is specified, which includes *general comments* (areas for further study, observations not directly related to the scope of the review, etc.); *repeat significant findings* (a finding reported in the current review that was also listed during a previous formal PRD review); and *significant findings* (material findings of deficiencies found during the review). Closure of the program review process is discussed, outlining the reviewer's responsibility and the responsibility of the institution. When the review authority has obtained reasonable assurance that deficiencies have been corrected, the review authority notifies the CEO that the program review is considered closed. Operational Reviews are conducted under the authority of the Chief Executive Officer and must be conducted within 10 to 14 months from the week the previous PRD review occurred. Operational reviews are conducted using the same process as PRD reviews.

11. **REVIEW/AUDIT STAFF:** There are 68 Program Review Examiners who are responsible for reviews at institutions. These reviewers are assisted by up to 12 institutional field personnel, depending upon the discipline being reviewed. To ensure independence and objectivity, institutional field personnel do not review operations within their own facility.

12. **CERTIFICATION:** The BOP does not provide funds for professional certification of review staff.

13. **TRAINING:** Specialized training is provided all program review staff. The BOP has developed a *Program Review and Strategic Management Course* as part of the Institutional Cross Development Series. This training is provided all PRD and institutional staff involved in operational reviews. The course includes 1) a section concerning management assessments, which addresses the process and how to use the data; 2) a chapter addressing performance monitoring, which discusses operational reviews (an annual review conducted under the jurisdiction of the installation CEO) and program reviews (comprehensive

reviews conducted at the direction of the review authority that include preparing for and conducting a program review with supporting data); and 3) a segment devoted to Strategic Planning, which discusses the planning process and implementation. The course material also contains information regarding the Key Indicator Strategic Support System (see item 16 below).

14. **AFFILIATION:** Review staff are not reimbursed for the costs of professional affiliation by the BOP.

15. **STANDARDS:** As indicated in *Program Statement 1210.12,* PRD program reviews are conducted in accordance with *Standards for Audit of Government Organizations, Programs, Activities and Functions,* 1988 Revision, General Accounting Office (GAO). The statement further indicates program review procedures shall comply with these standards for purposes of program and financial program reviews. The American Institute of Certified Public Accountants (AICPA) has issued standards that are applicable to and generally accepted for financial audits. The AICPA standards for field work and reporting have been incorporated into GAO standards.

General Standards. These refer to qualifications of audit staff, organizational and individual independence of the auditors, the importance of auditors exercising due professional care, and the need for internal and external quality control of the audit function.

Field Work for Financial Audits. These standards describe the necessary planning, audit evidence gathering procedures and understanding of the internal control structure, which is necessary for completing financial audit field work.

Reporting Standards for Financial Audits. The unique needs of government financial audits are addressed by these standards. A statement is required in the report that the audit was conducted in accordance with generally accepted government auditing standards. Where these standards are not followed, an explanation is required. The auditors should report on their tests of compliance, citing applicable laws and regulations indicating where there is material noncompliance. The auditors should also provide positive assurance on those items that were tested for compliance and negative assurance on those items not tested. The auditors are to report in writing to appropriate officials within the organization and outside the organization, unless law prohibits such reporting, on the entity's internal control structure. This report regarding the internal control structure should 1) indicate the scope of the auditor's work in obtaining an understanding of the structure and control risk, 2) comment on the entity's internal controls, including those established in compliance with laws and regulations having an impact on the financial statements and results of the financial related audit, and 3) include reportable conditions, incorporating potential weaknesses such as fraud, abuse, and illegal acts.

Field Work Standards for Performance Audits. These standards relate to audit planning, supervision of auditors during the onsite phase, the requirement that the auditors assess compliance with the applicable requirements of law and regulation, auditors providing reasonable assurance that fraud, abuse or illegal acts related to the audit objectives are detected, a statement that an assessment be made of applicable internal controls, and assurance that the auditors gather sufficient, competent, and relevant audit evidence.

Reporting Standards for Performance Audits. These standards require written reports to communicate results on a timely basis to officials at all levels of government. The reports should be complete, accurate, objective, and convincing, and be clear and concise. These reports are to be distributed to the appropriate officials of the organization audited, and to the appropriate officials of the organization arranging for the audits. Copies of reports are to be sent to officials responsible for taking action on audit findings. Unless restricted by law or regulation, reports may be limited in distribution.

16. **AUTOMATION:** The Program Analysis Branch (PAB) coordinates analyses of reviews to determine trends and patterns that are both discipline-specific and cross-disciplinary in nature. The PAB also has responsibility for assisting program administrators and managers at all levels with the use of management indicators from systems such as the Key Indicator Strategic Support System (KI/SSS), which is a PC-

based management information tool providing users access to a range of BOP information on inmates, staff and fiscal operations. Management indicators include budget reports, past program reviews, special studies, routine operating/analytical reports, and program reviews and other tools. Much of the information used in management assessment is provided by the PAB, which in turn results in the revision of program review guidelines. These guidelines are the general instructions to the PRD program reviewers for a particular program or group of programs. KI/SSS is described fully in chapter IX.

17. **AUDIT UNIVERSE:** The BOP has defined 15 operational disciplines, also referred to as programs. The PRD has assigned responsibility to the Program Review Branch (PRB) Operations Section for review of the following disciplines: 1) Correctional Programs, 2) Correctional Services, 3) Community Corrections, 4) Human Resources, 5) Medical Services, 6) Religious Services, 7) Financial, and 8)Computer Services. The PRB Program Section has been assigned responsibility to review: 1) Facilities, 2) Safety, 3) Inmate Sentence Management, 4) Educational Services, 5) Food Services, 6) Psychological Services and 7) UNICOR (industries). Thirteen of these disciplines have regional and central office counterparts, which are reviewed annually. UNICOR has a central office counterpart only.

18. **PRIORITIES:** The purpose of the BOP Management Assessment process is to examine each component of a discipline or program to determine 1) the vulnerability of the program to fraud, waste, abuse, and mismanagement, 2) the potential for serious problems if policy and regulations are not followed, or systems of internal control are not adequate, 3) the degree to which resources are being used efficiently, 4) program review priorities, and 5) management indicators by which program operations are to be evaluated. The one-week process addresses all three BOP management levels: the Central Office, regional offices, and institutions. The Strategic Management Branch (SMB) has responsibility for coordinating annual management assessments of each discipline. The management assessment consists of 1) a review of past and current performance, examining various management indicator data, and 2) an assessment of the program's level of risk and need for improvement by means of a structured review methodology (risk assessment).

Each SMB evaluator has responsibility for several disciplines and coordinates the identification of legal and professional requirements pertaining to the discipline. Since SMB evaluators are process experts rather than content experts, they facilitate the Management Assessment by meeting with the Regional Administrator, Wardens and managers from various levels and the BOP Discipline Director. The purpose of these meetings is to 1) identify an objective for operational activities, 2) assess the level of risk, 3) articulate procedures or control techniques that provide reasonable assurance operational objectives will be met and problems avoided, 4) identify the perceived adequacy of these controls and safeguards, 5) anticipate the significance of actual risk to the program's mission, 6) distinguish methods of reviewing the activity to ensure controls are adequately tested, and 7) index specific program review objectives and steps to carry out testing.

Central office administrators are fully involved in the management assessment process. It is the responsibility of the Central Office Program Administrator to ensure that necessary documentation is maintained regarding the management assessment process. This documentation is subject to audit by the Department of Justice, General Accounting Office and review by the PRD. It must be maintained for two years and must be reasonably sufficient to lead a person who is not an expert in the field to the same conclusion.

A Management Assessment form has been developed, which 1) identifies the program—usually defined as the *discipline*—see 17: Audit Universe, 2) articulates an objective statement (i.e., to ensure institutions are operated in a manner that provides a safe environment for staff and inmates and prevents inmate escape, 3) includes an identification of the process (i.e., tool, weapon and hazardous material control), and 4) provides a listing of the steps necessary in the process from start to finish. An inherent risk factor is applied to each step in the process, and the adequacy of internal controls is assessed for each

step. Overall risk is seen as high, medium or low. An attempt is made to balance the inherent risk against the level of internal controls to determine the overall risk.

Key responsibilities of the assistant directors include ensuring that management assessments of all division programs are conducted and related results are incorporated into the long-term Management Control Plan (a brief written plan summarizing the results of the Management Assessment and planned related action). Management Assessments are used to determine the degree of risk for each important process or activity. Assistant directors also must 1) determine the need for special reviews or studies and ensure they are conducted, 2) analyze the results of program reviews, management assessments, and other reviews and studies to determine if a pattern of noncompliance or weaknesses in internal controls is found, 3) update Management Control Plans and monitor progress in correcting deficiencies, and 4) annually review and update Program Review Guidelines, which are the measures by which program reviews are conducted.

19. **CYCLE:** Following *Program Statement 1210.12*, each program or operational area at each Bureau installation is comprehensively reviewed, in accordance with published Program Review Guidelines, by reviewers at least once every two years. Newly established facilities should be reviewed within 12 to 16 months of activation.

20. **SCHEDULES:** Management Control Plans are developed for five year periods by Central Office and Regional Program Administrators. These plans are based on Management Assessments and include planned actions. In addition to outlining the frequency of routine PRD program reviews, Management Control Plans identify the level of risk associated with program areas, plans to correct problems that do not require additional review, plans for special studies, surveys or task force efforts to examine problems in detail along with dates for completion, and a certification that all high risk areas have been included in the Program Review Guidelines or will be addressed in a special review. The PRD Assistant Director issues a compiled Annual Program Review Schedule for all programs and is responsible for ensuring the timeliness of program review schedules. BOP *Program Statement 1210.12* specifies reviews are 1) scheduled via the Annual Program Review Schedule, 2) included in a special sampling of sites to test the adequacy of specific controls, or 3) conducted in response to a specific event or request.

21. **SCOPE:** The nature of the discipline in which a review occurs dictates the scope. Program Review Guidelines are developed subsequent to the Management Assessment process. The BOP *Program Statement 1210.12* indicates the scope of a review may include 1) a complete examination of one program, 2) an examination of one or more components of a program, or 3) a special review affecting several programs.

22. **SURVEY:** A reviewer-in-charge is assigned responsibility to prepare for each review scheduled. The BOP *Program Statement 1210.12* indicates that, as part of preparation for a review, data collection should occur (to include the use of the Key Indicator/Strategic Support System) and an assessment before arrival at the review site in order to help focus program review objectives. A written site plan is prepared which includes the review site, program area (discipline), scope, dates of review, suggested team members, estimated budget in dollars and reviewer days, date of last review, status of last review, a summary of indicators (previous review findings and other data, potential problems and any anticipated adjustments to the Program Review Objectives). Upon obtaining input from the respective Regional and Central Office Administrators, the reviewer-in-charge submits the plan to the PRD Assistant Director or designate for approval. The reviewer-in-charge then implements the plan that includes arranging for the services of and notifying the team members, and arranging onsite logistics.

23. **WORK PROGRAM:** Program Review Guidelines that are developed as part of the Management Assessment process contain general instructions for reviewers of a program or group of programs.

Development of these guidelines afford Program Administrators (discipline experts) the opportunity to outline review instructions unique to the program. The guidelines also contain instructions as to the frequency of reviews, the number of reviewer days required, general sampling techniques, the period of examination, composition of the review teams, types of checklists, and other review tools needed. All guidelines are reviewed by the Strategic Management Branch before being used.

Program Review Objectives. Based on the results of the Management Assessment, Central Office staff and Regional Program Administrators, with input from the Warden advisory groups and institutional managers, establish a series of objectives that will enable reviewers to focus on areas where attention is most needed in the subsequent 12 to 24 months. These objectives relate to areas that are highly vulnerable to risk, areas having the potential for savings, and areas where there have been problems. Central Office Administrators have responsibility to ensure the objectives encompass all *criteria* necessary to measure whether the objectives of the program are being accomplished. Minimally, objectives address all significant policy requirements necessary for achievement of the objectives. A background statement provides additional information as to why the objective has been included in the Program Review Guidelines. If the objective involves a policy requirement, government regulation and/or mandatory ACA standards, they are listed in the background statement.

Program Review Steps. After each program review objective, background statement, and policy citation is a listing of program review steps. These steps describe the work that is required to meet the program review objectives. The steps outline the work to be done during the review, the specific documents to be examined, sampling techniques to be used, span of time to be reviewed, processes to be observed, persons to be interviewed, and purpose of the program review step. These steps represent the minimum acceptable testing that must occur to obtain the evidence necessary to meet the program review objective. Where applicable, the program review step cites an appropriate reference to policy, regulation, standards, etc., which will reduce the amount of time required by reviewers to become familiar with review criteria from these sources. These cites are an aid to other audit agencies and allow the guidelines to be used as a training tool. Management indicators that may be contained in program review steps reflect the expected results or outcomes of programs. They result in information allowing the monitoring of goal attainment.

Mandatory Program Review Objectives. These are a separate component of the Program Review Guidelines for each discipline that are applied at the regional level. They are reviewed by a department head or staff of greater rank for inclusion in the program review report.

24. **NOTIFICATION:** The review authority notifies the CEO in writing of an upcoming review 30 days before the review. According to *Program Statement 1210.12,* the notification contains 1) dates of the review, 2) names, titles, and duty stations of the reviewer-in-charge and reviewers, 3) scope of the review, 4) program area(s) to be examined and type of review, 5) special focus areas if any, 7) program review objectives if different from those published in the Program Review Guidelines, 8) requests for any specific information from officials at the review site (requests for such information are limited to those pieces of information not available from any central data base or central information location), and 9) a request that the CEO respond if there are any additional special concerns or areas that the CEO would like examined. The review authority reserves the right to conduct reviews without prior notification if deemed necessary to achieve reasonable assurance that a site/program is operating in accordance with applicable law and policy, and property and resources are efficiently used and adequately safeguarded.

25. **ONSITE VERIFICATION AND EVALUATION:** An entrance interview is conducted upon the review team's arrival at the review site. At this meeting the reviewer-in-charge defines the scope of the review, describes how the review will be organized so as to cause as little disruption as possible, informs the Warden/Superintendent and staff that consideration will be given all related findings, establishes lines of communication, and establishes a date and time for closeout. BOP *Program Statement 1210.12* indicates the examination phase of the review involves all the data collection, interviewing, and observations

conducted at the review site. The steps, procedures, principles, and tools required for the examination phase include 1) a meeting by the reviewer-in-charge with the program review team members to brief them on the plan, including division of labor, time frames, objectives, and sampling techniques; 2) informing the department head and staff that all comments that might alter findings and recommendations or that provide information concerning the cause of deficiencies will be fully reviewed and given consideration and that the reviewers will work with them to find causes and solutions; 3) the reviewer-in-charge keeping the department head/or Associate Warden informed concerning all preliminary findings, including providing sufficient detail to allow a full understanding of the issues; and 4) the reviewer-in-charge providing adequate supervision of the review team.

The reviewer-in-charge conducts daily closeout meetings with institution staff, associate warden, and warden when deemed appropriate to discuss deviations from the review scope, recommendations, misunderstandings and resolution of issues, and evaluate areas where immediate correctable action may occur. The reviewer-in-charge is also responsible for debriefing the review team on a daily basis. This includes a discussion of information gathered and any needed adjustments to work distribution. There may be situations where problems are so pervasive or serious that reviewers will find it necessary to halt the review or drastically redirect the program review work. The reviewer-in-charge discusses the matter with the review authority who has final authority to halt or redirect the review. Before a review can be halted, the reviewer-in-charge ensures that sufficient evidence has been gathered to prepare a report of major findings. Ending or redirecting a review before completion of the planned review scope does not relieve the reviewer-in-charge from preparing a Program Review Report in accordance with policy. The next course of action is discussed with the review authority. Action may include providing technical assistance for the remainder of the review period, scheduling a later return to the review site to provide the necessary assistance, or naming a special staff assistance team comprised of program (discipline) experts.

Reviewers are to be alert to situations or transactions that would indicate fraud, abuse or illegal acts. Any evidence of this activity is reported immediately to the CEO and the review authority and may be referred to Internal Affairs for investigation. The evaluation phase is where reviewers begin making judgments about every document examined, every interview conducted, and every observation to ascertain the interrelatedness of evidence. As reviewers organize evidence into findings, they ensure it is sufficient, reliable, and relevant. They analyze the evidence for indications of patterns, trends, interrelationships, common causes and effects of the problems, and for innovative methods of improving operations. A Program Review Draft Report is prepared and the reviewer-in-charge holds an exit interview with institution staff and the CEO. As indicated in the *Program Review and Strategic Management Course, Institutional Cross Development Series* (December, 1990 Edition), a positive attitude and manner are important for setting the tone for improved performance of the program. The draft of the report on the findings is discussed in order to provide information, clarify any misunderstandings that may have arisen during daily briefings, resolve any differences of interpretation on factual assessment where possible, and explain the next steps in the review process and set timetables. Any confidential matters are discussed in a private meeting with the CEO. An effort is made throughout the review process to ensure open communication.

26. **WORKING PAPERS:** Comprehensive working papers are developed and maintained for each review. The reviewer-in-charge has responsibility for oversight of working paper development, ensuring that this review-related evidence is accurate and complete, understandable, legible, neat, and relevant. The types of evidence gathered by reviewers may be categorized as follows:

- physical evidence that consists of direct observation and is considered the most dependable in determining the adequacy of internal controls;
- documentary evidence consisting of files, records, etc.;
- analytical evidence, which is developed by making judgments; and

- testimonial evidence, including interviews, which are considered the least dependable type of evidence.

Any review-related evidence of a serious problem is organized into a finding or series of findings. According to *Program Statement 1210.12*, working papers are a record of the reviewer's work, written and organized in such a manner that an independent reader can come to the same conclusions as the reviewers, based upon the evidence. Working papers provide a systematic record of the work done and supporting documentation for findings. They serve as evidence in the event program review conclusions are challenged. Working papers consist of 1) the management indicators reviewed in preparation for the program review, 2) notes taken during interviews, 3) a record of observations, 4) reviews of documents, including computer printouts, logs, and files, 5) analyses or computations that support findings, and 6) all pre-printed program review checklists and interview sheets. A file is established for each program review, and the original working papers are placed in the file.

BOP *Program Statement 1210.12* specifies that if maintaining the original working papers is not practical, the documents must be at least referenced by name, date, title, result, etc., to enable another person not involved in the review to follow or recreate the program review paper trail if this becomes necessary. The file's contents are to be clearly identified as official program review material and include the review site, program area, and dates. The working paper format is specified and forms are provided the reviewers on which to prepare working paper documentation. The Program Statement indicates working papers should be 1) complete and accurate to provide proper support for program review conclusions; 2) clear, concise, and understandable; 3) legible and neat; and 4) restricted to matters that are materially important and relevant to the program review objectives.

27. **REPORTING RESULTS:** Review findings are developed to address weaknesses in internal controls. According to *Program Statement 1210.12* the materiality of deficiencies and whether or not they need to be placed in the official report is a matter of professional judgment on the part of the reviewer with concurrence of the reviewer-in-charge. This is based on the evidence, extent of the problem, the risk to efficient and effective management of the program, and the program review objectives. Criteria for assessing materiality include 1) importance to the accomplishment of the mission of the program, institution, or the Bureau, 2) pervasiveness of the condition, 3) whether indications of fraud, waste, abuse or illegal acts are found, 4) the extent of the deficiency, 5) the importance of maintaining internal controls, 6) the dollar amount involved compared to allocation for the program, and 7) the relationship to the Mandatory Program Review Objectives.

The elements of review findings include *criteria, condition, effect, cause, overall rating, and recommendation(s)*. The BOP Executive Staff determined that it is essential to have an efficient method of gathering information from Program Review Reports. The rating system reflects the overall judgment of the reviewer-in-charge as to how well the mission and objectives of the program are accomplished. Rating factors include 1) *Superior*, which means the program is operated in an exceptional manner and deficiencies are limited; 2) *Good*, indicating vital functions are being performed, there are few deficiencies, and internal controls are functioning so that program performance is above an acceptable level; 3) *Acceptable*, meaning the vital functions of the discipline are being performed and, although numerous deficiencies exist, they do not detract from the acceptable accomplishment of the program area; 4) *Deficient*, reflecting that one or more vital functions are not being performed at an acceptable level and internal controls are weak, thus allowing serious deficiencies in one or more program areas; and 5) *At Risk*, meaning program operation is impaired to the point it is not presently accomplishing the overall mission and internal controls are not sufficient to reasonably assure acceptable performance in the future.

According to *Program Statement 1210.12*, the written report of findings is submitted to the review authority within twenty business days after the end of the review. Exceptions to this deadline must be approved by the review authority. Within ten working days after receipt by the review authority, the review report is forwarded to the CEO of the review site, under cover of a memorandum from the review

authority. The memorandum includes 1) an indication of the overall rating, 2) a statement of the scope of the review, 3) a summary of significant findings, 4) a listing of repeat findings, and 5) a directive that a written response to the report is required within twenty business days. The response includes 1) planned corrective action and time frames for each significant finding, 2) a statement as to the action taken to correct repeat findings noted in the last review with certification that internal controls have been implemented to ensure the deficiencies remain corrected, 3) a brief response to any issue needing attention, and 4) a certification statement that all deficiencies have been corrected (which is a blanket statement with exceptions noted). Copies of the report and cover memorandum are sent to the respective administrators (assistant director, regional director and regional and central office administrators of the discipline). If a separate report containing confidential information is being issued, this is stated in the report/or cover memorandum.

28. **LOCAL REVIEWS OR AUDITS:** Operational reviews are to be conducted within ten to fourteen months from the week the previous program review was conducted. It is the responsibility of the CEO to ensure this occurs and these reviews are conducted, including the five phases of PRD reviews (preparation, verification/examination, evaluation, reporting, and followup). Operational reviews for newly activated facilities should be conducted six to eight months after activation. The CEO determines Operational review team composition. Unlike followup reviews (see 30, Followup) these full-scale reviews are considered to be a function and responsibility of each department. According to *Program Statement 1210.12,* the entire review team can be comprised of staff of the department being reviewed.

29. **SAFEKEEPING AND ACCESSIBILITY:** Program Review Reports are retained by the review authority for eight years, in accordance with the provisions of the National Archives and Records Administration, General Records Schedules (Number 22). If an outside party requests a report or related working papers, a written request must be made to the Director. Generally, information that could impact security of an institution or negatively affect the functioning of a discipline if released is confidential.

30. **FOLLOWUP**: The CEO ensures a followup review is conducted locally to ascertain if adequate internal controls are in place to prevent problems from recurring. The appropriate Associate Warden (AW) or Assistant Superintendent is responsible for the followup being conducted. The AW may personally conduct the review or head a review team. Local options include appointing other institution department heads or members of the review team to provide cross-discipline training or including the department head and/or staff in question on the review team. Since a program review should be closed within 120 business days of receipt of the review report and closure cannot be made before the followup review, the local review should be conducted in advance to allow closure on time. Each deficiency mentioned in the review report is examined by means of an adequate sampling of documents, observations, etc. The intent is to determine not only whether the deficiency has been corrected, but whether adequate, cost-effective controls have been instituted, where appropriate, to lessen the likelihood of a recurrence of the deficiency.

It is the responsibility of the Regional Program Administrator of each discipline to monitor the implementation of corrective actions and the placement of internal controls as outlined by the CEO in response to program review findings. The reviewer-in-charge informs the review authority as to the adequacy of the response and corrective actions taken by the institution. It is also the reviewer's responsibility to ensure that review closure is warranted and that a local monitoring system is in place to followup on "post-closure" long term actions.

31. **CONTINUING QUALITY IMPROVEMENT AND PEER REVIEW:** Various levels of continuing quality improvements efforts occur with respect the PRD function. For example, *Program Statement 1210.12* requires that the reviewer-in-charge establish and maintain a quality assurance program for the purpose of providing reasonable assurance that program review work conforms with GAO auditing

standards and with the requirements of the program statement. This includes the requirement that the reviewer-in-charge conducts a Quality Assurance Review (QAR) for each review report. The QAR includes: assurance that review findings are fully supported by sufficient, reliable, and relevant evidence; an indication that the program review objectives have been met; statements indicating review team members were properly supervised and their work was adequately reviewed; verification that review findings can be traced to working papers and that supporting documentation is accurate; and an indication that interim meetings were regularly conducted with institution management. The review authority examines the report to ensure compliance with the provisions of the program statement and standards of auditing.

In March 1992 the U.S. Department of Justice, Justice Management Division published an *Internal Control Report: Bureau of Prisons—Management Control Quality Assurance Review*. The report addressed BOP operations with regard to the Federal Manager's Financial Integrity Act (FMFIA) of 1982 that was enacted to help reduce waste, loss, unauthorized use, and misappropriation of resources. The Act and its implementing guidelines and circulars are also concerned with the efficiency and effectiveness of agency programs. The involvement of individual managers in risk assessments, corrective actions, reporting, and the provision of reasonable assurance that the requirements of the FMFIA are being met is essential to the process, according to the report.

The BOP control report analyzed 1) the BOP implementation strategy regarding FMFIA and OMB Circular A-123; 2) the organizational segmentation of the BOP; 3) the staffing and support given to operational evaluation and reporting in the BOP; 4) the level of internal control elements in managers' performance of work plans; 5) the training provided managers pertaining to FMFIA/A-123; 6) the risk assessment process (management assessment) and related benefits; 7) field office involvement or the manner in which the organization is segmented into assessable units and reasonable assurance of adequate internal control is communicated up the chain of command; 8) automated systems of tracking the organization's internal control process, which includes management/risk assessments and risk rating, program review and operation review issues, and the management review plan; 9) the reporting process of assurance of internal controls within the organization; 10) the level of management reporting, participation by the management review officials, and internal reviews and audits as a means of achieving quality assurance; 11) the ability of the organization to identify operational weaknesses, determine appropriate corrective action, and provide reasonable assurance up the chain of command that internal controls are effective (including reporting assurance through the Director to the U.S. Attorney General); and 12) the certification process of "reasonable assurance" within the BOP that is used by the U.S. Attorney General and contributes to the aggregate of assurances for the Department of Justice; it is given to the President and Congress by December 31 of each year. The Justice Management Division's quality assurance review of the BOP did not reveal any serious shortcomings. The report reflects that the program is both well conceived and well managed, and provides a sound basis for the year-end reasonable assurance provided by the Director to the U.S. Attorney General.

32. **EXTERNAL REVIEWS AND AUDITS:** External reviews are regularly conducted of BOP operations. For example, the GAO reviews the quality of medical care within the institutions. The Office of the Inspector General conducts reviews of trust funds and OSHA conducts regular inspections.

Illinois Department of Corrections Internal Audit Functions

Units visited were the Illinois Department of Corrections (IDOC) Operations and Program Audit Unit (OPA) and the Fiscal Internal Audit Unit (FIA).

1. **ORGANIZATION:** The Director of the IDOC has a Chief Deputy Director responsible for eight areas some of which include Correctional Industries and Personnel. In addition there are deputy directors over

each of six divisions: Adult Institutions, Community Services, Juvenile, Employee and Inmate Services, Administration and Planning, and Inspections and Audits.

2. **NUMBER OF EMPLOYEES:** The IDOC employs 11,500 individuals with 9,700 assigned to the Adult Institutions Division.

3. **NUMBER OF INSTITUTIONS:** The Adult Institutions Division is responsible for 23 institutions with one currently under construction. There are six juvenile institutions under the authority of the IDOC.

4. **NUMBER OF INMATES:** The adult inmate population exceeds 30,000. There are 21,000 parolees. Four hundred juvenile offenders are incarcerated and 1,200 are on parole.

5. **LEGISLATION:** State law requires establishment of a full-time program of internal auditing to maintain an effective system of internal control. Appointment of a chief internal auditor is required who is a certified internal auditor or a certified public accountant with four years of auditing experience, or is an auditor with five years auditing experience. The chief internal auditor is required to report directly to the chief executive officer. Internal audit staff is to be free of all operational duties. A two-year audit plan is specified to include major systems of internal accounting and administrative control.

6. **CHARTER:** IDOC administrative directives have been published for both OPA and FIA. Although these directives are dissimilar they 1) include the purpose of the respective audit function, 2) state the applicability of the directive, 3) list a definition of audit terms, 4) provide general information about the audit function and indicate audit requirements, which include reporting responsibilities, 5) indicate that the (FIA) auditing program will follow standards promulgated by the Institute of Internal Auditors, and 6) detail auditing procedures.

7. **REVIEW OR AUDIT COMMITTEE:** Both OPA and FIA develop audit schedules for review and approval by executive staff. The OPA Audit Manager reports directly to Deputy Director of Inspections and Audits who in turn reports to the Director of the IDOC. The Chief Internal Auditor of FIA, in accordance with state law, develops a two-year plan for review and approval by the Director of the IDOC. No organizationally independent review or audit committee provides oversight of the audit process. The scope of audits and related audit work of FIA is reviewed, however, by the Illinois Office of the Auditor General.

8. **ORGANIZATIONAL STATUS:** According to the most current IDOC table of organization, the Audit Manager of OPA reports to the Deputy Director of Inspections and Audits. The Chief Internal Auditor of FIA reports to the Director.

9. **CATEGORIES:** As indicated in an IDOC administrative directive, staff of OPA conduct expanded scope audits, which include compliance with federal law, state law and department policies; economy and efficiency; and, program results.

Staff of FIA have responsibility, according to an IDOC administrative directive, for 1) audits of major systems of internal accounting and administrative control, which include testing of the obligation, expenditure, receipt, and use of public funds and grants; 2) reviews of the design of major new electronic data processing systems and major modifications; and 3) special audits of operations, procedures, programs, electronic data processing systems, and activities. The Deputy Director of Inspections and Audits has used the combined professional expertise of OPA and FIA on specialized audits.

10. **POLICIES AND PROCEDURES:** The administrative directive guiding audits includes written procedures for audit planning that require written notification of the scheduled audit; the conduct of a pre-

audit survey, which includes input from executive staff; the review of previous audits; coordination with the facility audit liaison; planning meetings; obtaining special expertise to assist in the audit, if needed; and audit scope development. The directive also addresses the verification phase, including presentation of the audit scope to the chief administrative officer of the facility and immediate reporting of any security-related problems found. Also, any impairments encountered by auditors are reported to the chief administrative officer of the facility and the Audit Manager of OPA. The verification phase also includes audit testing procedures, the audit liaison's role as the facility's representative in assuring the audit progresses according to the planned scope and schedule, development of working papers, evaluation of audit evidence obtained, omission of confidential information, development of a draft report and obtaining the chief administrative officer's evaluation of the audit team.

The administrative directive for the FIA requires submission to the director of 1) an audit plan, and 2) an annual report stating how the plan was carried out, to include significant findings and the extent to which recommended changes were made. The chief internal auditor's responsibility to coordinate external audits is also addressed. The administrative directive also states the auditor's right of access and the responsibility of managers in providing the auditors information. A reference to generally accepted audit standards is also made.

11. **REVIEW/AUDIT STAFF:** There are 10 personnel assigned to OPA and include the audit manager, an executive secretary and eight management operations analysts. Duties and responsibilities are detailed in position descriptions that include how audits are to be planned and conducted.

Ten personnel are assigned to FIA, to include a chief internal auditor, a secretary, a supervisor, three senior auditors, three internal auditors, and electronic data support staff. The duties and responsibilities of FIA staff are specified in Illinois State class series statements.

12. **CERTIFICATION:** OPA personnel do not possess audit-related certification. Within FIA the Chief Internal Auditor is a Certified Internal Auditor.

13. **TRAINING:** Specialized in-service audit training is provided to newly hired OPA staff and local internal auditors in the facilities by the OPA Audit Manager. Specialized audit training for FIA staff is obtained through the Springfield Chapter of the Institute of Internal Auditors. This provides audit staff the opportunity to participate in professional development seminars. Also, new auditors participate in on-the-job training for 6 to 12 months to develop professional internal auditing skills.

14. **AFFILIATION:** FIA personnel are provided membership in the Institute of Internal Auditors by the IDOC.

15. **STANDARDS:** The administrative directive for OPA indicates the unit "...shall follow the guidelines established by the current Standards for Audit of Governmental Organizations, Programs, Activities, and Functions published by the United States General Accounting Office. The audit process shall include five phases: planning, verification, evaluation, reporting, and followup."

The administrative directive for FIA indicates the ". . . internal auditing program will follow the Standards for the Professional Practice of Internal Auditing promulgated by the Institute of Internal Auditors and adopted by the State of Illinois Internal Audit Advisory Board." These standards address auditor independence, proficiency and due professional care, the scope of internal audits, a statement as to what audit work includes, and management of the auditing department.

16. **AUTOMATION:** OPA support personnel prepare audit checklists and other materials using data processing equipment. Staff of FIA are complemented by an electronic data support staff person. By administrative directive FIA staff review the design of major new electronic data processing systems. The information system used by the IDOC is described fully in chapter IX.

17. **AUDIT UNIVERSE:** Staff of OPA conduct audits of all adult and juvenile facilities and programs. FIA personnel audit major systems of internal accounting control and administrative control, including revenues and cash receipts, expenditures and cash disbursements, property and equipment, personnel and payroll, purchasing, accounting and financial reporting, planning and budgeting, inventories, electronic data processing, locally held funds, grant administration and federal financial reports.

18. **PRIORITIES:** The Audit Manager of OPA in conjunction with the Deputy Director of Inspections and Audits establishes audit priorities based upon direct input from Executive staff and prior audit histories of various facilities and programs. The FIA Chief Internal auditor, in preparing an annual audit plan, calculates the number of staff hours required by the audit plan and the actual staff hours available. Assumptions and judgmental risk assessments are made based primarily on prior external and internal audit results. In establishing audit priorities, key assumptions are made that 1) the quality of fiscal operations tend to remain the same if staffing remains the same, 2) the department has developed adequate systems of internal control, 3) the size of an institution's budget is an inherent risk, 4) the overall audit risk grade of high, medium or low is a judgment grade based on both the audit risk and inherent risk, 5) the interests of the department are better served by conducting comprehensive audits at institutions where higher risk is assessed than by attempting limited scope audits at all institutions.

19. **CYCLE:** Audits are conducted by OPA of all institutions and offices as required by administrative directive. Staff of FIA develop a two-year audit plan as required by state statute.

20. **SCHEDULES:** The audit manager of OPA develops audit schedules for each quarter of the fiscal year indicating the dates of the onsite, the facility or program to be audited, the audit staff assigned and the lead auditor. The proposed schedule is reviewed and approved by the deputy director and distributed. The Chief Internal Auditor of FIA develops an audit plan or schedule for each fiscal year, which includes the number of planned audit hours, the audit risk grade, the institution, a summary of previous internal and external audit findings, the number of repeated findings, and the percent of audit hours versus the percent of expenditures for each institution.

21. **SCOPE:** Staff of OPA audit for compliance to the administrative directives of the IDOC. The audit manager oversees the updating of an appendix for each division under audit. These appendices contain a listing of administrative directives by category, the related number and title, and an indication as to which are administrative directives that must be audited (mandatory). Also included in the appendices are listings of special issues and medical issues. The Chief Internal Auditor of FIA identifies major systems of internal accounting and administrative control to be audited as required by statute. The class series for internal auditors published by the State of Illinois indicates the auditor reviews and evaluates 1) agency operation in regard to the adequacy and efficiency in achieving agency goals, 2) the soundness, adequacy and use of operational (including financial) controls toward the goal of effective control at reasonable cost, 3) the reliability and integrity of reporting systems, 4) agency operations deemed inappropriate resulting from actions by employees that are believed to be fraudulent, and 5) the agency's compliance with local, State and Federal statutes and regulations, agency policies, plans and procedures, and good business practice.

22. **SURVEY:** Much of the preparation for audits by OPA is done through the review of administrative directives, updating appendices used to catalog administrative directives and special issues, and the preparation of audit questionnaires. When written notification is given to a facility or program to be audited a pre-audit survey form is provided. According to the administrative directive guiding OPA operations, the pre-audit survey lists specific Department policies and requires the facility to provide information relative to what can be observed at the facility to indicate compliance, what documentation can be provided which will indicate compliance, and who specifically can be interviewed to provide information

or clarification with regard to the specific policies. Similarly, FIA personnel under the supervision of the Chief Internal Auditor develop familiarity with the facilities to be audited and participate in the development of audit questionnaires in such areas as commissary funds; employee benefit fund; inmate trust fund; and personnel, payroll, and timekeeping.

23. **WORK PROGRAM:** OPA personnel develop comprehensive questionnaires or checklists and detailed instructions for their completion for all administrative directives. These forms include 1) the number and title of the administrative directive, 2) an indication of the facility where compliance with the administrative directive is to be assessed, 3) the names of the audit staff, 4) the date and time audit tests were conducted, 5) an indication of the facility staff interviewed, 6) notations of whether there is a finding and whether it is a repeated finding, 7) a notation indicating if the results have been dictated by the auditor, 8) a series of questions based upon the requirements of the administrative directive, 9) a column to indicate whether the requirements of the administrative directive have been met or whether they are not applicable, 10) an indication of the methods of observation or verification and the documentation obtained to establish the level of compliance with the administrative directive, and 11) a section for notations. Specialized matrices are also developed and used for functions such as counseling services to assess the amount of time spent on noncounseling and caseload activities. Audit questionnaires are prepared by FIA personnel that include 1) an indication of the institution audited, 2) the title of the major systems of internal accounting and administrative control to be addressed, 3) a statement of the audit objective(s), and 4) the audit steps to be followed, including development of conclusions.

24. **NOTIFICATION:** The administrative directive guiding OPA operations indicates that written notice shall be provided eight weeks in advance to the facility where an audit has been scheduled. The Chief Internal Auditor of FIA develops a two-year audit plan that is reviewed and approved by the Director and distributed to the deputy directors.

25. **ONSITE VERIFICATION AND EVALUATION:** Both the Audit Manager for OPA and the Chief Internal Auditor for FIA have developed comprehensive methods for managing the audit onsite verification phase. For each audit conducted by OPA an audit *recap spreadsheet* is maintained which includes rows for each administrative directive being audited. These spreadsheets have 1) the audit name, 2) the function (i.e., subject) of the administrative directive, 3) an indication as to whether an audit finding was developed, 4) the date the administrative directive was audited, 5) the time spent, 6) whether the finding is a repeated finding, and 7) a statement as to the cause of noncompliance with the administrative directive. The audit onsite verification phase conducted by FIA is documented along with other aspects of the audit, which includes the development of draft reports, preparation of a progress sheet, and an auditor assignment appraisal. These documents address, among other activities, the time budgeted, the entrance meeting, and when field work ended.

26. **WORKING PAPERS:** Both OPA and FIA staff maintain working papers to document each audit. OPA personnel develop files containing all pre-audit survey material, audit questionnaires and notations of auditors testing procedures and conclusions. Audit *recap spreadsheets* and all other pertinent documents are maintained, including draft findings. OPA personnel use an *audit actuarial form* to assess the materiality of a finding using criteria such as whether 1) it is a system problem, 2) an isolated incident, 3) whether the problem was found during an internal audit by facility staff, 4) resolved at the facility after the facility internal audit, or 5) whether it recurred after resolution. FIA personnel maintain extensive working papers containing pre-audit survey information, audit questionnaires and checklists, and related evaluations and conclusions. Draft findings are referenced to the supporting working papers. For purposes of audit oversight or supervision tracking forms, point sheets, and process flow spreadsheets that document audit activity are maintained as part of the working papers.

27. **REPORTING RESULTS:** OPA personnel are required by administrative directive to conduct an exit conference to be attended by the Director or his/her designee, appropriate executive staff, the manager of the facility or program site under audit and his/her assistants. An oral presentation is made of the audit findings and recommendations, and the manager of the facility or program site under audit responds by 1) accepting the findings and recommendations, 2) clarifying the information presented, or 3) rejecting the findings and recommendations with a verbal explanation for nonacceptance. The manager of the facility or program site under audit discloses to the Director how the recommendations or appropriate alternatives will be implemented, who will be responsible for resolving audit findings, and when those findings can be expected to be eliminated. This information is recorded by the audit team and is reflected in the final report that is submitted to the Director within 15 working days of the exit conference. The final report includes 1) a description of the audit scope and objectives, 2) a statement that the audit was conducted in accordance with generally accepted government auditing standards, 3) a description of material weaknesses found in the internal control system (administrative controls), 4) a statement of positive assurance on those items of compliance tested and negative assurance on those items not tested, 5) recommendations for action to improve problem areas identified in the report and to improve operations, 6) pertinent views of responsible officials of the organization, program, activity or function audited concerning the auditor's findings, conclusions, and recommendations, 7) a description of noteworthy accomplishments, particularly when management improvements in one area may be applicable elsewhere, 8) a listing of any issues and questions needing further study and consideration, and 9) a statement as to whether any pertinent information has been omitted because it is deemed privileged or confidential.

The administrative directive which guides FIA requires that by September 30 of each year the chief internal auditor submits to the Director a written report detailing how the audit plan for that year was carried out, the significant findings, and the extent to which recommended changes were implemented. Audit reports are issued after each onsite audit. Staff of FIA report audit results to the Director and the chief administrative officer of the facility or program. The reports typically include 1) an introduction that indicates the reasons the audit was ordered, 2) the purpose and audit scope, 3) conclusions, and 4) findings, which include recommendations. The Chief Internal Auditor of FIA arranges an exit conference with the chief administrative officer and staff to review and finalize the report.

28. **LOCAL REVIEWS OR AUDITS:** IDOC administrative directive requires all correctional facilities and program sites (including parole offices) to establish a procedural system for conducting internal audits that ensure compliance with rules, regulations, directives, operation and program standards, and policies and procedures. Internal audits are to be conducted at least annually, including those set out in fiscal directives identified by FIA in its audit schedule. The directive also addresses development of an audit schedule and the need for facility and program site staff to describe in writing the process used to conduct internal audits. This description should include working paper development, methods for reporting results, and a description of the followup process to be implemented.

29. **SAFEKEEPING AND ACCESSIBILITY:** Both OPA and FIA staff maintain working papers in a secure fashion in their respective offices. The OPA audit manager and the FIA chief internal auditor maintain control and oversee working paper access.

30. **FOLLOWUP:** The administrative directive guiding OPA requires that specific audit findings be identified that warrant followup. Followup audits are conducted to assess progress toward the elimination of findings. The facility or program site audited must compile all documentation indicating resolution of items noted in the final audit reports that have been corrected by the date specified in the report. Followup audits may be scheduled or unscheduled and documentation is collected and returned to the Central Office. Forms have been developed for followup audits that, when completed, are submitted to the director.

31. **CONTINUING QUALITY IMPROVEMENT AND PEER REVIEW:** Internal assessment for improvement is conducted by the OPA Audit Manager. Audits conducted by FIA are examined by Auditor General of the State of Illinois.

32. **EXTERNAL REVIEWS AND AUDITS:** The chief internal auditor of FIA, by administrative directive, coordinates the external compliance audit process with the Office of the Auditor General and assists the Director in the annual evaluation and certification to the Auditor General regarding the adequacy and effectiveness of the Department's system of internal control. This process is mandated by state statute.

Utah Department of Corrections (UDC) Bureau of Internal Audit (BIA)

1. **ORGANIZATION:** The UDC is one of 15 departments in Utah State government. The Executive Director is appointed by the Governor. The deputy director oversees five division directors who administer each of the five divisions: institutional operations, field operations, administrative services, correctional industries, and the division of personnel, training and records. An assistant director has responsibility for public affairs.

2. **NUMBER OF EMPLOYEES:** There are 1,697 employees and 400 volunteers within the UDC.

3. **NUMBER OF INSTITUTIONS:** Nine institutions are located statewide with seven centrally located near Salt Lake City. Some inmates are also housed by contract in county jails and those nearing release may be placed in community correctional centers operated by Field Operations.

4. **NUMBER OF INMATES:** In the custody of the UDC are approximately 2,800 inmates with over 10,000 offenders on parole, probation or undergoing evaluation for the courts.

5. **LEGISLATION:** Utah Code requires the UDC to audit all programs every three years. An overview of the UDC Bureau of Internal Audit is found at the end of this chapter.

6. **CHARTER:** UDC policy and procedure guide the internal audit function, including audit authority, reporting relationships, access to information and management's responsibility.

7. **REVIEW OR AUDIT COMMITTEE:** No audit committee independent of the Department provides oversight of the audit process. The BIA Bureau Director submits proposed audit plans based on a Department-wide risk assessment to the Executive Director for approval. The plan is then presented to executive staff for review and comment.

8. **ORGANIZATIONAL STATUS:** The BIA Bureau Director reports to the Deputy Director of the UDC who also supervises all division directors. The Bureau Director is of equivalent rank to a warden and auditors are equivalent to correctional institution captains. A career path for upgrading auditors has been approved and is being developed.

9. **CATEGORIES:** The BIA conducts performance and financial audits of all Divisions. The scope of past audits has included, for example, compliance with policy and procedure, security issues, offender program results, the adequacy of medical services, inmate accounts, probation and parole supervision issues, and restitution.

10. **POLICIES AND PROCEDURES:** UDC policies and procedures guide all aspects of internal audit, which include department risk assessments to establish audit priorities, audit schedules, audit programs, the onsite verification and evaluation phases, reporting results, audit followup, and local internal audits.

11. **REVIEW/AUDIT STAFF:** The BIA Bureau Director supervises five internal auditors and one support person. State job descriptions require a college degree in a job-related field and allow hiring preference for graduate work and audit experience.

12. **CERTIFICATION:** One BIA employee is a Certified Internal Auditor (CIA), Certified Fraud Examiner (CFE) and Certified Social Worker. Four other auditors have a CFE and one is also a professional in human resources. The UDC provides reimbursement for one certification per auditor annually.

13. **TRAINING:** Specialized audit training of up to 40 hours annually for each auditor is funded by UDC and obtained from local and national sources. The BIA Bureau Director provides initial training to all new personnel and has developed an audit training package used by the National Institute of Corrections and other agencies.

14. **AFFILIATION:** BIA personnel are affiliated with the Institute of Internal Auditors, the Utah Government Auditor's Association and the National Association of Certified Fraud Examiners. The UDC reimburses personnel for two professional memberships.

15. **STANDARDS:** UDC policies and procedures require all audits be completed in compliance with generally accepted government and internal audit standards as promulgated by the Comptroller General of the United States and the Institute of Internal Auditors.

16. **AUTOMATION:** BIA personnel have personal computers, some of which are portable units. The portable units are often used in the field during audits. A plan is being developed to maximize the use of personal computers and reduce paperwork. All UDC policies and procedures, the criminal code and the administrative code have been placed on an automated electronic data processing system. All audit personnel are on a local area network that provides the ability to communicate with and schedule staff. The BIA Bureau Director schedules audits using an automated database that systematically calculates due dates based upon BIA policy and procedure. The system is activated when the notification date is entered. It advises when pre-audit survey information is due from the auditee along with the date of the entrance conference, the end of onsite visit, when working papers are due to the auditor-in-charge, and when draft and final reports are due.

17. **AUDIT UNIVERSE:** The audit universe consists of all entities and functions within the UDC. For example, entities are defined as individual facilities and community centers, probation and parole regions, and support service bureaus such as medical, food services, management information systems, and planning and research. Major functions are also the object of audit and include, for example, inmate accounts, restitution, personnel deployment, and inmate disciplinary. When conducting entity audits, efforts are made to audit all major entity functions; however, some functions represent such a high degree of potential risk if not adequately controlled that an audit of the function alone is warranted. The UDC Executive Director frequently calls upon BIA staff to perform training and technical assistance assignments and provide assistance to other state agencies.

18. **PRIORITIES:** A formalized risk assessment tool is used by BIA staff to establish audit priorities. This tool is based upon a model developed by the Institute of Internal Auditors, for use primarily in the private sector. Twenty criteria are rated and ranked which are used to prioritize all entities and functions

within the UDC audit universe. Some of the criteria include completeness of policies and procedures, the degree of formalized planning that occurs, the time since the last audit, the level of supervision occurring and the completeness of related documentation, facility environmental issues and staff training.

19. **CYCLE:** By Utah State statute and UDC policy, every program included in the audit universe must be audited every three years.

20. **SCHEDULES:** Based upon a three-year audit plan, the BIA Bureau Director develops a long-term plan indicating the audit resources available. BIA staff meet quarterly and audit schedules are prepared for each three-month period and submitted to the UDC Executive Director for review and approval. This is done at least eight weeks before the commencement of the three-month audit plan.

21. **SCOPE:** Typically, the scope of an entity audit will include assessing compliance with UDC policies and procedures, including the staff performance appraisal process, staff familiarity with policies and procedures, key control, inmate discipline, emergency procedures and inspections; the completeness and adequacy of UDC policies and procedures; economy and efficiency of operations; and program effectiveness.

22. **SURVEY:** The BIA Bureau Director assigns an auditor-in-charge for each scheduled audit. This staff member is responsible for planning the audit by initiating a comprehensive pre-audit survey. The auditor-in-charge becomes thoroughly familiar with the entity or function to be audited through methods such as reviewing all applicable laws, regulations and policies and procedures; obtaining and analyzing organizational charts, job descriptions, and post orders; examining past audits, investigations and reviews of the entity or function, conducting an inspection of the entity and interviewing staff; and interviewing executive and legal personnel as well as individuals outside the UDC to identify relevant issues. Management is responsible for identifying weaknesses in internal controls and reporting these weaknesses to the auditors.

23. **WORK PROGRAM:** An audit program is prepared by the auditor-in-charge after the pre-audit survey phase and before the onsite verification phase of the audit (see Appendix D). The audit program identifies general areas to be audited, including a narrative explaining what was found during the pre-audit survey. A series of audit objectives is developed for each area with the specific audit test indicated to accomplish each audit objective. Checklists and other forms are developed as required by the audit program. The audit program is submitted to the BIA Bureau Director for review and approval before implementation.

24. **NOTIFICATION:** Customarily, written notice is provided of each audit eight weeks in advance of the onsite verification phase. The audit announcement includes the planned dates for the onsite visit, the preliminary scope and objectives, the audit team composition, a request for pre-audit survey information, and the name of the audit liaison person who represents management and coordinates auditor activity.

25. **ONSITE VERIFICATION AND EVALUATION:** The onsite verification phase of each audit customarily begins with an entrance conference attended by the BIA Bureau Director, all auditors, the audit liaison and management of the entity or function being audited. The onsite usually lasts four weeks. Each auditor-in-charge is responsible for ensuring that all audit tests outlined in the audit program are conducted by auditors and appropriate working papers are prepared, including draft audit findings. If a portion of the planned audit tests are not conducted due to a modification of the audit scope or other factors, the auditor-in-charge is required to document what was not completed and the reason(s). During the onsite visit, facility management receives briefings to clarify preliminary audit results, which is coordinated through the audit liaison. If issues are identified by the auditors that require immediate

attention, such as security, health or life safety deficiencies, the auditors will report these matters immediately both verbally and in writing. The BIA Bureau Director does this, and these issues are ultimately included in the audit report. A final briefing is conducted with management on the last day of onsite phase with the auditor-in-charge providing preliminary results of the audit and an indication of when the draft report will be provided management.

26. **WORKING PAPERS:** Pursuant to UDC policy and procedure all audit tests are thoroughly documented whether these tests are done on a computerized spreadsheet or through other means. The auditor-in-charge has responsibility to ensure the adequacy of working papers. The auditor's work is evaluated and a written report provided the BIA Bureau Director. Working paper summaries are prepared for each audit work program area and objective or series of objectives. Working paper summaries include 1) a purpose statement, i.e., why the summary was prepared with a reference to the audit program objective; 2) a definition of the scope of the inquiry, including the nature of the testing, verification and evaluation efforts that occurred; and 3) sources of information, including personnel interviewed, practices observed, and documents reviewed. All working paper summaries and supporting documents such as records of discussion, checklists, computer spreadsheets, etc., are coded to a referencing system developed for the audit work program.

27. **REPORTING RESULTS:** By UDC policy and procedure audit reports are distributed in draft form in preparation for an exit conference 30 calendar days after the last day of the onsite verification phase. The report contains written audit findings that state *criteria, condition, cause, effect,* and *recommendation.* An exit conference is conducted with management, the BIA Bureau Director and the UDC Executive Director or designee. The purpose of this conference is to review the report for accuracy, obtain a response from management and finalize action plans for resolution of audit findings. A final report of findings and recommendations is distributed within 10 working days of the exit conference. Both draft and final audit reports are distributed only on order of the Executive Director. BIA controls all distribution, and reports are labeled confidential.

28. **LOCAL REVIEWS OR AUDITS:** Local internal audits are conducted by staff within the facilities and the other UDC divisions who have been trained by the BIA Bureau Director. BIA oversees these local internal audits. The local internal auditors are generally more familiar with operations than BIA auditors and are content experts. Oversight from BIA provides a degree of objectivity to the process.

29. **SAFEKEEPING AND ACCESSIBILITY:** Each auditor-in-charge is responsible for safekeeping audit working papers for audits they oversee. Files are stamped as confidential and kept in locking file cabinets in the auditors' offices. Like audit reports, working papers are confidential documents as indicated in statute and by policy. By Utah statute and UDC policy, audit reports are confidential and available only when authorized by the Executive Director, governor or court order.

30. **FOLLOWUP:** Followup audits are scheduled and conducted by BIA as authorized by the Executive or Deputy Director. They are prioritized based upon the dates agreed upon in the exit conference for completion of action plans. Also considered is the risk the entity or functions represent to the Department based upon the UDC risk assessment and other factors identified by management. The follow up audit report reflects the degree of resolution with the original audit report based upon the judgment of the auditors. The report reflects whether *full, partial or nonresolution* was achieved. The auditors may also ascertain that resolution has become *nonapplicable.* Judgments made by the auditors are supported by a general discussion in the report.

31. **CONTINUING QUALITY IMPROVEMENT AND PEER REVIEW:** Annual planning retreats are conducted by BIA where time is spent reviewing staff performance. Typically, input comes from each

division director whose entities and related functions undergo regular audit. BIA staff establishes short- and long-term goals, reviews the progress of the previous year goals, and submits a written report to the Executive Director. In addition to these internal efforts for continued quality improvement, external peer reviewers were hired in 1990. Bureau personnel received a comprehensive review over a one week period based on peer review standards established by the Institute of Internal Auditors. It was concluded that Bureau performance was in compliance with audit standards.

32. **EXTERNAL REVIEWS AND AUDITS:** External audits and reviews are conducted of the UDC. Generally, the BIA Bureau Director functions as the liaison with the external auditors. Organizations that conduct external audits and reviews of the UDC include the Utah Legislative Auditor General (performance audits), the Utah State Auditor (financial compliance audits), various consultants in specialized areas such as inmate medical services, prison warehouse inventory, etc., the Federal Bureau of Prisons (inspections pertaining to housing federal inmates), state and county health departments, Occupational Safety and Health Administration (OSHA), the Utah State Fire Marshall, and local fire departments.

New Jersey Department of Corrections Internal Audit Functions

Units include the Internal Audit Unit (IAU), Office of Human Resources (OHR), Custody Overtime, Bureau of Management Information Systems (MIS), Correctional Information Systems, Classification Services (CICS), Bureau of Training, and the Office of Institutional Support Services.

1. **ORGANIZATION:** The New Jersey Department of Corrections is headed by a Commissioner, which is a cabinet level post appointed by the Governor, requiring confirmation by the Senate. There is one Deputy Commissioner who reports to the Commissioner and is supported by four Assistant Commissioners. Structurally, the Department is composed of four separate divisions, each headed by an Assistant Commissioner. In addition, there are several other smaller administrative units that report directly to the Office of the Commissioner or the Office of the Deputy Commissioner. The four divisions are: Adult and Juvenile Institutions, Juvenile Services, Policy and Planning, and Administration.

2. **NUMBER OF EMPLOYEES:** The number of employees that the Department maintains to provide its services is directly related to the number of offenders supervised. As of January 1, 1992, the Department employed approximately 10,000 individuals of which about 58% are uniformed or custody personnel. The remaining 42% are civilian employees and are classified as administrative/professional (30%), clerical (8%) and technical (4%).

3. **NUMBER OF INSTITUTIONS:** The Department is responsible for 12 major adult institutions and their satellite units: three major juvenile facilities, 50 adult and juvenile residential and nonresidential community-based facilities and 13 district parole offices throughout the state.

4. **NUMBER OF INMATES:** As of January 1, 1992, the Department was responsible for a jurisdictional inmate population of 24,337 (compared to 6,490 in 1980). The parolee population for the same date stood at 27,400 (compared to 8,470 for 1980). By the end of fiscal year 1993, these figures are projected to increase by about 2,200 inmates and by approximately 2,500 parolees.

5. **LEGISLATION:** The Internal Audit Unit (IAU) within the Division of Administration conducts internal financial audits of the Department's institutions, Adult and Juvenile Residential Programs, District Parole Offices and the Central Office Revenue Unit. In accordance with the Single Audit Act of 1984 and applicable federal and state circulars, the IAU also completes desk reviews of Single Audit Reports submitted by state grant recipients. "Recipients" are defined as any local government, including school boards, and any not-for-profit organization that receive from a state agency any federal grants, state

grants or state aid funds. Each audit is conducted by a CPA firm that is independent of the entity to be audited. Desk reviews are conducted by the IAU to assure that each audit report complies with applicable federal and state circulars.

6. **CHARTER:** An IAU staff member has drafted an audit charter that addresses the responsibility and scope of the IAU and includes the right of auditor access to information and records and reporting responsibilities.

7. **REVIEW OR AUDIT COMMITTEE:** IAU audit plans are reviewed and approved by the Assistant Commissioner of the Division of Administration. Coordination of audit results is the responsibility of the Director of the Division of Administration in conjunction with the other division directors.

8. **ORGANIZATIONAL STATUS:** There is no one centralized division or unit within the department that is responsible for the total internal financial audit and/or programmatic review process. Audits and internal reviews are currently conducted by the individual unit or bureau that has the functional responsibility for its respective discipline or program. For example, internal financial audits of the institutions, residential programs, and parole district offices are conducted by the central office IAU, which is within the Division of Administration. Similarly, programmatic reviews of health, dental and food services in the institutions are undertaken by the Office of Institutional Support Services (OISS), the agency of the Department responsible for the coordination of these services. OISS is within the Office of the Deputy Commissioner but reviews programs within the Division of Adult and Juvenile Institutions, another entity within the Department. Presently, the internal control and audit function within the department is not integrated or coordinated between the units who perform financial audits and programmatic reviews.

9. **CATEGORIES:** IAU internal financial audits generally include reviews and evaluations of the financial aspects of an entity's nonappropriated funds, reviews of petty cash, procurement procedures, fixed assets and certain personnel procedures. The Division of Administration, through its Office of Human Resources (OHR) is responsible for all personnel activities, which include employment, payroll records, timekeeping, etc. OHR conducts audits of timekeeping activities. In addition, the OHR provides direction and training sessions to the institutional, residential and District Parole Office timekeeping units to ensure standardization and uniformity of timekeeping operations and to comply with DOC timekeeping procedures.

The Division of Adult and Juvenile Institutions is responsible for the administration of 15 major adult and juvenile institutions that supervise and provide security for approximately 24,500 offenders. One of the primary review and audit responsibilities of this unit is to monitor and control the use of custody overtime within the Department. During the past year, more than $45 million was spent for custody overtime, including both uncontrollable (contractual) and controllable expenditures. On a weekly basis, custody overtime reports are submitted to central office by each institution providing data and information on the overtime hours expended for the previous week. These data are compiled by division staff to produce Department-wide totals and are then compared with overtime expenditures for previous pay periods to determine increasing or decreasing trends. Overtime data is shared with the Division of Administration and is used for determining the projected costs for the fiscal year and possible shortages or overages in the salaries accounts.

The Division of Policy and Planning is responsible for planning, program analysis, information systems, classification services, training and standards development in the Department. Several internal review functions are conducted by division staff, including auditing processes in the management information systems, classification services, and training areas. The Bureau of Management Information Systems is responsible for the operation, coordination, maintenance and security of the department's 20 IBM S/36 minicomputers, which make up the CMIS system. This system provides direct service to the 15 major adult and juvenile institutions for the five direct service applications, which are trust fund

accounting, canteen services, health, pharmacy, and inmate information (classification). In addition, seven other administrative applications such as financial management, personnel, correction officer scheduling, time and attendance, fixed assets, inventory control and training also operate on the S/36 CMIS system. The CICS Bureau audits both the use of the S/36 CMIS inmate information application and the manual classification procedures which backup or support the computerized classification operation. The audit includes a systematic review of each major function within the application such as posting of additional sentences, detainer, agenda schedules, etc. In addition, manual folders and files are researched to verify entries in the system.

10. **POLICIES AND PROCEDURES:** The IAU Unit has been in the process of developing a DOC auditing manual, which would encompass all of the documents used by the IAU; however, due to budget cutbacks and reduced personnel levels, this consolidated report has not been finalized.

11. **REVIEW/AUDIT STAFF:** The Bureau of Audits' Internal Audit Unit, which consists of seven professionals (two supervisors, two auditors and, at present, three vacant positions), serves a total of 79 institutions, District Parole Offices and Central Office Business units spread throughout the state. There are 15 major adult and juvenile facilities, 13 Regional Parole Offices, 1 Central Office Revenue Unit (CORU) and 50 adult and juvenile residential and community treatment centers.

12. **CERTIFICATION:** One IAU employee is a Certified Public Accountant. Two employees have recently took the Certified Internal Auditor examination offered by the Institute of Internal Auditors.

13. **TRAINING:** New auditors assigned to IAU receive on-the-job training with supplemental training available from an inter-agency audit forum in New Jersey. Also, the Deputy Director of the Division of Policy and Planning provides training regarding various aspects of the 20 IBM S/36 that make up the CMIS system.

14. **AFFILIATION**: IAU employees affiliate with the local chapter of the IIA and a local accounting organization. The NJ DOC does not provide funding for these memberships.

15. **STANDARDS:** IAU internal audits are conducted in accordance with generally accepted government and internal audit standards, as established by the United States General Accounting Office (GAO) and the Institute of Internal Auditors (IIA).

16. **AUTOMATION**: The Department of Corrections has two primary computer systems for processing critical inmate and administrative computerized functions. These are the Offender Based State Correctional Information System (OBSCIS) and the S/36 Corrections Management Information System (CMIS; see chapter IX).

17. **AUDIT UNIVERSE**: IAU internal audits entail financial audits of 1) Inmate Trust Funds, 2) Inmate Organization Funds, 3) Inmate Enterprises, and 4) Canteen Operations; evaluations of the internal control structures of the various operating units within the Department; examinations of the various institutions and other programs with the Department of Corrections to determine if operations are in compliance with applicable statutes, state regulations and state and departmental policies and procedures. The OHR conducts regular timekeeping audits of the four operating divisions and other Central Office timekeeping units on a regular basis. The Division of Adult and Juvenile Institutions conducts reviews and audits of custody overtime to monitor and control overtime expenditures within the Division.

Electronic Data Processing (EDP) audits are conducted by employees of the Division of Policy and Planning, MIS Bureau. These audit efforts address NJ DOC training and inmate classification, as well as management information systems. The MIS Bureau conducts audits of the S/36 CMIS system at each

institution to ensure that the system is being used efficiently and that the proper security precautions are in compliance with DOC guidelines. Various OISS personnel conduct audits in the area of Health Services, for example. Based upon the content expertise of Health Services staff, Medical and Dental audits are conducted.

18. **PRIORITIES:** Management determines audit priorities, usually placing emphasis upon institutions or functions that have not been recently audited or those areas presenting problems.

19. **CYCLE:** The overall goal of the IAU is to audit each facility or organizational unit once every three years. The Bureau of Management Information Systems attempts to audit each institution once every three years.

20. **SCHEDULES:** Audit schedules and internal review dates are established by managers within each individual organizational unit based upon predetermined work schedules. Emergency reviews and audits are undertaken in response to situations or conditions that warrant immediate action. Although the IAU follows an audit schedule, the schedule is frequently modified to accommodate special audit requests prioritized by management and generally responds to emergent conditions.

The Bureau of Management Information Systems attempts to audit each institution once every three years. Due to personnel cutbacks and budget limitations, audits of the S/36 CMIS institutional applications has been suspended with the exception of the inmate information application that is conducted by the CICS. The CICS audit schedule for the inmate information application is to review each of the 15 major institutions once every three years. Firing range audits are completed every three years. OISS internal audits, generally, are completed on an annual basis or upon request if there is an emergent condition. External audits are completed on a contractual basis with other Departments of State Government and generally are scheduled as annual inspections.

21. **SCOPE:** IAU staff define the scope of each audit in an entrance conference at the commencement of each audit. An effort is made to define an audit scope based upon the resources allocated for each audit. The scope of programmatic reviews or audits conducted within the NJ DOC is based on assessing compliance with State of New Jersey Administrative Code sections pertaining to Medical and Health Services, in the case of OISS Health Services for example. EDP audits assess computer operations, system security, and hardware controls.

22. **SURVEY:** Pre-audit surveys are conducted by IAU staff through developing and administering internal control questionnaires to preliminarily assess operations in such areas as personnel, inventories, fixed assets, debt and liabilities, petty cash, and procedures manuals. MIS personnel, for example, develop audit questionnaires and also generate computer reports in preparation for an audit.

Recently several of the NJ DOC operational units have expressed an interest in using the Department's S/36 CMIS system to do preliminary analyses of institutional disciplines or programs prior to their audit or review onsite visits. According to these internal auditors, this would facilitate the identification of potential problem areas or material weaknesses that could be thoroughly analyzed during the onsite visit. Efforts to pursue this model have been undertaken and are awaiting security clearance from the Commissioner's office.

23. **WORK PROGRAM:** Comprehensive audit programs are prepared by IAU staff and amended as appropriate based upon the results of individual pre-audit surveys. Audit programs typically are divided into general areas (e.g., personnel), contain audit objective statements and related audit steps (e.g., review payroll records of all employees to determine if any employees have negative time balances in any category), and provide a reference to applicable law, regulation or policy. The majority of NJ DOC

divisional units responsible for audits and reviews ensure preparation of written audit programs developed by staff members possessing the appropriate expertise, or who are content experts.

24. **NOTIFICATION:** The IAU provides written notification to employees of the entity scheduled for audit two weeks before an upcoming audit. Customarily, prior notification is provided when programmatic reviews or audits are scheduled.

25. **ONSITE VERIFICATION AND EVALUATION:** IAU personnel commence the audit onsite verification phase with an entrance interview where staff of the entity being audited are informed of the audit scope and schedule. The logistical aspects of the audit are addressed, including auditor access to records, availability of staff for interviews, and other accommodations necessary to ensure a successful audit. IAU staff also answer questions at this point to minimize apprehension on the part of staff.

IAU personnel remain onsite for six to eight weeks interviewing individual employees, observing practices and examining records. Most audit testing procedures are detailed in the audit program with emphasis placed upon internal control weaknesses identified during the pre-audit survey phase. If auditors encounter an audit impairment it is immediately reported to the Bureau Director of Administration. If fraud, abuse, or illegal acts are suspected by the auditors a referral is made to the NJ DOC internal affairs unit.

When conducting audits MIS Bureau personnel conduct site visits to observe operations. Interviews are conducted, and appropriate material (for example, documentation and backups) are examined. Most audit functions are conducted using the computer system by accessing the audit site through network communications facilities from a Central Office location. On-line examination occurs and includes a review of the system service log, which is a record of system service calls and unusual events such as overrides of initial program loads. Also examined are 1) the system history, which is a log of all systems jobs and job control language, 2) the system configuration, which includes operating system definition of devices and program support, 3) volume table of contents which lists all disk objects, 4) the PTF log, which keeps a history of operating system program temporary fixes, 5) the update control file, which identifies application program updates, 6) and description files, which are tables for application programs. Manual console logs, physical sight layouts, system and application documentation, and training procedures are also reviewed. The review of system security includes an examination of physical security, communications, and resource security. Hardware controls are reviewed (e.g., inventory, maintenance procedures, and related documentation).

26. **WORKING PAPERS:** Comprehensive working papers are developed and maintained by the IAU. These documents contain all audit-related correspondence, internal control reviews, audit program objectives and questions, results of audit tests conducted (including spreadsheets, interview results, computer printouts, analyses, etc.), and audit reports. All working papers are bound, labeled, and numbered.

27. **REPORTING RESULTS:** An exit debriefing is conducted by IAU staff with management in order to provide feedback on preliminary audit results. This informal reporting process is followed by a written report. IAU staff prepare audit reports that include *criteria, condition, cause, effect,* and *recommendation.* Pursuant to NJ DOC Accounting Bulletin 88-3, formal responses to IAU reports are required from each institution within 15 days subsequent to the audit exit conference. Included in the response are statements about concurrence or disagreement with the findings and recommendations, actions taken or planned to resolve each finding, including the time frame required and indicating reasonable assurance the finding will not recur. Firing range audits are sent to the appropriate institutional warden, deputy director and assistant commissioner.

28. **LOCAL REVIEWS OR AUDITS:** Since there is no centralized division or organizational unit within the NJ DOC that is responsible for the internal audit process department-wide, all audits and programmatic reviews are local efforts.

29. **SAFEKEEPING AND ACCESSIBILITY:** All working papers are maintained by the individual units conducting the audit. Control and release of these documents are determined by each unit and division.

30. **FOLLOWUP:** IAU staff report that a Resolution Report is to be prepared pertaining to each audit. Due to the limited number of IAU staff, reliance is placed upon management's report with little independent corroboration by IAU staff.

31. **CONTINUING QUALITY IMPROVEMENT AND PEER REVIEW:** Legislative Services has informally reviewed IAU and an independent CPA has conducted a formal review.

32. **EXTERNAL REVIEWS AND AUDITS:** Other than the internal reviews conducted by the NJ DOC organizational units, additional audits and programmatic reviews are conducted on a regular basis by state and federal agencies external to NJ DOC. The NJ Department of Health, the NJ Department of Labor, the NJ Office of Legislative Services and the U.S. Department of Justice (Federal Bureau of Investigation) are just a few of the external organizations who audit NJ DOC operations and programs.

In addition, the NJ DOC has participated in the American Correctional Association's Commission on Accreditation in Corrections (CAC) process which also requires an extensive self-analysis and external audit by Corrections professionals from the ACA. The NJ DOC has had seven of its correctional institutions and the Bureau of Parole accredited during the past 10 years. Generally, the appropriate organizational unit within the Department that is responsible for the program or discipline works with the external auditing organization in arranging logistical and operational support to assist the external review team. For example, Management Information Systems staff of the Division of Policy and Planning may provide access codes to the S/36 CMIS system and hard copy reports of the S/36 CMIS system for the external review by the independent auditors. NJ DOC is required by statute to provide support to the external review team.

There are two outside agencies that perform the majority of financial and administrative audits within the DOC, the Office of Legislative Services (OLS), Office of the State Auditor and the Department of the Treasury, Office of Management and Budget (OMB). These two agencies focus primarily on appropriated funds. Also, internal control reviews and certain tests of the internal control structure are performed at the various facilities and locations throughout the DOC as directed by OMB.

The Office of the State Auditor, Office of Legislative Services, conducts audits pursuant to the State Auditor's audit responsibilities as set forth in Article VII, Section 1.6 of the State constitution, and N.J.S.A. 52:24-4. State statute requires the officers and employees of each accounting agency to assist the state auditor, when required, for the purposes of carrying out the provisions of this chapter. The Department of Treasury, Office of Management and Budget, Internal Audit Unit conducts audits of specific locations or functions within the DOC at the discretion of the Director and State Comptroller. There are no written administrative directives regarding this audit. However, OMB Circular 85-31 sets forth the authority, responsibility and guidelines for preparing the annual internal control statements of each agency within State Government that helps to determine risk assessment throughout the State. In addition to the State Auditor and OMB, other agencies within the State of New Jersey conduct financial audits to ensure compliance with grants made to the Department of Corrections, such as the Department of Education, Department of Human Services, etc. These audits are conducted administratively at the discretion of the funding agencies, such as the National Institute of Justice (NIJ), the National Institute of Corrections (NIC), etc., and, generally, occur as a result of grant conditions. There are no written directives regarding these audits.

Multi-State Audit (MSA) Approach

The multi-state audit (MSA) group consisted of Washington State Department of Corrections (WDC), the Oregon Department of Corrections (ODC), and the Idaho Department of Corrections (IDC). These states have developed a procedure for doing audits at sites in member states other than their own, using a common set of standards as audit criteria.

1. **ORGANIZATION:** The Washington Department of Corrections (WDC) is organized into six divisions each administered by a director. These include prisons, community corrections, human resources, offender programs, budget and correctional industries. The Oregon Department of Corrections (ODC) is divided into branches each administered by an assistant director. These include administration and planning, institutions, community services and inspections. The Idaho Department of Corrections (IDC) is organized into four divisions each headed by an administrator. These are institutions, field and community services, management services, and correctional industries. All administrators report to the Director.

2. **NUMBER OF EMPLOYEES:** The WDC has 5,596 employees with 4,139 in the Division of Prisons. The ODC has 2,332 positions allocated in the current budget with 1,880 employees assigned to the Institutions Branch. The IDC employs 1,031 individuals with 663 assigned to the Division of Institutions.

3. **NUMBER OF INSTITUTIONS:** In Washington there are 14 institutions classified as either major or minor. In Oregon there is one maximum security institution, four medium security institutions, seven minimum security institutions and one intake center. In Idaho there is one maximum security institution, two medium security institutions with an additional medium security women's institution under construction, three minimum security institutions, and three community work centers.

4. **NUMBER OF INMATES:** In Washington there are approximately 8,700 inmates and 37,900 offenders on probation and parole. In Oregon there is an average daily inmate count of 6,677. In Idaho there are 2,300 inmates.

5. **LEGISLATION:** Although no individual state statutes guide the MSA process, an interstate agreement has been developed that includes the standards by which various institutional operations will be measured when audited, the audit planning which will occur, audit team composition, methods for facilitating the onsite verification phase of the audit, and the advisory nature of the reports.

6. **CHARTER:** The interstate agreement establishes the audit process, including reporting responsibilities, auditor access to information, and the appeal process when institution staff disagree with the auditors.

7. **REVIEW OR AUDIT COMMITTEE:** Each state oversees development of an audit schedule and resolution of audit findings.

8. **ORGANIZATIONAL STATUS:** The auditors involved in each audit are from the other two states that make up the multi-state group. Auditors are usually management level personnel and include assistant wardens, associate superintendents, legal counsel and captains.

9. **CATEGORIES:** The audit team addresses facility compliance with the standards adopted by the multi-state participants.

10. **POLICIES AND PROCEDURES:** No comprehensive policies and procedures have been published by the multi-state participants to guide the audit process.

11. **REVIEW/AUDIT STAFF:** Typically two auditors are assigned to audit a facility. The auditors are not employed by the state being reviewed, but are assisted onsite by a multi-state audit coordinator (or liaison), who is also an auditor for the host state in doing audits for other states in the group. It is the responsibility of the host state liaison to prepare for the auditors' visit and facilitate the onsite verification phase.

12. **CERTIFICATION:** Not Applicable.

13. **TRAINING:** Staff of the WDC have prepared a video training program for the multi-state audit process. This training includes: 1) the advisory nature of the audit process; 2) an emphasis upon the auditors working with management when a problem is found, and the role of the auditor as a "teacher"; 3) a review of the audit grading system; 4) a discussion of the re-audit process; 5) the pre-audit survey process and the importance of the auditors being familiar with facility terminology; 6) facility tours; 7) taking notes to document the auditors' work; 8) exit interviews and audit score sheets; 9) audit file construction; 10) primary documentation; 11) report distribution; 12) secondary documentation; 13) file construction; and 14) audit documentation requirements.

14. **AFFILIATION:** Not Applicable.

15. **STANDARDS:** Not Applicable.

16. **AUTOMATION:** Audit questionnaires and other documents are prepared by support staff using computers. Audit testing processes are conducted and documented using paper and pencil methods.

17. **AUDIT UNIVERSE:** Each participating State identifies which facilities will be included within the audit process. The standards used as audit *criteria* are adapted from those promulgated by the American Correctional Association and include, for example, security, custody, staff training, inmate funds, HVAC systems, deadly force policies and procedures, emergency communication and inmate classification.

18. **PRIORITIES:** Within each state, managers and staffs establish audit priorities based upon the needs of the organization. No formalized risk assessment process is used by the MSA participants to identify audit priorities.

19. **CYCLE:** A three year audit cycle has been established by practice. The first round of audits began in 1990 and a second was completed in 1993.

20. **SCHEDULES:** Each member state establishes schedules based upon the needs of the organization.

21. **SCOPE:** Auditors determine compliance with standards.

22. **SURVEY:** Multi-state audit coordinators conduct extensive pre-audit surveys in preparation for the visiting auditors. File folders are prepared for each standard, which include work sheets, primary documentation (local policy or field instructions), and a section for secondary documentation (verifying the level of compliance with local policy or field instructions).

23. **WORK PROGRAM:** Through the pre-audit survey process the MSA coordinators also provide the visiting auditors an indication of sources for purposes of verification.

24. **NOTIFICATION:** Based upon the MSA contract date, facility staff may have from several months to one year notice of an upcoming audit.

25. **ONSITE VERIFICATION AND EVALUATION:** The onsite verification phase commences with introductions of the visiting auditors and facility staff. The auditors are given a facility tour. Two to three days are spent onsite. Various methods are used by the auditors to assess compliance with standards, including interviews with personnel, observing practices, and reviewing documents. The MSA coordinator plays a central role in providing the auditors with general information, arranging for supplies and a work area, answering questions, obtaining documents, scheduling interviews, coordinating the observation of practices and generally ensuring a positive audit engagement. Auditors indicate the level of compliance with standards on checklists and make notations explaining the reasons for their judgment. On the last day of the visit auditors provide the superintendent or warden and the MSA coordinator a briefing indicating the preliminary results of the audit.

26. **WORKING PAPERS:** Working papers are generally maintained at the facility and include all the pre-audit survey information originally prepared by the MSA coordinator. This consists of the standard, the related departmental policy or order, and an indication of sources for purposes of verification. Also included are some notations made by the auditors in support of the judgments made regarding the level of compliance to each standard. Representatives of the MSA participating States met after the first round of audits and agreed that auditors, when finding noncompliance with standards, should prepare more supporting documentation.

27. **REPORTING RESULTS:** Audit reports are generally prepared and submitted within 30 days as required by the MSA agreement. The reports indicate the overall degree of facility compliance with standards as expressed in a percentage. Upon receipt of the report, each State prepares an action plan to address material weaknesses in operations identified in the report. If management disagrees with the auditor's findings, an appeal process is provided.

28. **LOCAL REVIEWS OR AUDITS:** WDC staff pre-audit their own facilities in preparation for the MSA auditors' visit. Responsibility for compliance with internal policies and procedures is normally designated by Facility Field instruction. Facility Field instructions refer to the MSA standards in their reference sections. Often the wording of the audit standard is incorporated into the field instruction. The staff member(s) designated are responsible for meeting/complying with the audit standards. Security audits of practices and procedures are conducted annually by institution/facility personnel and by personnel from other facilities pursuant to division directive.

According to staff of the ODC, audits are conducted of security and custody standards six months before a scheduled MSA visit. Several wardens are selected to audit a facility other than their own and are required to report to the Director. Also, an internal auditor within the Inspections Branch audits various operations, including capital equipment, the inmate canteen, and inmate mail. Most of the internal auditors' time is spent on institutions and trusts. The ODC Manager of Business Support Services, based upon Oregon's emphasis to strengthen internal controls, has assessed the cost of the current level of internal control relative to fixed assets inventory tracking. It was determined that the costs of control exceeded the benefit derived when considering the value of the assets to the organization. As a result, internal control training will be developed by the Department with reliance on the American Institute of Certified Public Accountants Statements on Audit Standards (SAS).

29. **SAFEKEEPING AND ACCESSIBILITY:** Working papers are maintained at each facility under the control of the warden or superintendent.

30. **FOLLOWUP:** Followup audits are not conducted. The second cycle of MSA is currently being planned.

31. **CONTINUING QUALITY IMPROVEMENT AND PEER REVIEW:** Representatives from each State meet periodically to assess the MSA process and make recommendations for improvement.

32. **EXTERNAL REVIEWS AND AUDITS:** WDC facilities are inspected by the Federal Bureau of Prisons annually. Examples of other external audits conducted are Department of Health audits/ inspections, fire department inspections, labor and industries audits and inspections, Department of Human Services inspections, Division of Human Resources safety audits and inspections, and State Auditor's Whistleblower audits. Fiscal audits are also conducted by the State Auditor's Office. These external audits are conducted to assure that facilities are meeting the requirements of DMB/OFM and to ensure accounting accuracy. Financial operations for the IDC are audited by the State Auditor and the Legislative Auditor.

For purposes of comparisons, Table 5 provides page references to operational categories for all organizations studied.

Table 5

Program Review/Internal Audit Process Summary
(Page References)

Agency	Bureau of Prisons	Illinois	Utah	New Jersey	Multi-State
OPERATIONAL CATEGORY	Program Review Division	Operation and Program Audit, Fiscal Internal Audit Units	Bureau of Internal Audit	Various Internal Audit Functions	MSA: Washington, Oregon, and Idaho
1-Organization	71	82	88	92	98
2-Number of Employees	71	83	88	92	98
3-Number of Institutions	72	83	88	92	98
4-Number of Inmates	72	83	88	92	98
5-Legislation	72	83	88	92	98
6-Charter	72	83	88	93	98
7-Review or Audit Committee	73	83	88	93	98
8-Organizational Status	73	83	88	93	98
9-Categories	73	83	88	93	98
10-Policies and Procedures	73	83	89	94	98
11-Review/Audit Staff	74	84	89	94	99
12-Certification	74	84	89	94	99
13-Training	74	84	89	94	99
14-Affiliation	75	84	89	94	99
15-Standards	75	84	89	94	99
16-Automation	75, chapter IX	84, chapter IX	89, chapter IX	94, chapter IX	99
17-Audit Universe	76	85	89	94	99
18-Priorities	76	85	89	95	99
19-Cycle	77	85	90	95	99
20-Schedules	77	85	90	95	99

Agency	Bureau of Prisons	Illinois	Utah	New Jersey	Multi-State
OPERATIONAL CATEGORY	Program Review Division	Operation and Program Audit, Fiscal Internal Audit Units	Bureau of Internal Audit	Various Internal Audit Functions	MSA: Washington, Oregon, and Idaho
21-Scope	77	85	90	95	99
22-Survey	77	85	90	95	99
23-Work Program	77	86	90	95	99
24-Notification	78	86	90	96	99
25-Onsite Verification and Evaluation	78	86	90	96	100
26-Working Papers	79	86	91	96	100
27-Reporting Results	80	87	91	96	100
28-Local Reviews or Audits	81	87	91	97	100
29-Safekeeping and Accessibility	81	88	91	97	100
30-Followup	81	87	91	97	100
31-Continuing Quality Improvement and Peer Review	81	88	91	97	101
32-External Reviews and Audits	82	88	92	97	101

CHAPTER VIII

ANALYSIS OF AUDIT/REVIEW SYSTEMS

Administrative Controls

This chapter provides an analysis of the program review/internal audit systems described in chapter VII through an examination of the components of administrative controls that relate to any activity or function and to the various program review/audit steps. The methods used by each organization are systematically compared within the framework of administrative controls, procedures for planning and initiating the program review/internal audit, conduct of the audit, local reviews, followup procedures, and techniques for quality assurance.

Administrative controls were introduced in chapter IV. They represent one category of internal control, which may be used to analyze an organization or a component of an organization. Typically, program review/internal audit staff analyze operations in the context of the administrative and financial or accounting controls developed by management. Administrative controls may include:

- organizational controls, consisting of the table of organization, chain-of-command, and reporting responsibilities;
- planning controls, such as short- and long-term planning efforts, program proposals, and budget proposals;
- operating controls, which refer to policies and procedures, supervision, supervisory review, and personnel training;
- informational controls, such as automated and manual reports generated to monitor operations.

Organizational Controls

Organizational Status

Organizational status refers to the independence of the program review unit in terms of the lines of authority established in an organization. Both generally accepted government and internal audit standards address the importance of the location of the program review/audit unit in the organization. The IIA standards (1989:9) address the importance of the independence of the program review/audit director in the organization. They say that this person "should be responsible to an individual with sufficient authority to promote independence and to ensure broad audit coverage, adequate consideration of the audit reports, and appropriate action on audit recommendations."

Government auditing standards (Comptroller General, 1988:3-8) are more specific as to lines of authority:

> To help achieve organizational independence, the program review/audit unit should report the results of their audits and be accountable to the head or deputy head of the government entity. Organizationally, it should be located outside the staff or line management of the unit under audit.

The program review/audit unit should be located in the organization in a way that will maximize its independence in reporting results to top management.

Reporting Practices

The Federal Bureau of Prisons (BOP) Program Review Division (PRD) is administered by an Assistant Director who reports to the Director of the BOP. The Illinois Department of Corrections (IDOC) Director of Operations and Program Audit (OPA) reports to a Deputy Director of Inspections and Audits. As indicated in law and practice, the Chief Internal Auditor responsible for the Fiscal Internal Audit (FIA) unit reports to the Director. However, in practice this person reports to the Deputy Director of Inspections and Audits.

The Director of the Bureau of Internal Audit (BIA) for the Utah Department of Corrections (UDC) reports to the Deputy Director of the department. The multi-state audit (MSA) system developed between the departments in Washington, Oregon, and Idaho uses auditors from outside the state facility under audit. The New Jersey Department of Corrections (NJ DOC) Internal Audit Unit (IAU) conducts audits under the direction of the Assistant Commissioner, Division of Administration.

The Bureau of Prisons Program Review Division, the Illinois Fiscal Internal Audit Unit, and the Utah Bureau of Internal Audits exemplify an organizationally independent audit function. Program review/audit managers in each organization have sufficient authority to provide reasonable assurance that their reports and recommendations receive adequate consideration. MSA audit reports are advisory in nature and, since the auditors are not affiliated with the department under audit, their position within the organization is not critical. External auditors may provide a degree of independence to the process, thus enhancing the objectivity of the audit process.

Enabling Legislation and Charter

Federal agencies are required to establish a continuous process for the evaluation and improvement of the agency's system of internal controls. This is done in accordance with 31 U.S.C. 3512 (b)(1), which refers to executive accounting systems, and the Office of Management and Budget (OMB) Circular A-123, which addresses internal control systems. Audit legislation has been enacted in several of the states studied. Sample enabling legislation is found in Appendix A.

Audit charters are essential tools developed within an organization to facilitate a program review or internal audit function. They establish the department's position within the organization, authorizing access to records, personnel, and physical properties used for the performance of audits. They also define the scope of internal auditing activities.

The IIA standards (1989:10) establish the importance of an audit charter for an organization operating an internal audit function:

> The purpose, authority, and responsibility of the internal auditing department should be defined in a formal written document [charter] . . . The charter should (a) establish the department's position within the organization, (b) authorize access to records, personnel and physical properties relevant to the performance of audits, and (c) define the scope of internal auditing activities.

Requirements of Enabling Legislation

The BOP Program Review Division Assistant Director is responsible for coordinating the agency-wide effort to comply with the Integrity Act (P.L. 97-255), which also requires that the agency's methods of assessing the adequacy of internal controls comply with this act. Illinois State law requires establishment of a full time program of internal auditing to maintain an effective system of internal control. This requires the appointment of a Chief Internal Auditor who is a certified internal auditor or a certified public accountant with four years of auditing experience, or is an auditor with five years auditing experience. This person reports directly to the chief executive officer, and audit staff are free of all operational

duties. A two-year audit plan is specified to include major systems of internal accounting and administrative control. The Utah Code requires the UDC to audit all programs every three years. The Code requires that all working papers and reports are classified as confidential, available only upon authorization of the director, governor, or by court order.

Although no individual state statutes guide the multi-state audit (MSA) process, the interstate audit agreement defines the process by which institutional operations are measured through the application of accepted standards. The agreement also addresses standards for audit planning, audit team composition, facilitating the onsite verification phase of the audit, and the advisory nature of the reports.

In accordance with the Single Audit Act of 1984 and applicable Federal and state circulars, the New Jersey Internal Audit Unit (IAU) completes desk reviews of single audit reports submitted by state grant recipients. "Recipients" are any local government, including school boards, and any not-for-profit organization that receives any federal grants from a state agency, state grants, or state aid funds. Each audit is conducted by a CPA firm that is independent of the entity being audited. Desk reviews are conducted by the IAU to assure that each audit report complies with applicable federal and state circulars.

The New Jersey State Comptroller is responsible by law (N.J.S.A. 52:27B-45) for preparing reports on the condition of state appropriations. As a result, the state established an internal control program, which requires an annual statement about how internal control systems comply with standards prescribed by the Comptroller. The annual statement is accompanied by a report on all identified material (i.e., significant) weaknesses and corrective actions taken or planned; internal and external reports are considered when formulating statements of assurance.

Requirements of the Charter

The BOP has a program statement, or policy, that includes a detailed description of the authority of the Program Review Division. Wardens/superintendents must fully support and cooperate with the PRD. They must ensure freedom of access to all property, records, employees and inmates, and give prompt consideration of findings. Duties include timely initiation and completion of appropriate corrective action to enable closure of the program review within specified time frames.

BOP *Program Statement 1210.12*, shown in Appendix C, systematically defines the responsibility of all key managers and executives in assisting the Director. The Director is required to submit an assurance statement to the Attorney General at the end of each fiscal year. This statement certifies that BOP programs are operating effectively, in accordance with applicable law, and that the systems of internal control are adequate to protect resources. Material weaknesses and significant concerns in the Bureau's systems of controls are identified and a plan for correcting them is included. The PRD Assistant Director is the designated BOP Internal Control Officer.

Illinois Department of Corrections Administrative Directives have been published for both Operations and Program Audit and FIA. Although there are many differences between these two sets of directives, they 1) include the purpose of the respective audit function, 2) state the applicability of the directive, 3) list a definition of audit terms, 4) provide general information about the audit function and indicate audit requirements including reporting responsibilities, 5) indicate that the (FIA) auditing program will follow standards promulgated by the Institute of Internal Auditors, and 6) detail auditing procedures.

Utah Department of Corrections policy and procedure guides the internal audit function, including audit authority, reporting relationships, auditor access to information and management's responsibility. The MSA interstate agreement establishes the audit process, including reporting responsibilities, auditor access to information, and the appeal process when institution staff disagree with the auditors. An audit charter has been drafted for consideration by the IDOC administration that addresses the responsibility and scope of the IAU, including the right of auditor access to information and records, and reporting responsibilities.

Enabling legislation supports and guides operations of the PRD, FIA, BIA, and IAU. Management for the BOP, IDOC, and the NJ DOC, respectively, is obligated by law to develop internal control

systems. Program review/internal audit systems play a major role in helping directors with their annual assurance statements. Audit charters are essential tools developed within an organization to facilitate a program review or internal audit function. They do so by establishing the department's position within the organization; authorizing access to records, personnel, and physical properties used for the reviews/ audits; and defining the scope of internal auditing activities.

Planning Controls

Identifying the Review/Internal Audit Universe

Various methods are used within audit organizations to identify important audit areas. As discussed in chapter II, there is a growing literature on performance review in corrections. Such measures are found in a study undertaken by Logan (1993:2). Specific "empirical indicators" are detailed in eight major areas, or "dimensions." Review of these types of measures against organizational criteria is necessary to identify the review universe and to develop review criteria. These measures include security, safety, order, care, activity (programs), justice (fairness), (living) conditions, and (efficient) management, with a variety of "subindicators." Similar performance criteria have been developed in a study sponsored by the Office of Juvenile Justice and Delinquency Prevention (Parent et al., 1993).

Program review/internal audit procedures use formalized risk assessment tools, which incorporate quantitative techniques into decisionmaking processes. According to Sawyer (1988:446-447), risk assessments are a type of analytical review procedure (ARP) in which:

> There is a direct correlation between solid risk analysis and an internal audit department's effectiveness and value to the organization. If important audit areas are not identified, auditors will not have an opportunity to address them. Instead, valuable audit resources may be spent on items of less importance and value with less positive impact on the organization . . . Risk analysis is perhaps one of the greatest challenges to auditors. It requires skill, experience, knowledge of operations, personal contacts, awareness of the operating climate, and understanding of the firm's objectives and operating philosophy.

The first step in determining operational risk, vulnerability, or exposure is to segment the organization into assessable units. As explained by Arthur Andersen and Company (1986:9):

> There is no single method to divide an agency into assessable units (i.e., organizational components, programs, administrative functions, etc.) for which vulnerability assessments will be performed, particularly since agencies vary widely in organizational structure and the nature of activities and functions conducted. The important thing to remember is that the inventory should encompass the entire agency, and the individual assessable units should be of an appropriate nature and size to facilitate the conduct of a meaningful vulnerability assessment.

Program review/internal audit staff should focus on issues that present material risk to the organization. As indicated by Sawyer (1988:203), "The professional internal auditor should be able to identify the objectives of an operation, the risks that lie in the path leading to the objectives, and the key controls in effect, or needed, to help achieve the operation's objectives."

IIA standards (1989:47-48) address the tasks of establishing the audit universe and developing priorities for planning and conducting the audit:

520 Planning

The director of internal auditing should establish plans to carry out the responsibilities of the internal auditing department.

.04 Audit work schedules should include (a) what activities are to be audited; (b) when they will be audited; (c) the estimated time required, taking into account the scope of the audit work planned and the nature and extent of audit work performed by others. Matters to be considered in establishing audit work schedule priorities should include (a) the date and the results of the last audit; (b) financial exposure; (c) potential loss and risk; (d) requests by management; (e) major changes in operations, programs, systems, and controls; (f) opportunities to achieve operating benefits; (g) changes to and capabilities of the audit staff. The work schedules should be sufficiently flexible to cover unanticipated demands on the internal auditing department.

Establishing Priorities: the Utah Risk Assessment Scale

The Utah BIA uses a formalized risk assessment tool in all departments and at the local level to establish audit priorities. This scale is based on a model developed by the IIA. An example of a local level risk assessment includes all institutional functions and processes identified, as shown in Exhibit 1. Risk factor criteria were established and were used to set priorities for all entities and functions within the audit universe, using the risk assessment form shown in Table 3, chapter III. The results of the application of this form are displayed in Exhibit 2.

The central office auditors validate each local risk assessment, which often changes the priorities shown in Exhibit 2. A similar tool has been developed to set priorities for all entities and functions within the UDC. A complete risk assessment results in a listing of entities and functions from highest to lowest risk. High risk entities or functions are scheduled for comprehensive audit, while moderate and low risk entities and functions are addressed with less frequency and intensity.

Based upon a department-wide risk assessment and in accordance with the requirement to develop a three-year audit plan mandated by statute, the BIA bureau director develops short and long term audit plans with consideration given the audit resources available. BIA staff meet quarterly, and audit schedules are prepared for each three-month period and submitted to the UDC Executive Director for review and approval. This is done at least eight weeks before the commencement of each quarterly plan.

The Bureau of Prisons (PRD), Illinois (FIA), Utah (BIA), and New Jersey (IAU) have developed various formalized methods for identifying the review/internal audit universe and scheduling activities based upon quantifiable measures. The purpose of the BOP Management Assessment process is to examine each component of a discipline or program to determine the vulnerability of the program to fraud, waste, abuse, and mismanagement; the potential for serious problems if policy and regulations are not followed, or systems of internal control are not adequate; the degree to which resources are being used efficiently; program review priorities; and management indicators by which program operations are to be monitored.

Exhibit 1

Central Utah Correctional Facility Audit Universe

Outside Programming

1-A Outside Programming/Volunteers
1-B Outside Programming/Tours
1-C Outside Programming/Religious Services

Inside Programming

2-A Inside Programming/Contract Staff
2-B Inside Programming/Library
2-C Inside Programming/Education
2-D Inside Programming/Recreation
2-E Inside Programming/Habilitative Tracks
2-F Inside Programming/Full Productivity

Perimeter

3-A Perimeter/K-9
3-B Perimeter/Special Weapons and Tactics
3-C Perimeter/Towers
3-D Perimeter/Vehicle Direction Station
3-E Perimeter/Fences
3-F Perimeter/Communication
3-G Perimeter/Armory
3-H Perimeter/Transportation
3-I Perimeter/Emergency Access

Housing Security

4-A Housing Security/Housing Units
4-B Housing Security/Counts
4-C Housing Security/Movement Control
4-D Housing Security/Key Control
4-E Housing Security/Inmate Property
4-F Housing Security/Urinalysis
4-G Housing Security/Incident Reports
4-H Housing Security/Full Productivity
4-I Housing Security/Unit Management Teams
4-J Housing Security/Work Crews

Support Services

5-A Support Services/Fixed Assets
5-C Support Services/Warehouse
5-D Support Services/Inmate Accounting
5-E Support Services/Maintenance
5-F Support Services/Food Service
5-G Support Services/Mail
5-H Support Services/Property
5-I Support Services/Records
5-J Support Services/Management Information Systems

Administration

6-A Administration/Disciplinary
6-B Administration/Classification
6-C Administration/Grievances
6-D Administration/Officer In Charge
6-E Administration/Policy & Procedure
6-F Administration/Command Post
6-G Administration/Inmate Housing Assignments
6-H Administration/Personnel
6-I Administration/Budget
6-J Administration/Purchasing

Building/Physical Plant

7-A Building & Physical Plant/External Inspections
7-B Building & Physical Plant/Emergency Safety
7-C Building & Physical Plant/Space Utilization
7-D Building & Physical Plant/Disaster Planning
7-E Building & Physical Plant/Modification

Medical

A.1 Medical/Medical Services/Clinic
8-A.2 Medical/Medical Services/Nursing Services
8-A.3 Medical/Medical Services/Infirmary
8-A.4 Medical/Medical Services/Optometry
8-A.5 Medical/Medical Services/Audiology
8-A.6 Medical/Medical Services/Contract Services
8-A.7 Medical/Medical Services/Specialist Serv.
8-B Medical/Dental Services
8-C Medical/Pharmacy
8-D.1 Medical/Mental Health/Psychiatric Services
8-D.2 Medical/Mental Health/Crisis Intervention
8-D.3 Medical/Mental Health/Mental Health
8-D.4 Medical/Mental Health/Sexual Offenders

Exhibit 2

Central Utah Correctional Facility

RISK ASSESSMENT RESULTS

Note: These ratings were decided by staff at the institution and validated by central office auditors in a department-wide risk assessment.

Sorted by Risk Assessment

2-A	Inside Programming/Contract Staff	3.43055
8-A.3	Medical/Medical Services/Infirmary	3.06452
2-E	Inside Programming/Habilitative Tracks	2.96444
5-H	Support Services/Property	2.87097
6-E	Administration/Policy & Procedure	2.83333
6-H	Administration/Personnel	2.80555
2-C	Inside Programming/Education	2.77778
8-D.4	Medical/Mental Health/Sex Offender	2.77143
8-A.7	Medical/Medical Services/Specialist Serv.	2.75758
5-F	Support Services/Food Service	2.75000
6-I	Administration/Budget	2.72222
4-H	Housing Security/Full Productivity	2.69444
5-E	Support Services/Maintenance	2.69444
1-C	Outside Programming/Religious Services	2.65714
6-J	Administration/Purchasing	2.63889
1-B	Outside Programming/Tours	2.46667
5-J	Support Services/MIS	2.44444
5-I	Support Services/Records	2.44444
2-F	Inside Programming/Full Productivity	2.43333
6-G	Administration/Classification Committee	2.40000
8-A.6	Medical/Medical Services/Contract Services	2.39394
5-D	Support Services/Inmate Accounting	2.36111
5-G	Support Services/Mail	2.33333
6-F	Administration/Command Post	2.30556
8-A.1	Medical/Medical Services/Clinic	2.27778
3-E	Perimeter/Fences	2.26667
8-A.2	Medical/Medical Services/Nursing Services	2.25000
4-I	Housing Security/Unit Management Teams	2.22222
4-E	Housing Security/Inmate Property	2.20589
5-A	Support Services/Fixed Assets	2.16667
7-C	Building & Physical Plant/Space Utilization	2.13889
8-D.2	Medical/Mental Health/Crisis Intervention	2.13889
4-G	Housing Security/IR-1's	2.13889
2-B	Inside Programming/Library	2.07407
3-I	Perimeter/Emergency Access	2.05556
7-D	Building & Physical Plant/Disaster Planning	2.00000
3-H	Perimeter/Transportation	1.91667
4-B	Housing Security/Counts	1.91666
3-B	Perimeter/SWAT	1.88889
8-C	Medical/Pharmacy	1.88889
8-A.5	Medical/Medical Services/Audiology	1.87879
6-D	Administration/OIC	1.85714
4-C	Housing Security/Movement Control	1.83333
3-A	Perimeter/K-9	1.83333
4-J	Housing Security/Work Crews	1.83333
8-B	Medical/Dental Services	1.83333
1-A	Outside Programming/Volunteers	1.82609

3-F	Perimeter/Communication	1.78788
6-A	Administration/Disciplinary	1.76190
5-C	Support Services/Warehouse	1.72222
6-C	Administration/Grievances	1.61111
4-A	Housing Security/Housing Units	1.58333
6-B	Administration/Classification	1.57143
8-A.4	Medical/Medical Services/Optometry	1.52941
8-D.1	Medical/Mental Health/Psychiatric Services	1.44444
3-D	Perimeter/VDS	1.44444
7-A	Building & Physical Plant/External Inspections	1.44444
8-D.3	Medical/Mental Health/Mental Health	1.44444
7-E	Building & Physical Plant/Modification	1.41667
4-D	Housing Security/Key Control	1.36111
7-B	Building & Physical Plant/Emergency Safety	1.19444
3-C	Perimeter/Towers	1.19444
4-F	Housing Security/Urinalysis	1.13889
3-G	Perimeter/Armory	1.00000

The Federal BOP management assessment reviews past and current performance, examines various management indicator data, and assesses the program's level of risk and need for improvement by means of a structured review methodology (risk assessment). Management assessment meetings are conducted with the Regional Administrator, Wardens, and managers from various levels and the BOP discipline director. The purpose of these meetings is to 1) identify an objective for operational activities, 2) assess the level of risk, 3) articulate procedures or control techniques that provide reasonable assurance that operational objectives will be met and problems avoided, 4) identify the perceived adequacy of these controls and safeguards, 5) anticipate the significance of actual risk to the program's mission, 6) distinguish methods of reviewing the activity to ensure controls are adequately tested, and 7) index specific program review objectives and steps to carry out testing.

Central office administrators are fully involved in the management assessment process. It is the responsibility of the central office program administrator to ensure that necessary documentation is maintained regarding the management assessment process.

A management assessment form has been developed that 1) identifies the program, 2) articulates an objective statement (e.g., to ensure institutions are operated in a way that provides a safe environment for staff and inmates and prevents inmate escape), 3) includes an identification of the process (e.g., tool, weapon and hazardous material control), and 4) provides a listing of the steps necessary in each operation or process from start to finish. An inherent risk factor is applied to each step in the process and the adequacy of internal controls is assessed for each step. An overall risk rating is listed, which is the result of the inherent risk minus the level of internal control.

The BOP develops management control plans for 5-year periods. These plans are based on management assessments and include planned actions. In addition to outlining the frequency of routine PRD program reviews, management control plans identify the level of risk associated with program areas. Plans to correct problems that do not require additional review are included, as are arrangements for special studies, surveys or task force efforts to examine problems in detail, with dates for completion. The management control plan also includes a certification that all high risk areas have been included in the Program Review Guidelines or that they will be addressed in a special review. The PRD Assistant Director issues a compiled Annual Program Review Schedule for all programs and is responsible for ensuring the timeliness of program review schedules.

The Chief Internal Auditor of Illinois FIA develops an audit plan or schedule for each fiscal year. It includes the number of planned audit hours, the audit risk grade, the institution, a summary of previous internal and external audit findings, the number of repeated findings, and the percent of audit hours versus the percent of expenditures for each institution. In preparing an annual plan, the number of staff

hours required by the audit plan and the actual hours available are calculated. Assumptions and judgmental risk assessments are made based primarily on prior external and internal audit results.

Establishing audit priorities requires several assumptions: 1) the quality of fiscal operations tends to remain the same if staffing remains the same; 2) the department has developed adequate systems of internal control and the effectiveness of these systems in a specific institution is an audit risk; 3) the size of an institution's budget is an inherent risk; 4) the audit risk grade of high, medium or low is a judgmental grade based on both the audit risk and inherent risk; and 5) the interests of the department are better served by conducting comprehensive audits at institutions where higher risk is assessed than by attempting limited scope audits at all institutions.

The Bureau of Prisons (PRD), Illinois (FIA), and Utah (BIA) have developed quantifiable methods of identifying assessable units and assigning relative risk to each. BOP and UDC management are directly involved in this process in their respective agencies. The management assessment process within the BOP includes annual meetings with various levels of management to establish program review guidelines. The FIA Chief Internal Auditor establishes audit priorities based upon risk, audit resources, characteristics of the institution, a summary of previous internal and external audit findings, the number of repeated findings, and the percent of audit hours versus the percent of expenditures for each institution. Within the UDC, formalized risk assessments are prepared and updated annually both at the department level and within individual divisions. Management has direct input into this process.

Operational Controls

Program Review/Internal Audit Policies and Procedures

The demands of maintaining a comprehensive program review/internal audit function require the development of operational guidelines. IIA standards (1989:48-49) address this issue:

> **530 Policies and Procedures**
> The director of internal auditing should provide written policies and procedures to guide the audit staff.
>
> .01 The form and content of written policies and procedures should be appropriate to the size and structure of the internal auditing department and the complexity of work. Formal administrative and technical manuals may not be needed by all internal auditing departments. A small internal auditing department may be managed informally. Its audit staff may be directed and controlled through daily, close supervision and written memoranda. In a large internal auditing department, more formal and comprehensive policies and procedures are essential to guide the audit staff in the consistent compliance with the department's standards of performance.

Summary

The Federal Bureau of Prisons (PRD), Illinois (OPA and FIA), and Utah (BIA) have developed comprehensive, written policies and procedures to guide the program review/internal audit function. Comprehensive, written policy and procedures guide the PRD review process, as detailed in BOP *Program Statement 1210.12*. Included in appendices are standards for audit that include a summary of *Standards for Audit of Government Organizations, Programs, Activities and Function,* 1988 Revision, GAO, and program review process examples (see Appendix B). The conduct of a program review begins with the development of a program, or plan, for program review, which is based on an identification of vulnerable areas, the classification of the types of reviews required (routine program reviews or special reviews), the availability of resources, and the sites to be included. Types of review or audit evidence

are enumerated along with the standards associated with obtaining evidence (sufficiency, competence/ reliability, and relevance). Procedures are listed to cover serious or unusual problems that may dictate halting or redirecting the review work. Development of working papers is discussed in detail (see Appendix E). A discussion on closure of the program review process outlines the responsibilities of reviewers and the institution. Operational reviews are conducted using the same process as PRD reviews.

The Illinois Department of Corrections (IDOC) administrative directive guiding OPA includes written procedures for audit planning, which require written notification of the scheduled audit. A pre-audit survey is also required; this includes input from executive staff, a review of previous audits, coordination with the facility audit liaison, planning meetings, obtaining special expertise to assist in the audit if needed, and audit scope development. The directive also addresses the verification phase, refers to generally accepted audit standards, and requires that an audit plan and annual report be submitted to the director to say how the plan was carried out. The directive also states the auditor's right of access to, and the responsibility of managers in providing, information.

Utah Department of Corrections (UDC) policies and procedures guide all aspects of internal audit, including 1) department risk assessments to establish audit priorities, 2) audit schedules, 3) audit programs, 4) the onsite verification and evaluation phases, 5) reporting results, 6) audit follow up, and 7) local internal audits. These guidelines are in an administrative manual series issued department-wide, with more detailed information in a technical manual issued to BIA staff and local internal auditors.

Planning and Initiating a Program Review/Internal Audit

An essential first step in preparing to conduct an audit involves the preliminary survey. As Sawyer (1988:129-130) explains, the preliminary survey determines who participates in the review, what they do, and why, when, and how they do it. Other factors include audit cost and an examination of risk factors and controls that are in place to minimize risk.

The Comptroller General of the United States (1988:6-2) suggests that the value of the survey is in:

> providing information about the key systems and procedures used . . . the size and scope of the entity's activities [including areas of] internal control weaknesses, uneconomical or inefficient operations, lack of effective goal achievement, or lack of compliance with laws and regulations. However, tests to determine the significance of such matters are generally conducted in the detailed audit work as specified in the audit program.

An audit program is developed after completion of the preliminary survey. The elements of an audit program are outlined by Sawyer (1988:193-194):

> A management-oriented program provides a series of analytical procedures or steps for internal auditors to follow. These steps will provide for the gathering of evidence and allow internal auditors to express opinions on the efficiency, economy, and effectiveness of the activities under review. The program lists directions for the examination and evaluation of the information needed to meet the audit objectives, within the scope of the audit work.

The IIA standards interpret individual audit planning efforts:

> **410 Planning the Audit**
> Internal auditors should plan each audit.
> .01 Planning should be documented and should include:
> .1 Establishing audit objectives and scope of work.
> .2 Obtaining background information about the activities to be audited.
> .3 Determining the resources necessary to perform the audit.

.4 Communicating with all who need to know about the audit.
.5 Performing, as appropriate, an onsite survey to become familiar with the activities and controls to be audited, to identify areas for audit emphasis, and to invite auditee comments and suggestions.
.6 Writing an audit program.
.7 Determining how, when, and to whom audit results will be communicated.
.8 Obtaining approval for the audit work plan.

Summary

A reviewer-in-charge is assigned the responsibility to prepare for each scheduled Federal BOP review. BOP *Program Statement 1210.12* requires that preparation for a review will include data collection, including data from the Key Indicators system, and an assessment before arrival at the review site. This helps focus program review objectives. A written site plan summarizes all elements of the review (see chapter VII), including input from the respective regional and central office administrators. The PRD Assistant Director or designate approves the plan submitted by the reviewer-in-charge, who then implements it. Program review guidelines developed as part of the management assessment process contain general instructions for reviewers of a program or group of programs.

Central office staff and regional program administrators, based on the input from warden advisory groups and institutional managers, establish a series of ***program review objectives*** that will enable reviewers to focus on areas where attention is most needed in the subsequent 12 to 24 months, particularly in areas of high risk, where there is potential for savings, and where there have been problems. Central office administrators have responsibility to ensure the objectives encompass all *criteria* necessary to measure whether the objectives of the program are being accomplished. Minimally, objectives address all significant policy requirements necessary for achievement of the objectives. Background information is provided as to why the objective has been included, noting where it is part of a policy requirement, government regulation, and/or mandatory national standards.

Each program review objective, background statement, and policy citation is followed by a listing of ***program review steps***, which represent the minimum acceptable testing that must occur to obtain the evidence necessary to meet the program review objective (see chapter VII, Bureau of Prisons, topic 23). Where applicable, the appropriate references to policy, regulation, standards, etc. are made. A separate component of the program review guidelines for each discipline are ***mandatory program review objectives*** applied at the regional level. These are specific areas that require special review, such as suicide prevention controls. A department head or administrator of greater rank reviews them for inclusion in the program review report.

Much of the Illinois OPA's preparation for audits is done by reviewing administrative directives, updating appendices used to catalog administrative directives and special issues, and preparing audit questionnaires. When a facility or program is notified of an impending audit, a pre-audit survey form is provided. According to the OPA guidelines, the pre-audit survey lists specific Department policies and requires the facility to document observations regarding compliance and identify information sources. Similarly, Illinois FIA staff, under the supervision of the Chief Internal Auditor, develop familiarity with the facilities to be audited and participate in the development of audit questionnaires. The areas they commonly audit are commissary funds, employee benefit fund, inmate trust fund, personnel, payroll, and timekeeping. Illinois OPA staff develop comprehensive questionnaires, checklists, and detailed instructions for completing all administrative directives and various audit questionnaires, as discussed in chapter VII, IDOC topic 23.

For each scheduled audit the Utah BIA Bureau Director assigns an auditor-in-charge who is responsible for planning the audit by initiating a comprehensive pre-audit survey. The auditor-in-charge becomes thoroughly familiar with the entity or function to be audited, as detailed in chapter VII, UDOC, topic 22. Management is responsible for identifying weaknesses in internal controls and reporting these

weaknesses to the auditors. An audit program is prepared by the auditor-in-charge after the pre-audit survey phase and before the onsite verification phase of the audit (see Appendix D). The audit program identifies general areas to be audited, and audit objectives are developed for each area with specific tests indicated to accomplish each audit objective. Appropriate forms are developed. The audit program is submitted to the BIA Bureau Director for review and approval before implementation.

Utah BIA internal auditors conduct extensive preliminary surveys in preparation for each audit. A critical aspect of the preliminary survey process is establishing criteria for measuring performance. Sources used in establishing criteria include the National Institute of Corrections Information Center; state law and administrative rules; and UDC policies and procedures, which are available to BIA staff on a software system; current correctional case law, which is accessible through subscription to a corrections case law catalog and a correctional law reporter; American Correctional Association standards; and the opinion of various UDC legal and content experts, to include individuals outside the department. BIA staff prepare written audit programs that provide guidelines to auditors in conducting audit tests and obtaining audit evidence.

Analysis shows that PRD, OPA, FIA, and BIA conduct and document preliminary surveys and develop written programs to guide the reviewers/internal auditors. For example, the BOP develops a written site plan. Content experts in each discipline prepare review guidelines as a result of a management assessment process, which provide direction to program reviewers.

Conducting and Managing the Onsite Verification and Evaluation Phases

For each state studied, field work reflected the basic requirements of the program review/internal audit program. This is consistent with the literature, which discusses field work as a systematic process of objectively gathering evidence about an organization's operations, evaluating it, and finding out whether those operations meet acceptable standards. The term "systematic process" implies planned audit steps that are designed to meet audit objectives, and that the internal auditor will employ professional discipline while gathering, arraying, recording, and evaluating evidence in the audit (Sawyer, 1988:227-228).

Once in the field, verification of assumptions made during the preliminary survey is integral to the program review. According to the Comptroller General (1988:3-11), the quality of audit work and the resulting reports is determined by the degree to which ". . . the audit scope, methodology, and the tests and procedures used in the audit are adequate to provide reasonable assurance that the audit objectives are accomplished," suggesting that it may be appropriate to use statistical sampling, statistical inference, and other aspects of quantitative analysis, as necessary. Concerning the standards for performance auditing, the Comptroller General (1988:6-16) states the following:

> Sufficient, competent, and relevant evidence is to be obtained to afford a reasonable basis for the auditor's judgments and conclusions regarding the organization, program, activity, or function under audit. A record of the auditor's work is retained as working papers. Working papers may include tapes, films, and disks.

Audit objectives are achieved through *a process of testing*. According to Sawyer (1988:240):

> The audit test usually implies evaluation of transactions, records, activities, functions, and assertions by examining all or part of them. But testing—when viewed as putting something to proof—does not necessarily exclude a complete examination. Testing is any activity that supplies the auditor with sufficient proof to support an audit opinion.

Sawyer (1988:240) identifies the steps to be taken in testing as:

- determining the standard,
- defining the population,
- selecting a sample transaction or process,
- examining the selected transactions or processes.

Comparing practices with standards or criteria identified in the preliminary survey and included in the program is only the first of two review phases. After measurements are taken, reviewers/auditors must evaluate findings and arrive at conclusions. In doing so they can and should evaluate the criteria/ standards used, all of which are subject to ongoing review (see Sawyer, 1988:232).

The verification and evaluation efforts that result from conducting audit tests, assembling working papers, and making judgments must be of high quality. According to the Comptroller General (1988:3-11), "Findings and conclusions in reports are [to be] fully supported by sufficient, competent, and relevant evidence obtained or developed during the audit." Sample working papers are in Appendix E.

Program review/internal audit personnel must possess professional proficiency and exercise due professional care. The Comptroller General (1988:3-12) again states:

> A body of knowledge on types of audits, tests, procedures, and methodology exists. Some are generalized and some are specific to certain industries, types of audits, or special circumstances. Auditors should have sufficient awareness of this body of knowledge to apply it to the audit being undertaken. This awareness is necessary to ensure that the selected methodology, tests, and procedures are appropriate.

IIA standards (1989:39) address examining and evaluating information:

> All audit working papers should be reviewed to ensure that they properly support the audit report and that all necessary auditing procedures have been performed. Evidence of supervisory review should be documented in the audit working papers. The director of internal auditing has overall responsibility for review but may designate members of the internal auditing department to perform the review. Review should be conducted at a level of responsibility higher than that of the preparer of the audit working papers.

Summary

The onsite verification phase of program reviews and internal audits conducted by staff of the BOP, IDOC, UDC, NJ DOC, and the multi-state (MSA) group (Washington, Oregon, and Idaho) is generally based upon well prepared program review guidelines and audit programs. The specifics of policy and procedures are found in chapter VII. Field work generally commences with an entrance conference with management of the entity under audit and a presentation of the general scope and procedures to be followed during the review. A predominant theme is to maintain open communication with management and ensure a positive experience for all involved. Specific audit testing procedures are conducted under the supervision of a reviewer or auditor-in-charge. Program review/internal audit evidence generally consists of physical evidence gained through direct observation, which is considered the most dependable in determining the adequacy of internal controls. This is followed by testimonial evidence, including interviews, which are considered the least dependable type of evidence; documentary evidence consisting of files, records, etc.; and analytical evidence, which is developed by making judgments.

Working papers are prepared to document all program review/audit tests conducted and their results. Also included under the definition of working papers are all preliminary survey materials, correspondence, program review guidelines or audit programs, and any other material relevant to the audit. The review/audit team meets frequently to assess progress during the field work. Also, they frequently meet with management to provide feedback. Documented supervision of the field work is important in

assessing the audit team's performance. When UDC auditors encounter audit impairments or problematic areas, they verbally inform management and followup in writing to the BIA Bureau Director.

An exit conference is conducted shortly after the field work is completed, at which time the draft report is presented. On the last day of field work, each unit reviewed provides feedback that includes follow up with an exit conference and a written report. Finally, the reviewers/auditors themselves are evaluated by the agency and by the reviewer-in-charge. Examples of auditor evaluation forms are found in Appendix G. Specific procedures for each jurisdiction are given in chapter VII.

Local Operational Reviews/Internal Audits

Within the BOP (PRD), IDOC, UDC, MSA, and NJ DOC, various forms of local operational reviews/internal audits are generally done by various management staff. These operational reviews yield many benefits. First, management may ensure that operations are in order between central office program reviews/audits. Also, management may assign content experts to examine operational areas with resulting training and cross-training of staff. In addition, ownership for action plans to correct deficiencies is enhanced; and, in larger organizations such as the Federal Bureau of Prisons, local program reviews/ internal audits are more cost-effective than central office program reviews/internal audits.

Details of local operational reviews are provided for each jurisdiction in chapter VII. Operational reviews for the Bureau of Prisons are outlined in *Program Statement 1210.12*. The Illinois DOC administrative directive requires all correctional facilities and program sites (including parole offices) to establish a procedural system for conducting annual internal audits. The purpose is to ensure compliance with rules, regulations, directives, operational and program standards, policies, procedures, and FIA-determined fiscal directives. In Utah local internal audits are conducted by facility staff and the other UDC divisions who have been trained by the BIA Bureau Director. BIA oversees these local internal audits. The local internal auditors are generally more familiar with the operational intricacies than BIA auditors. Oversight from BIA provides a degree of objectivity to the process.

Washington State Department of Corrections staff members pre-audit their own facilities in preparation for the MSA auditors' visit. Designated units are responsible for compliance with audit standards. The Oregon Department of Corrections conducts audits of security and custody standards six months before a scheduled MSA visit. Several wardens are selected to audit a facility other than their own and are required to report to the Director. Also, an internal auditor within the Inspections Branch audits various operations including capital equipment, the inmate canteen, and inmate mail. Most of the auditors' time is spent on institutions and trusts. Because of Oregon's focus on strengthening internal controls, the ODC Manager of Business Support Services assessed the cost of the current level of internal control relative to fixed assets inventory tracking. It was learned that the costs of control exceeded the benefit derived when considering the value of the assets to the organization. As a result, the Department will develop and provide to management and staff internal control training based on the American Institute of Certified Public Accountants Statements on Audit Standards (SAS). Since there is no centralized unit within the NJ DOC responsible for the internal audit process, all audits and programmatic reviews are local efforts. In this case, they should be more concerned with gaining outside input in both performing and reviewing the audit process.

Followup Program Reviews/Internal Audits

Professional internal audit standards reflect the purpose and importance of program review/internal audit followup. The IIA standards (1989:46) state:

> **440 Following Up**
> Internal auditors should follow up to ascertain that appropriate action is taken on reported audit findings.

.01 Internal auditors should determine that corrective action was taken and is achieving the desired results, or that senior management or the board has assumed the risk of not taking corrective action on reported findings.

According to IIA standards (annotations), followup activity is part of auditing and when management accepts the risk associated with not taking action recommended by the auditors, ". . . the internal auditor's responsibility is normally discharged and no further audit action is required" (Sawyer, 1988:1205). However, the IIA Code of Ethics states that "a member shall not knowingly be party to any illegal or improper activity" (Sawyer, 1988:1206).

According to Sawyer (1988:314):

> Hence, internal auditing is responsible for appraisal of operating management's performance in carrying out its responsibilities. It is, thus, an extension of top management . . . It would be inconsistent for the auditor to be charged with detecting a systems defect, and then be excused or prevented from looking for defects in the correction of that defect, or from pointing out the failure to achieve correction.

Summary

The Chief Executive Officer for the Bureau of Prisons facility ensures that a followup review is conducted locally to determine whether adequate internal controls are in place to prevent problems from recurring. The appropriate associate warden or assistant superintendent is responsible for conducting the followup, as discussed in chapter VII, BOP topic 30. The Regional Program Administrator of each discipline oversees the accomplishment of corrective actions and the internal controls as outlined by the CEO in response to program review findings. The Illinois OPA requires the identification of audit findings that warrant followup audits. These audits would check progress made toward corrective actions. The facility audited must present documentation supporting the resolution of problematic areas by the deadlines indicated in the final report. Forms have been developed for followup audits, which when completed are submitted to the director with documentation.

The Utah BIA schedules and conducts followup audits as authorized by the Executive or Deputy Director. They are prioritized in two ways: 1) according to the dates agreed upon in the exit conference for completion of action plans, and 2) by the risk represented to the Department based on the UDC risk assessment and outside (external) scrutiny. The followup audit report shows whether *full, partial or nonresolution* was achieved and may also determine that resolution is *nonapplicable.* Auditor's judgments are supported by a general discussion in the report. New Jersey IAU staff prepare a Resolution Report for each audit. IAU staff limitations place heavy reliance on management's report; there is little independent corroboration by IAU staff. MSA member states do not yet conduct followup audits, although they are currently being planned.

Sawyer (1988) reports varying opinion as to auditors' responsibilities for follow up. However, if internal auditing is to be an independent appraisal function, they have responsibility ". . . to identify and report on both actual and potential risks to the enterprise" (Sawyer, 1988:314). Within the BOP, IDOC, UDC, and NJ DOC, followup efforts occur, although the type of followup varies by organization. Ideally, these agencies should have outside participation in followup reviews, although this is often not the case.

Quality Assurance/Peer Review—Auditing the Auditors

An organization must have an ongoing quality improvement procedure concurrent with its program review/internal audit. Both the Comptroller General and the IIA have promulgated standards for continued quality improvement. The Comptroller General (1988:3-17 to 3-18) states:

> Audit organizations conducting government audits should have an appropriate internal quality control system in place and participate in an external quality control review program.
>
> 45. The internal quality control system established by the organization should provide reasonable assurance that it: (1) has established, and is following, adequate audit policies and procedures and (2) has adopted, and is following, applicable auditing standards. The nature and extent of the organization's internal quality control system depends on many factors, such as its size, the degree of operating autonomy allowed its personnel and its audit offices, the nature of its work, its organizational structure, and appropriate cost-benefit considerations. Thus, the system established by individual organizations will vary, as well as the extent of their documentation.
>
> 46. Organizations conducting government audits should have an external quality control review at least once every 3 years by an organization not affiliated with the organization being reviewed. The external quality control review program should determine that: (1) the organization's internal quality control system is in place and operating effectively and (2) auditing standards are being followed in its audit work, including its government audits. However, external quality control review procedures should be tailored to the size and nature of the organization's audit work . . .

The IIA standards define quality assurance and specify the elements of such a program (Sawyer, 1988:910-911):

> **560 Quality Assurance**
>
> The director of internal auditing should establish and maintain a quality assurance program to evaluate the operations of the internal auditing department.
>
> .01 The purpose of this program is to provide reasonable assurance that audit work conforms with these Standards, the internal auditing department's charter, and other applicable standards. A quality assurance program should include the following elements:
>
> .1 Supervision
> .2 Internal reviews
> .3 External reviews
>
> .02 *Supervision* of the work of the internal auditors should be carried out continually to assure conformance with internal auditing standards, departmental policies, and audit programs.
>
> .03 *Internal reviews* should be performed periodically by members of the internal auditing staff to appraise the quality of the audit work performed. These reviews should be performed in the same manner as any other internal audit.

.04 *External reviews* of the internal auditing department should be performed to appraise the quality of the department's operations. These reviews should be performed by qualified persons who are independent of the organization and who do not have either a real or apparent conflict of interest. Such reviews should be conducted at least once every three years. On completion of the review, a formal, written report should be issued. This report should express an opinion as to the department's compliance with the *Standards for the Professional Practice of Internal Auditing* and, as appropriate, should include recommendations for improvement.

Summary

Analysis of these agencies shows various efforts to improve the quality of the review/audit function for the BOP, IDOC, UDC, NJ DOC, and the MSA. Internal and external methods of quality assurance were found in all the organizations examined. Quality assurance and total quality management (TQM) are discussed in greater detail in chapter X, to include the applicability of TQM to government auditing.

The Federal Bureau of Prisons Program Review Division (PRD) makes continuing efforts to address quality improvements. For example, *Program Statement 1210.12* requires that the reviewer-in-charge establish and maintain a quality assurance program to ensure that program review work conforms with GAO auditing standards and with the requirements of the program statement. The reviewer-in-charge is required to conduct a Quality Assurance Review (QAR) for each review report, and this report is examined by the review authority. This procedure is discussed in chapter VII, BOP topic 31. Reference is made to the Federal Manager's Financial Integrity Act (FMFIA) of 1982, which was enacted to help reduce waste, loss, unauthorized use, and misappropriation of resources. The Act and its implementing guidelines and circulars are also concerned with the efficiency and effectiveness of agency programs.

In the Illinois DOC, the OPA audit manager conducts internal assessment for improvement. Audits conducted by FIA are examined by the Auditor General of the State of Illinois. The Utah BIA holds annual planning retreats at which attendees review Bureau performance. Short- and long-term goals for the coming year are established based on a review of the progress of the previous year's goals, and a written report is submitted to the Executive Director. The New Jersey IAU has been reviewed informally by legislative services and formally by an independent CPA. Representatives of the multi-state group meet periodically to assess their audit process and make recommendations for improvement.

Reporting Results of the Program Review/Internal Audit

The organization should establish a uniform method for reporting program review/audit results to management and developing action plans to correct deficiencies. According to Sawyer (1988:685), written reports:

> . . . are the auditor's opportunity to get the attention of management. Auditors have an admirable story to tell: they should not miss that opportunity through inept or unprofessional reporting. Reports should meet the standards of accuracy, clarity, conciseness, timeliness, and tone.

The need for continual written and oral feedback to management is expressed in IIA standard 430 Communicating Results (IIA, 1989:40), which provides guidance as to how auditors should report the results of their audit work. **Section .01 states**:

> A signed, written report should be issued after the audit examination is completed. Interim reports may be written or oral and may be transmitted formally or informally.

.1 Interim reports may be used to communicate information which requires immediate attention, to communicate a change in audit scope for the activity under review, or to keep management informed of audit progress when audits extend over a long period. The use of interim reports does not diminish or eliminate the need for a final report.

.2 Summary reports highlighting audit results may be appropriate for levels of management above the auditee. They may be issued separately from or in conjunction with the final report.

Reports based on audit findings identify material (significant) weaknesses in operations. The IIA standards (IIA, 1989, pages 43-44) discuss report structure. In section .07 they indicate that "Audit findings emerge by a process of comparing what should be with what is. Whether or not there is a difference, the internal auditor has a foundation on which to build the report. When conditions meet criteria, acknowledgment in the audit report of satisfactory performance may be appropriate."

Findings should be based on attributes that address deficiency findings using the following format:

Title: a statement of the area in which the deficiency was found. This is customarily based upon the program review guidelines or audit program (i.e., key control).

Criteria: a statement of the policy, law, regulation, or accepted professional practice that reflects the accepted level of performance (i.e., all security key rings are to be checked in at the control desk at the end of each shift and documented in the shift log).

Condition: a statement or series of statements indicating the actual practices occurring at the time of the program review/internal audit (i.e., key control logs for the period of October 1, 1992 to December 1, 1992 reflected not all security key rings were documented as having been checked in at the end of shift). For example, Facility A, Shift 1, shift logs indicated only 45% of the required log entries were made.

Effect: a statement of the actual or potential effect of the disparity between *criteria* and *condition.* If there is significant risk to the facility or organization because of this disparity, there is a material deficiency finding.

Cause: the program review/internal audit team must determine the *cause* of the disparity between *criteria* and *condition* to make a *recommendation* that is logical and will result, if followed, in providing reasonable assurance the problem will be resolved.

Recommendation: the program review/internal audit staff suggestions for resolution.

The purpose of a review is to identify operational deficiencies and facilitate corrections. Management's concurrence with the auditor's recommendations is essential to developing a workable action plan. According to IIA standards (1989:45):

.06 The auditee's views about audit conclusions or recommendations may be included in the audit report.

.1 As part of the internal auditor's discussions with the auditee, the internal auditor should try to obtain agreement on the results of the audit and on a plan of action to improve operations, as needed. If the internal auditor and auditee disagree about the audit results, the audit report may state both positions and the reasons

> for the disagreement. The auditee's written comments may be included as an appendix to the audit report. Alternatively, the auditee's views may be presented in the body of the report or in a cover letter.

The Comptroller General standards (1988:7-1) stress the importance of written reports for purposes of communicating audit results to officials at all levels of government: "Written audit reports are to be prepared communicating the results of each government audit." The report makes the results less susceptible to misunderstanding, facilitates follow up to determine whether appropriate corrective actions have been taken, and makes the results available for public inspection. While availability of reports to the general public is encouraged by the Comptroller General (1988:1-5), legal restrictions or ethical considerations may justify limited release of reports.

Summary

Review findings are developed and reported in order to address weaknesses in internal controls. The Federal PRD, Illinois OPA and FIA, Utah BIA, and New Jersey IAU provide written reports of all audit results and generally address deficiency findings. Generally, an exit conference is held to review the audit results with management and develop an action plan. This is in addition to the requirement that review/audit staff keep management informed of progress and preliminary results during the onsite or field work phase. Action plan results indicating who will do what by when are documented as part of the report.

According to BOP *Program Statement 1210.12* the materiality of deficiencies and their inclusion in the official report is determined by the professional judgment of the reviewer with concurrence of the reviewer-in-charge. These procedures are detailed in chapter VII, BOP topic 27. The elements of review findings noted above are used. The rating system reflects the judgment of the reviewer-in-charge about how well the mission and objectives of the program are met, ranging from superior to "at risk." Within 20 business days following the review, the report of findings is submitted to the review authority, who must respond within 10 working days of receipt. The review authority must retain the program review reports for eight years by law. Outside party requests for a report or related working papers must be in writing to the Director. Sensitive information that might impact an institution's security or negatively affect a unit's functioning if released remains confidential.

Staff of the Illinois OPA must (by administrative directive) conduct an exit conference that includes the Director or a designee, appropriate executive staff, the manager of the audit site and his/her assistants. Audit findings and recommendations are orally presented, to which the audit site manager responds. The manager tells the Director how the recommendations or appropriate alternatives will be implemented, the person responsible for resolving audit findings, and when negative findings will be rectified. This information is recorded by the audit team and appears in the final report submitted to the Director within 15 working days of the exit conference. The form of the final report is detailed in chapter VII, IDOC topic 27, to include submission deadlines and plans for correcting deficiencies. The OPA audit manager and the FIA chief internal auditor maintain control and oversee working paper access.

Utah Department of Corrections policy and procedure require the distribution of audit reports in draft form preliminary to the exit conference, held 30 calendar days after the last day of the onsite verification phase. The report has audit findings that specify *criteria, condition, cause, effect* and *recommendation*. The conference is attended by management, the BIA Bureau Director and the UDC Executive Director or designate, who review the report for accuracy, obtain management response, and finalize corrective action plans. A final report of findings and recommendations is distributed within 10 working days of the exit conference. Both Utah statute and UDC policy deem audit reports, both draft and final versions, as confidential.

For the MSA states, audit reports are generally prepared and submitted within 30 days, as required by their agreement. The reports indicate the overall degree of facility compliance with standards, expressed as a percentage. Upon receipt of the report, each state prepares an action plan to address identified material weaknesses in operations. Managers who disagree with audit findings may appeal. Working papers are maintained at each facility under the control of the warden or superintendent.

New Jersey IAU staff conduct an exit briefing with management to provide feedback on preliminary audit results. This informal reporting process is followed by a written report. IAU staff prepare audit reports that include *criteria, condition, cause, effect,* and *recommendation*. Pursuant to NJ DOC Accounting Bulletin 88-3, formal responses to IAU reports are required from each institution within 15 days following the audit exit conference. The response contains statements of concurrence or disagreement with the findings and recommendations. It states actions taken or planned to resolve each finding, including the time required, and indicates reasonable assurance the finding will not recur. Firing range audits are sent to the appropriate institutional warden, deputy director, and assistant commissioner. All working papers are maintained by the individual units conducting the audit. Control and release of these documents are decided by each unit and division.

CHAPTER IX

MANAGEMENT INFORMATION SYSTEMS IN PERFORMANCE REVIEW

The development, implementation, and maintenance of a sound internal control system depends on accurate, timely and relevant management information, which provides the "indicators" needed to monitor and measure performance against clearly defined and quantifiable goals. The Bureau of Prisons, within the past seven years has created a comprehensive and integrated internal control system, including a computerized strategic support system to monitor its internal control process. This chapter describes the BOP's Key Indicators/Strategic Support System (KI/SSS) and its relationship to the internal control process, strategic management and planning, and the day-to-day management operations of the Bureau. Information systems in Illinois, New Jersey, and Utah are described with respect to their support of internal controls and audit systems.

Federal Bureau of Prisons Key Indicators System

Organizational Structure of the Bureau of Prisons

To fully understand the capability and functionality of Key Indicators, it is important to understand the organizational structure of the Federal Bureau of Prisons and its strong commitment to planning, performance monitoring and managing by information. The Bureau's Chief Executive Officer is the Director, assisted by an executive staff of nine Assistant Directors and six Regional Directors.

Each Assistant Director is responsible for an operating division covering: 1) Administration; 2) Health Services; 3) Industries, Education, and Vocational Training; 4) Program Review; 5) Information, Policy, and Public Affairs; 6) Correctional Programs; 7) Human Resource Management; 8) Community Corrections and Detention; and 9) the Office of the General Counsel and Review. Each of the six Regional Directors is responsible for approximately 8,000 to 10,000 inmates, 12 to 16 institutions, and a staff of regional administrators who coordinate and oversee services and programs within the region. The regions are North Central, Northeast, Southeast, Western, South Central, and Mid-Atlantic. The organization of the Bureau is shown on the following page.

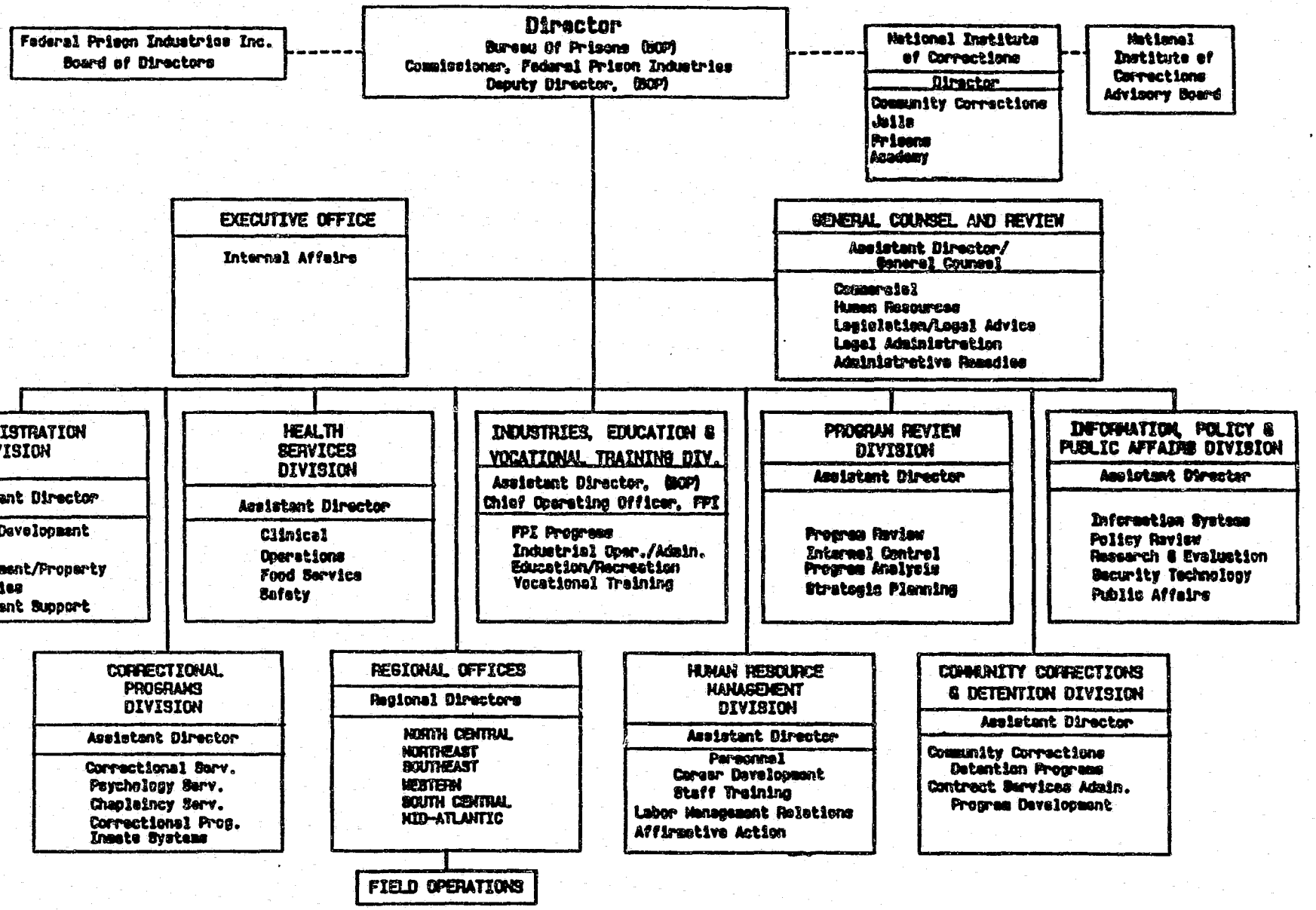
The Bureau encompasses 70 institutions and plans to construct 32 additional facilities. Each institution is organized along programmatic (discipline) lines (e.g., correctional services, education, food services, etc.). Similar organizational structures exist at both the regional and central office levels (Internal Controls Reports, March 1992).

Each institution is headed by a warden or superintendent, who is considered the chief executive officer. The CEO is supported by several Associate Wardens who are responsible for specific programs or "disciplines" of operation within the institution. The wardens report to the Regional Directors, who report to the Director.

Strategic Management and the Internal Control Process

In 1988 under the direction of former Director Quinlan, the Bureau embarked on a formal Strategic Planning strategy. Director Quinlan expressed his belief, "that our success, as corrections professionals, would be enhanced if we, as a team, addressed issues and problems in a more systematic fashion" (U.S. Department of Justice, 1992). "The purpose of the introduction of a strategic planning capability was ... to seek continuous improvement and efficiency in accomplishing our mission and, by fully involving the entire work force, we seek to empower staff at all levels" (U.S. Department of Justice, 1992).

FEDERAL BUREAU OF PRISONS



Since 1980, the number of BOP institutions (including camps) has grown from 51 to 70. The offender population is rapidly increasing: from 24,000 in 1981 to over 49,900 in 1988, with 68,000 offenders presently and a projected population of over 100,000 inmates by the year 2000. In 1988, projected increases required planning for the construction of up to 32 new institutions. These demands led to the need to plan for growth and in doing so to contain costs, improve productivity and efficiency, and control budget increases.

Information is crucial to effective decisionmaking. To develop an effective strategic planning capability, the Director placed a top priority on the use of information in the decisionmaking process. "The phenomenal growth of the Bureau of Prisons in terms of staff, inmates and facilities requires management by information to complement management by walking around" (U.S. Department of Justice, 1992). The development of a strategic management capability coupled with the high priority of an information-oriented management approach provided direction to Bureau staff. As a result, the Program Review Division (PRD) was established in 1989 in order to develop the tools and methods to assist Bureau managers in this process. Prior to the creation of the PRD, the Bureau's Management Control Review process, as directed by OMB Circular 123, was under the regional offices. When the Department of Justice Office of Inspector General (OIG) was established in 1989, the BOP recast its entire management system in terms of management control process and created the Program Review Division (U.S. Department of Justice, 1992).

The Program Review Division, administered by an Assistant Director, is responsible for the ongoing, systematic review and evaluation of all programs and operations in the BOP (U.S. Department of Justice, 1992). A Deputy Assistant Director oversees the program review section, which incorporates the Operations and Programs branches. Recent restructuring has redefined the Strategic Management Branch, which now includes the former internal control branch. Program Analysis makes up another branch. The Program Review Division has 91 employees with 68 Program Review Examiners who complete onsite reviews at the institutions. In addition to the central office division review staff, institutional field staff from within a specific discipline assist in the program review process at outside institutions.

The PRD, with input from the executive staff, regional directors, central and regional office administrators, and institutional staff, has established formal criteria and guidelines for reviewing each of the Bureau's 15 major programs or disciplines at the institutional, regional and central office levels. The 15 disciplines are located in the Operations Branch and the Programs Branch. The Operations Section encompasses 1) Correctional Programs, 2) Correctional Services, 3) Community Corrections, 4) Human Resources, 5) Health Services, 6) Religious Services, 7) Financial, and 8) Computer Services. The Program Section encompasses 1) Facilities, 2) Safety, 3) Inmate Systems Management, 4) Educational Services, 5) Food Service, 6) Psychological Services, and 7) UNICOR (industries). Thirteen of these disciplines have regional and central office counterparts, which are reviewed annually. UNICOR has a central office counterpart only.

Each discipline within an institution completes an onsite program review once every two years, and each discipline is rated according to a Bureau-wide rating system of superior, good, acceptable, deficient, and at risk. The appropriate administrator at the institutional, regional and divisional level is informed of the results and initiates necessary corrective action. In addition, the Bureau considers innovative or positive features identified in the review process for further system-wide application. Program review results are also used by the Director and executive staff to monitor institutional performance and to collect information for Strategic Management and Long Range Planning purposes.

The PRD works with the Director and executive staff to prepare the annual management/risk assessment and review guidelines and to formulate the strategic management plan, which identifies the Bureau's goals for the upcoming year. This process is facilitated by a strategic management cycle which incorporates the continuous monitoring, review, and feedback of each institution, region and division into the planning process. The elements of this process include 1) strategic plan goals, 2) management assessment, 3) operational review, 4) program review, 5) social climate survey, 6) institution character

profile, 7) other information sources (e.g., special reports, IG and GAO audits), 8) information synthesis, 9) policy development, and 10) Key Indicators.

The cyclical nature of the planning process affects the regional and institutional levels as well as central or divisional offices. Planning is based on the annual risk assessment and the program review process as defined in the internal control guidelines. Different methods are used within each discipline to identify the issues that will need attention in order to meet overall goals for the next year. Information derived from the program reviews, environmental scans and the comments of the wardens and regional directors relative to the program reviews are included in the strategic management cycle. Similarly, the social climate surveys conducted by the Office of Research and Evaluation and the Institution Character Profiles completed by the regional offices provide subjective information on the quality of institutional life (for staff and inmates) and other perceived concerns of institutional operations. These factors, and the hard quantifiable data for the various BOP and Department of Justice computer systems, provide data for the Strategic Management Process.

Until 1993 the Strategic Management Cycle revolved around an annual plan involving a fixed (calendar) schedule of issue submission, management assessment, conferences, planning retreats, goal announcement, central office and institutional goal-setting and strategic planning, budget consideration and selection of areas of concentration. This process is now ongoing.

The strategic management cycle in the BOP developed as a result of several events. The Director's interest in an objective audit or review process led to the creation of the Program Review Division. The PRD provided a comprehensive internal control process that was integrated into daily management and annual planning processes. The Director emphasized an informational approach that encouraged all levels of BOP management to make information-based decisions. This innovative approach required a management information support system to provide Bureau management with meaningful data with which to run their daily operations. The system also gave them the capability to monitor operational performance and to measure it against generally established criteria. The combination of these factors in the BOP, coupled with advances in computer technology, led to the development of the Key Indicators/ Strategic Support System. The remaining sections of this report further describe this management tool.

The Key Indicators System

The core of the Strategic Management Cycle is the availability and access to the information. The Key Indicators/Strategic Support System (KI/SSS) was developed to support virtually every component of the strategic management cycle.

KI/SSS is a PC-based tool developed by the Bureau's Office of Research and Evaluation (ORE), in concert with Bureau administrators, which yields a range of BOP information on inmates, staff and financial operations (Saylor, 1988a, 1988b). The Key Indicators concept was first proposed by Saylor in 1983, and intensive design and development was initiated in 1986. The first prototype was distributed to a limited number of users in 1988-89 on a pilot basis (Gilman, 1991). KI/SSS does not replace or supplant the Bureau's SENTRY system or other Department of Justice mainframe systems, such as those for human resources and fiscal information. Rather, Key Indicators was developed to extract data from these direct service systems and provide a vehicle for aggregating, formatting, and disseminating meaningful information to Bureau managers. The mainframe applications remain the primary providers of individual support and direct service to the inmate population and to the institutions.

KI/SSS offers a range of information or "critical indicators" for key disciplines which are used to monitor Bureau performance. As a strategic support system its data are comprehensive, historical, relatively current, and vital to decisionmaking at each level of Bureau management. Information derived from KI/SSS is used for managing institutional operations, for comparative analysis and resource allocation at the regional level, and for monitoring performance and internal control purposes at the national level. The Director and the executive staff use the Executive Staff Module of KI/SSS for semi-annual reviews of institutional and divisional performance and for planning, management, and policy develop-

ment purposes. The Bureau's long-term goal is to incorporate KI/SSS and the Executive Staff Module into the annual budget cycle.

Key Indicators is a database of 2,000 data elements and offender/institutional characteristics, readily accessible by the CEO, Regional Director, or executive staff with a need to access it. To stay current with changing management needs, KI/SSS is continually monitored and updated to capture new information. KI/SSS differs from a management information system (MIS) because it provides current information on a specific area or discipline, as any MIS system does, but it also provides the longitudinal or trend data needed for comparative analysis. Strategic support systems integrate a wide array of data and allow a systematic assessment among these elements at a given time or on a continuous basis. Moreover, strategic systems provide support on demand (Saylor, 1988). A management information system requires a specific request at a point in time.

Before KI/SSS, management made decisions on information generated from routine reports or from ad hoc requests. Data needed for the latter were not readily available and often required extensive staff time to generate. This information was descriptive in nature and was used primarily for administrative purposes to meet a specific request. The KI/SSS model system is the vehicle for disseminating strategic information throughout the Bureau. It is a flexible system that allows Bureau managers to work from their own personal computers to select specific information for use. Access is immediate. The system is menu driven and the user may select key information by institution, region, security level and Bureau level. Format options include tables, graphs, and historical and trend comparisons, when applicable.

KI/SSS was designed for end-users at the institutional, regional and central office levels and for statisticians and researchers. It is user friendly and encourages the use of data and statistics by managers in the field. It presents key indicator information in a usable manner so that Bureau managers can spend more time analyzing, interpreting and applying the information in managing (Rausch, 1991).

KI/SSS contains extensive information on each BOP institution, region, security level and the Bureau nationally, including information about rated capacities, admissions and discharges, average daily population, inmate demographics, security designation, custody classification, urine surveillance, assaults, escapes, disciplinary hearings, inmate grievances, education program enrollments and completions, staff demographics, staff perceptions of institutional social climate and financial management (Saylor, 1989).

At the institutional level, Key Indicators allow the manager to review and analyze changes in the institution or areas of responsibility and to observe changes which may occur over time. Corrective action to address potential problems can be initiated in order to avoid serious incidents which might occur at a later time.

Current Status of the Key Indicators System

The majority of information in the system comes from existing mainframe databases originally developed to satisfy day-to-day operational needs (Saylor, 1989). Approximately 90 to 95% of all non-survey KI/SSS information is generated from large mainframe applications which are maintained by the BOP or the Department of Justice, including:

System Name	Database Application	Agency Maintaining
1. SENTRY	Inmate Information	Bureau of Prisons
2. FMIS	Financial Information	Department of Justice
3. HRMIS	Human Resource	Department of Justice
4. PERSPAY	Personnel Payroll	Department of Justice
5. JUNIPER	Justice Uniform Personnel	Department of Justice

Mainframe data have been collected to support daily operational systems, therefore, Key Indicators does not create additional burdens on existing institutional or administrative staff. Because Key Indicators integrates information from many sources, managers have easy access to prepared data (Saylor, 1989).

Other than the mainframe applications which feed KI/SSS, several local PC-based applications (e.g., dBase) are used to collect and input data on operations and significant incidents, including use of force, assaults, urinanalysis, etc. Data are collected from each institution through a standard electronic form and transmitted to the appropriate division via the SENTRY electronic mail system. BOP staff compile and edit the data from all 70 institutions through dBase applications and transfer them to a disk for updating KI/SSS.

The Bureau of Prisons has also instituted a self-reporting capability to collect information which currently cannot be extracted from mainframe databases or local dBase applications. Local database applications from Bureau organizational units, such as the Program Review Division and UNICOR, provide information for the executive staff module, which is produced in conjunction with the KI/SSS system. The semi-annual update of the Executive Staff Module provides information on program reviews, vacant/total authorized positions, executive (institution) staffing patterns, union grievances, bilingual staff, UNICOR, health services, etc.

Institution staff respond to a series of questions on a semi-annual basis, which is then compiled by Program Analysis staff, edited and entered into the KI/SSS database. Institution self-reports provide current information on management staffing patterns, union grievances, volunteer activities, etc. These data are then included in the Executive Staff Module of the KI/SSS system.

Special Data Collection Surveys

In addition to downloading data from mainframe applications and local PC-based and institution self-reporting systems, the Key Indicators database is also updated by special data collection procedures conducted by the Office of Research and Evaluation in the Bureau. The Social Climate Survey (Saylor, 1983), conducted by the ORE, and the Institutional Character Profile, conducted by the Program Review Division (Rausch, 1991), are two of these programs.

Social Climate Survey

The Prison Social Climate Survey (PSCS), administered annually to staff since 1988, is a comprehensive questionnaire containing over 275 items that assess staff's views of safety and security in the prisons, inmate quality of life, their work environment and personal well-being. These data are collected, edited, and entered into the Key Indicators for use in comparative analysis and review by management staff in conjunction with other indicators. Questionnaire items deal with operational issues (e.g., was equipment issued when necessary and did it work properly) and some with attitudes and feelings (such as staff's sense of personal efficacy in working with inmates, or satisfaction with their institution).

The Office of Research and Evaluation (ORE) analyzed the data from the four administrations to assess the ongoing reliability and validity of the PSCS. Its reliability was established by examining the consistency of staff's responses across the four years for which data were available (1992 data have just become available). However, validating the instrument is more complex, due in large part to the comprehensive nature of the instrument. The ORE is continuing its validation studies. The first is an assessment of the work environment scales that represent eight dimensions, or aspects, of organizational processes; these have traditionally been used to assess the social climate of an organization. The dimensions are:

- quality of institutional/organizational operations;
- quality of supervision;

- quality of training;
- sense of personal efficacy in working with inmates;
- job-related stress;
- satisfaction and commitment to one's job;
- satisfaction and commitment to the institution where currently employed;
- satisfaction and commitment to the Bureau of Prisons.

The original work to determine which of the 49 questionnaire items represented the eight psychological dimensions listed above was accomplished through statistical analyses, using the 1988 questionnaire data. Exploratory factor analyses of the items on one-half of the sample were consistent with the theoretical structure employed during the development of the questionnaire. The reliability of this structural pattern was assessed by performing the same analyses on the second half of the sample. Although the size of the coefficients varied slightly, the same pattern of factor loadings was observed, such that the items on the second half loaded highest on the same factors as for the first half of the sample. The variance explained was similar in the two sets of analyses. Similar analyses of 1989, 1990 and 1991 data provide for an initial assessment of the internal reliability and consistency of the scale structure that was developed with the 1988 data. While the size of the coefficients, by factor, varied slightly across the four years, the same pattern of factor loadings was observed for all years. The PSCS results from the 1992 administration are currently being prepared. Once available, confirmatory (constrained) factor analyses will be performed to provide a more rigorous assessment of the internal reliability of the scales' structure.

Analyses of the available data from all the administrations support the construct validity of the scales and show strong relationships along theoretically relevant measures of the work environment section. Current analyses are designed to assess the correspondence of the PSCS subjective measures with objective measures of the same phenomena (e.g., perceptions of the likelihood of assault and the actual number of assaults) to establish the external validity of the instrument. Preliminary analyses performed on items from the work environment, personal safety, and security sections reveal a high level of association among the subjective and objective measures.

Institutional Character Profile

Similarly, an institutional character profile provides information on the institutional environment and staff perceptions. Regional Directors and their staff interview institutional staff with open-ended questions, review institution records and observe specific institution operations. The institution character profile is less quantifiable than the social climate survey, because of the open-ended question format.

The summary results of program information obtained from these profiles are also entered into the Key Indicators for use in the Executive Staff Module for monitoring performance and planning purposes. ORE staff, in conjunction with the Office of Program Analysis, monitor the data needs of the Executive Staff Module and adjust or modify it at Executive Management staff request. They work closely with many divisions and branches in monitoring the data collection needs of the Bureau and modifying Key Indicators to include additional data indicators when required. The close working relationship of the ORE to the BOP divisions and branches, including the Program Analysis Branch, ensures data integrity and that the information and "indicators" collected are relevant to Bureau management needs.

Data Flow/Data Production

Each month data from the various mainframe computer systems are combined with data from the Bureau's local PC-based and institutional self-reporting applications and are downloaded to a compact disk (CD-ROM, i.e., non-tamperable). The CDs are distributed to each institutional warden, regional director,

executive staff and to selected branch chiefs, updating last month's CD. There are currently more than 120 PC locations throughout the Bureau on the monthly CD distribution list.

The updated CDs include all current and historical data as well as the report generator software and instructions for producing reports and responding to information requests. As a result, the current CD is self-contained and includes both the data and the software to retrieve the data and produce the reports on request. The KI/SSS CD uses proprietary software, and, as a result, each KI/SSS CD site must procure a one-time license for the use of the software. The following describes the KI/SSS data flow and data production process.

Data Archive and Extract of KI/SSS

At the end of each month, the KI/SSS mainframe applications are archived, and a data extract is produced which updates the KI/SSS relational database. Similarly, all KI/SSS data received from local PC and self-reporting databases are edited, finalized, and submitted to the Office of Research and Evaluation by operations staff. Generally, it takes three weeks to produce and process mainframe extracts and to edit and perform quality control checks on the extracts and the local data base disks. The new CD, which contains information for the previous month, is distributed at the end of the third week. Each institution receives identical data for its Key Indicators personal computer.

Data Archive and Extract of Executive Staff Module

The Executive Staff Module is updated twice a year, with information from both KI/SSS, local dBase, and institutional self-reporting systems; 50% of these data comes from Key Indicators. Every six months data from the local databases and the institutional self-reporting systems are combined with the KI/SSS generated data from the mainframe extracts. Each month thereafter the Executive Staff Module retains its unique information for five consecutive months until it is updated on the next semi-annual cycle.

Data Coordination and Quality Control

The Office of Research and Evaluation is responsible for the coordination and quality control of the monthly KI/SSS CDs. It ensures that all these data are edited, aggregated and processed according to the CD production schedule. The ORE works very closely with the Office of Information Systems to resolve any KI/SSS data discrepancies that arise. In addition, if new indicators are added to the KI/SSS system, the ORE makes sure that the appropriate processing modifications to update the KI/SSS database have been coordinated with the division or branch which requested the change.

There is an extensive amount of coordination, communication, and quality control between the ORE and the Program Analysis Branch to update and produce the Executive Staff Module, which is done in March and October. The process involves resolving data discrepancies and delivering local database disks; it requires a close, detailed working relationship between the two organizational units. The Data Analysis Branch has a screening function that is central to data integrity and correcting data discrepancies and inaccuracies in the Executive Staff Module updates.

Data Synthesis

Historically, Bureau managers faced the formidable challenge of obtaining relevant decisionmaking information (Gilman, 1991). Prior to developing KI/SSS, the Bureau, like many large organizations, used extensive amounts of data from several different computer systems, which often necessitated the creation of data retrieval programs.

In 1984 the Bureau began archiving data from several mainframes (SENTRY and JUNIPER) and categorized these data according to its newly proposed performance indicators, which then could be related to the Bureau on the national, regional, institutional and security levels. The aggregated format was downloaded from the mainframe to a local area network of personal computers, where it updated the relational database used by the Key Indicators system (Saylor, 1989). The aggregated data stored in PCs were easily accessible and retrievable in many formats, enabling system users to quickly respond to information requests. The KI/SSS system was further enhanced by the knowledge and experience of both ORE staff and Bureau management. Bureau regional and central office staff played a major role in defining the KI/SSS output reports. Furthermore, the ORE staff manipulated the various aggregated indicators into meaningful reports for management use, responding to, and even anticipating, management information requests. Reports for all levels of Bureau management were developed, including institutional, regional and executive staff. Security reports are also readily available from KI/SSS.

The ORE staff developed a user friendly report generator that allows the user to select the specific indicators or characteristics and presentation formats; that is, KI/SSS will generate a customized report based on the user's criteria. Key Indicators presents information as tables, with counts and percentages, and as graphs that help to depict trends in particular areas (e.g., inmate completion of education courses, inmate assaults and disciplinary rates) (Gilman, 1991). The reports appear directly on the screen and in print, should the user want a hard copy for duplication and distribution purposes.

KI/SSS is a valuable management tool used in daily Bureau operations. This easy integration into their operation results from ORE staff handling of germane data.

Data Distribution

The Office of Research and Evaluation produces and distributes the monthly CD updates to more than 120 offices, which include the director, assistant directors, regional directors, institutional wardens and selected branch offices. Aggregate KI/SSS data are available to every user; however, only wardens receive the Executive Staff Module and the social climate information for their respective institutions.

The Executive Staff Module is restricted to users with a password. All executive staff officers have passwords which access the entire Executive Staff Module. Any data from the Office of Internal Affairs requires an access password.

System Benefits

The KI/SSS system was designed to support strategic information delivery, assist Bureau managers in ongoing operations, and to monitor performance. The benefits of the system reflect the original design of the system, which was to make meaningful information readily available to Bureau Managers. Some of the benefits of the system include:

Immediate Access to Information

The PC-based system allows virtually instantaneous access to current information. No delays occur in waiting for a requested report to be processed, and current information is provided.

User Friendly Interface

The user friendly interface in the KI/SSS system allows non-technical staff to access data and information through a view/selection process. It requires no computer expertise or reliance on an intermediary (Saylor, 1989).

Flexibility

The relational database used in the Key Indicators file structure, combined with the way the data are organized (according to the Bureau's critical performance factors), allows the users to select data and groups of data in several ways. Users can organize information on a Bureau-wide, regional, institutional, or security level. Key Indicators provides aggregate information for a specific time or a longer span of time, for descriptive and comparative analytic purposes (Saylor, 1989).

Timeliness

Characteristic, programmatic and review data that appear in annual or special reports may be up to 12 months old before publication and distribution. Key Indicators, on the other hand, provide both historical and current information which is no more than two months old. Data are updated monthly, and each new CD includes all current and historical information for the prior month. It should be noted that despite a relatively quick turnaround on programmatic and characteristic data, line staff occasionally experience difficulties with data which does not match current counts. The Bureau's SENTRY system and the DOJ mainframe provide online information for individual records and limited aggregate data which, at times, will result in disparate counts with KI/SSS generated data. Efforts to orient line and field staff to the different types of data needs and data systems have been undertaken by Bureau analysts to minimize these difficulties.

Meeting Operational Needs

Data entered into mainframe databases, initially loaded and stored for the purpose of meeting the agency's operational needs . . . is the source of data for KI/SSS (Saylor, 1989). By using exiting data, the Bureau reduces data entry workload and costs associated with redundant data entry and editing. In addition, the integrity and quality of the data are enhanced because of their operational use.

Extensive Use of the System

The Key Indicators System is used by every level of Bureau management from the Director and executive staff to the regional director and institutional wardens and associate wardens. As the KI/SSS system has become assimilated into Bureau operations, its use has increased. The following identifies some of the more immediate uses of KI/SSS's data by the various levels of management in the BOP.

Director and Executive Officers

KI/SSS is used to measure, track and monitor institutional performance based on selected management indicators. This is done with the Executive Staff Management Indicators Module, which was introduced in the KI/SSS system and the Bureau in 1991. The Executive Staff Module contains information that was identified by the Bureau's executive staff as necessary for examining its institutions, and the layout of this information was determined by the Director and Assistant Director (Rausch, 1991). Much of the information in the Executive Staff Module was generated from KI/SSS mainframe systems or local databases within the Bureau's 15 major program disciplines.

The periodic Executive Staff Module update provides information in a standardized and uniform format for many of the Key Indicators which BOP management feels are critical to measuring institutional performance. It includes information on the status of the most recent program review results, and ORE's social climate survey results combined with quantitative information on personnel, offender and operations data. It also provides summary financial information, to include per capita costs, overtime obligations and line item funding, among the fiscal transactions. Its staff profile reports staff experience levels, perfor-

mance evaluations, separations and turnover, and sick leave percentages for each institution. Additionally, the Executive Staff Module provides comparative data for like security level institutions Bureau-wide.

As a result of the updated Executive Staff Module, executive staff can monitor institutional performance in a uniform and systematic manner across the Bureau and Regional Directors can review institutional performance within their own domain. Information generated from this system is also used by executive staff within each division during the semi-annual reviews in March and October to monitor the program areas or disciplines for which they are responsible. During these executive staff retreats, institutional assignments, reassignments and/or promotional opportunities for Wardens and Associate Wardens are considered for the upcoming year.

In addition to KI/SSS, numerous reports for the Director, executive staff, and other Bureau personnel are used to monitor programs. The program summary report, generated monthly from the Program Analysis Branch local database, provides information on major trends and findings in all program areas for the past quarter. The report is distributed to managers at all institutions and offices. The overall rating report reflects the status of each discipline for each of the Bureau's 70 institutions and is used exclusively by executive staff. This multi-page matrix report identifies the 15 disciplines, the date, and overall rating of the most recent program review for each BOP institution. Through this summary report, which is distributed separately from KI/SSS, the Director and executive staff can easily monitor the performance of each institution, identify potential problems, and determine corrective action.

Another report which is widely used throughout the Bureau is the institutional fact sheet, a comprehensive overview of the characteristics of the offender population. This inmate profile, one of the most useful KI/SSS reports, presents information on capacities, custody designation, mean sentence length, racial breakdowns, disciplinary rates, use of force rates, unusual incidents, etc. A copy of the institutional fact sheet is shown in Appendix H.

Program Review Division

The Program Review Division, which is responsible for the Internal Controls Process and the development of the annual Strategic Management Plan, makes significant use of the KI/SSS system. Staff of the two program review branches access information from KI/SSS to prepare for upcoming program reviews. In addition to those data returned from KI/SSS, information on previous program reviews, status reports on current operations of the institution, and operational rates of activities within each discipline are analyzed to identify potential review issues before the on-site visit. Other than the KI/SSS data, Division staff also research prior program review reports and corrective action reports. These data are compared with other institutions of a like security level and Bureau rates to identify possible anomalies and potential areas of review.

Aside from the program review function, KI/SSS data are used by PRD staff in its annual risk assessment process. Each discipline in the Bureau of Prisons conducts a yearly management/risk assessment in which it assigns risk levels to components of its programs based on an assessment of the previous year's program reviews and other relevant information (Rausch, 1991). This needs assessment process helps determine whether sufficient control techniques exist and if new controls are needed. This process allows for refinements or modifications to the program review guidelines for the appropriate discipline.

Information derived from formal program reviews and the needs assessment process provide input to Bureau management for policy development and its strategic management planning process. Through its audit oversight functions, the PRD is charged with integrating program review information with other data sources (objective and subjective), and with showing managers how it can be used to monitor, evaluate, and plan. These information sources allow managers to identify problems and why they are occurring. Thus managers are able to make informed decisions regarding problems and remedies or program termination. This level of feedback also enables managers to more accurately plan future

activities and resource needs. The system supports a program's credibility at a time of limited public resources and increased demands for accountability (Rausch, 1991).

Informational Policy and Public Affairs Division, Office of Research and Evaluation

The Office of Research and Evaluation (ORE) of the Information Policy and Public Affairs Division conducts research studies, develops and maintains PC-based information systems, produces and distributes reports and responds to information requests (Gilman, 1991). ORE also prepares reports for the Director; the executive staff; management staff of the Bureau; and the Congress, other executive departments, academia, private foundations, and the public.

ORE analysts use KI/SSS in virtually every information request received by the unit, because the wealth of current information in the database permits them to quickly access data and perform statistical functions to respond to information requests. Because KI/SSS is decentralized and easily retrievable, ORE staff have a greater capability for responding rapidly to requests. This allows them to better manage their time. As a result, ORE spends less time generating data in response to ad-hoc requests (data which are rarely ever useful for any other purpose), and concentrates on more complex long-term projects to which the office is committed (Saylor, 1988a). The use of KI/SSS is not limited to executive and central office staff, but is available to managers in the field offices and institutions as well.

Regional Directors

Regional directors use KI/SSS and its Executive Staff Module to monitor and manage the performance of institutions in their regions and to compare them to similar institutions throughout the Bureau. Some of the primary uses of the KI/SSS system on the regional level include monitoring institutional performance and making regional and Bureau-wide comparisons.

Monitoring Institutional Performance

Regional administrators use KI/SSS to monitor institutional performance within a specific discipline. Through it and other internal Program Review Division reports, regional administrators can determine the overall rating of a specific discipline, the number of repeat significant findings, and the number of repeat deficiencies from previous program reviews. Through Key Indicators, regional administrators and the regional directors to whom they report have immediate access to recent performance indicators on each of the 10 to 12 institutions in their respective region.

Performance Comparisons within the Region/Bureau

KI/SSS allows users to compare data, both current and historical, on different characteristics and programmatic variables, including disciplinary actions, use-of-force incidents, staff experience, and staff-to-inmate ratios. In addition, it provides fiscal year per capita cost data, overtime obligations and other financial expenditures. Through this readily available information, regional directors and their administrators can analyze institutional operations and current expenditures within their region, identify potential resource problems, and recommend appropriate action.

For example, a regional director can review the number of correctional officer separations within the region and compare it to institutions within the same security level in other regions or Bureau-wide. KI/SSS makes it possible to generate graphs that depict the number of correctional officer separations in a given facility and compare it to other regions and all institutions, and with all other facilities in the Bureau at that security level. Thus, it is possible to determine separations at one facility relative to the total separations for the region, the Bureau, and like security level facilities for that particular month.

Such comparative data on institutions within a region point out differences between the institutions. Similarly, comparisons of institutions of the same security level (minimum to high) are also available Bureau-wide, enabling regional administrators to compare their jurisdictional performance with similar organizational units in the Bureau.

Comparisons of inmate-to-staff ratios is another financial indicator that impacts an institution's budget. KI/SSS can generate inmate-to-staff counts at a specific facility on a given date as well as the ratio for both total staff complement and custody staff complement. A regional director or administrator can easily compare a facility's inmate-to-staff ratio relative to other organizational units in the Bureau.

Offender Characteristics Trends

Changes in sentencing laws affect the composition of the offender population. Specifically, the Federal priority on drug interdiction, drug trafficking and drug kingpins means the BOP offender population has shifted to drug-related offenders.

The KI/SSS system contains information on how offender population composition shifts in the institution and the region from one time period to another. Graphs can produce this information on the increase in drug-related offenders between given dates. Similar information can be produced to show change in security designations, disciplinary infractions, inmate demographics, assaults, and other variables. Regional managers and Bureau executive staff can analyze institutional trends over a period and make adjustments to resource allocations, funding requests, or Bureau policy, as required.

Institutional Character Profiles

Institutional character profiles are conducted for each institution at least once every three years. They supplement the hard, quantifiable data and provide wardens and associate wardens the opportunity to meet with the regional directors and their staff to discuss performance and other areas of concern. The survey team includes the relevant regional director or assistant director and three or more staff (Rausch, 1991). Preparations include review and analysis of information from KI/SSS relative to institutional performance, operations, and other critical factors, including the most recent Social Climate Survey. From these the team develops questions for the institutional character profile.

Using institutional profile data with Key Indicators, regional directors can monitor institutional performance, analyze inmate population trends, and review the impact of policy changes. This information is then used by Bureau executive staff for policy development or resource allocation purposes and by institutional wardens for performance monitoring and corrective action.

Institutional Administrators

The wardens and associate wardens use KI/SSS to monitor performance on the institutional and discipline levels within their program area. Current disciplinary adjudications, assaults, and use-of-force incidents can be compared with historic data to determine if institutional violence has increased or decreased. These data can then be compared with social climate survey results for the same time periods to determine if staff perceptions of safety are changing, and, if so, management can initiate training programs, policy changes, or other appropriate action to ameliorate the concerns.

Drug use and contraband are major concerns of wardens and associate wardens, because of the potential impact on security and control. They may access KI/SSS for data on substance use for a specific time period, and from these determine increases in drug activity. Wardens and staff can monitor substance abuse and take corrective actions.

Many wardens and associate wardens are beginning to assimilate Key Indicators into their operations and decisionmaking. Key Indicators allows administrators to monitor institutional expenditures—such as overtime obligations, staff turnover, and sick leave use—which, in turn, allows them to control costs,

increase productivity and identify potential trends that may affect institutional operations. An example is the comparison of several years of sick leave and staff turnover data. Negative trends in these two indicators may signify employee dissatisfaction or poor morale, which may result from changes in the composition of the offender population, an increase in assaults, or other operational issues. By monitoring these Key Indicator trends and spotting patterns, wardens and associate wardens can take corrective action to neutralize potential problems before they develop.

In addition to monitoring institutional performance, wardens and associate wardens use KI/SSS to monitor performance within each of the 15 disciplines. Data derived from KI/SSS identify strengths and weaknesses within a discipline and can be used by the appropriate associate warden to monitor progress toward corrective action recommended in a previous program review. Key Indicators is a management tool for quality control, to ensure that performance meets stated guidelines and that progress is measured when corrective action is undertaken to bring a program up to minimum standards.

Wardens and associate wardens increasingly incorporate Key Indicators into their daily operations and performance monitoring as they recognize its value. Although Key Indicators is now being used institutionally and regionally, the Bureau's long-term goal is for all wardens and associate wardens to be familiar with its capabilities and its integral relationship to the Internal Control process.

Future KI/SSS Applications and Developments

In an article on the future of Federal corrections, former BOP Director Quinlan (1989) underscored the need of the Bureau:

> . . . for monitoring our own performance. Public accountability in the information age means more than answering our mail. It means developing sophisticated feedback mechanisms to measure how well our programs work, allow for midcourse corrections and provide a solid database so that we can manage better.

The development of a centralized internal control process combined with the Key Indicators System, which provides the feedback to Bureau managers, has provided the Bureau with the tools to monitor performance in a comprehensive and systematic manner.

Since 1988, when Key Indicators was piloted, the Bureau has expanded the system to each of its institutions, the regional offices, the central offices and the executive staff. Today, all institutions receive the Key Indicators disk on a monthly basis and, in varying degrees, are incorporating its use into the management of their daily operations and in monitoring institutional performance levels. With the assimilation of the Internal Control Process and the Key Indicators System into Bureau operations, Bureau staff are now looking at additional uses for KI/SSS.

Review by Need

A long-term goal of the Program Review Division is to implement what were originally intended as "long-distance reviews." Currently, program reviews are conducted every two years for each of the 15 disciplines at the Bureau's 70 institutions. Each review requires an onsite visit by several PRD staff, and costs include travel and per diem, in addition to salaries. The Bureau projects an increase in offender population and several new institutions to accommodate this growth. Despite growth, the PRD does not expect to add new staff or resources to monitor institutional performance.

As the Program Review process has become part of institutional and regional operations, the review function has evolved from the concept of the "long-distance review," supported by Key Indicators, into a "review by need" strategy. Fewer onsite visits with reduced staffing levels has resulted. Program reviews may be moved back an additional year (to three years) if a facility retains good or superior ratings and has no major problems. Existing internal controls combined with the ongoing development

of Key Indicators are intended to provide a basic model for monitoring institutional performance in the Bureau well into the next century.

Module Enhancements

Several modules have been added to KI/SSS to further enhance its usefulness to Bureau managers. The Executive Staff Module is an example. The Warden's Quick Menu Module, which groups together those items identified by wardens as important factors to monitor, is an example of a group-specific enhancement. Modules for departmental level staff and by program discipline are now being considered. To complement the model enhancements, Bureau staff regularly hold training seminars and Key Indicator orientation sessions for Bureau management. ORE and Program Analysis staff continually work to develop meaningful reports and displays to encourage staff participation. With central office analysts acting as consultants, Bureau managers not only identify which tools they need, but they also help design their format, what they should measure, how they should perform, and what they should produce (Rausch, 1991). By joining into a partnership with field managers and executive staff, Bureau analysts have developed a process that will help integrate Key Indicators into the regular operations of the Bureau.

Implications for a Proposed Internal Control Review Model

Over the past four years, the BOP has implemented a comprehensive and integrated internal control review process. It is based on a well-defined needs assessment, a structured and defined program review capability of key program indicators and a sophisticated computerized feedback system which provides information used to monitor institutional and program performances. The development of this system would have been impossible without several critical factors which, taken in their totality, have led to this sophisticated performance monitoring process.

The BOP is a unique correctional system, notable for the wide geographical area for which it has responsibility and the number of institutions it has under its jurisdiction. Because of this, there has been a long tradition of strong central control and direction to the field units. This is particularly true in the development of the Bureau's internal control process. Although many state and local correctional systems lack the BOP's strong centralization, there are several factors which have contributed to their success in the development and implementation of a model internal control process.

Illinois Department of Corrections

The Illinois DOC management information system has 15 components that are used to track operations. These MIS operations are not specifically linked to audit functions at this time. Discussions with fiscal audit personnel did not reveal an intensive linkage to the electronic data processing (EDP) system, although audit personnel did have input into the design phase of their Budgetary Accounting Reporting System (BARS). Also, audit staff have the same access to the system as others in the department and have begun to develop an audit point tracking system. As with most such systems, the EDP system was designed to supply information for management purposes. While most of the system relies on a mainframe computer operated by Central Management Services (CMS), some aspects of it are restricted to personal computers.

Priorities in system development have been established, which are similar to those for other systems. Development of this system followed a familiar historical order, beginning with the Offender Tracking System (OTS), Automated Inmate Trust Fund System (or "TFS"), and the Budgetary Accounting Reporting System. Other components have developed as resources permitted. There is a plan for expanding and improving MIS services when the necessary resources become available.

The Illinois system was implemented over a five to six year period at a cost of $7 to $8 million. It was developed after a needs analysis. MIS applications exist in the three major areas of concern: operations support, direct service, and population summaries.

Operations Support

Fiscal

The fiscal system is critical to operations support. Foremost in their financial systems is the Budgetary Accounting Reporting System, an automated system (CICS COBOL) that tracks expenditures from requisition to payment. It allows on-line inquiries from correctional centers and the central office. It is table-driven. The Payroll System and a related sub-system is operated by the Department of Mental Health and Developmental Disabilities.

A Budget Development and Tracking System is used by business administrators and budget services staff in filling out various forms necessary to the budget process. It is PC-based, using an IBM PC XT or compatible. COBOL and Lotus 1-2-3 software function together to provide file security and simplification of use. In addition to the Automated Inventory Management System (AIMS) there is a Keys and Locks Control System (KALC). This PC-based security system allows key control officers at each facility to determine who has access to the facility by users' access levels.

Personnel

The Automated Roster Management System (ARMS) maintains security posts and produces reports for each institution. It provides a daily roster, master roster, seniority lists, and training reports. Additions, changes, and deletions for post and employee data can be done on-line. Computer files include two IMS-related databases each containing 7,500 records. Systems have been established for affirmative action reporting, auditing, and monitoring the hiring process (Automated Freeze Processing System). Systems are in place within the Illinois Central Management Services (CMS) computer system as part of the payroll system that are designed to monitor the hiring process and to track affirmative action hiring. The CMS is described below under the offender tracking system.

Direct Services

The automated Trust Fund System, which tracks inmate accounts at the commissary, has accelerated the commissary (canteen) process and made inmate accounting more accurate. It provides on-line commissary balances. Other functions include general ledger, accounts payable, accounts receivable, transfer/release of inmates, and reports used in reconciliation of offender and general ledger accounts. An audit trail is provided for all general ledger and inmate master lists; there are approximately 100,000 on-line transactions per month. The computer environment consists of approximately 200 CICS command-level COBOL programs, 100 CICS maps, and 50 batch application programs in addition to the standard CICS software. Approximately one million transactions occur per year; 13 system files are key sequenced VSAM files.

An automated Property Control System (PCS) was developed to track equipment, weapons, etc. This system maintains a "hardgoods" inventory at all IDC locations, providing on-line entry, maintenance, and inquiry capabilities. An audit trail is provided for all transactions with a seven year history. VSAM files are accessible on-line; a master file of 100,000 records contains information on all property worth more than $100.

Population Summaries

As noted, the top priority in system development includes the comprehensive Offender Tracking System (OTS), which keeps track of adult inmates. The control, tracking, and reporting system is operated through the state's Central Computer Facility located in Springfield, Illinois (Peters, 1991) and is controlled by Central Management Services (CMS). It was installed in October of 1988 after a three year development period.

Host hardware is an IBM 3090, model 600J. The system is a sophisticated data network with over 850 terminals accessing the centrally stored information and over 70 line printers located at 23 adult institutions. Additional terminals and printers can be added as needed. It uses Computer Associates database management system IDMS/R software in both on-line and batch environments. ADS/On-Line, COBOL II, and Easytrieve Plus are used for program development and maintenance of the database (Peters, 1991).

OTS is used regularly by some 1,500 staff throughout the state. It is supported by a staff of 10 data processing professionals and a help desk of computer information consultants who train end users in the system. All OTS staff are located in the central office (Springfield). Each institution has an OTS coordinator who assists institutional staff and acts as a liaison to central office. The OTS system admits inmates into the system and is used to determine their security classification and reclassification levels. It oversees transfers of records; housing placement; program/assignments changes; tracking of scheduled institutional movements; and writs, bonds, detainers, warrants, and furlough documents. Population counts are maintained by tracking cellhouse changes and movements. Health and dental information is kept in this system. Parole preparation information is kept in the system, which also tracks discharge dates (sentence calculation). The OTS was recently updated to include tracking of gang affiliations and visitor information.

The system provides 350 screens for new data entry, general inquiry, deletion and for changing existing data (updating). Color coding is used to identify data fields that are unprotected or protected; enterable or not; and errors, messages, and other information necessary to use the system. There are current user manuals explaining screen use and report generation.

There are more than 130 automated and "requestable" reports available to end users, depending on their access level. Automated reports are predefined and produced according to a controlled schedule; daily, weekly, and monthly reports can be generated depending on institution needs. Requestable reports are generally produced overnight, depending on the nature of the request. Specific criteria (e.g., a data range) can be stated in order to control the amount of information generated. Distribution and control involves questions of who receives the report, when it is produced, where it is printed, and the cycle of production.

Access security applies to screens and reports. A departmental User Design Committee develops user profiles that control access to security, and determines which screens and reports will be available to the OTS user. Every user may access at least four screen types: add, change, delete, or inquiry. Inmate data can be accessed by users at parent institutions, inmate locations (parole offices, community facilities, etc.), and central office. Major system enhancements for the future include tracking disciplinary actions, institution shakedowns, escape information, and personal property.

Summary

The OTS is designed to benefit institution and central office personnel in many ways. Most importantly, it assists in classification and reclassification by providing on-line access to an inmate's disciplinary history, movement, and "keep separate" status. Automated scheduling assists in seeing that medical and dental examinations and reclassifications are not missed due to personnel or inmate transfers. Assignments, transfers, and reclassification activities can be validated in the system. Assistance is

provided for incident investigations by having movement histories, which are also helpful in summarizing inmate activities, such as the numbers of inmates who have entered the hospital or used the law library.

Central office staff can account for inmates from entry to discharge, including community correctional center and parole populations. Also, projections of inmate population are enhanced through the use of available 'length of stay' data. The reporting system reduces the amount of time required to summarize offender data in evaluating classification and reclassification systems, recidivism rates, and proposed legislative or procedural changes. The system provides a "compliance report" for the internal audit group to assist in their audits of institutions.

Disciplinary tracking and incident reporting systems planned for the future will enhance the ability to identify trends in attacks on staff, contraband seizures, and property damage in order to take corrective action. These types of information are also useful in defending against inmate lawsuits.

Computerized Investigation Systems

Illinois has two computerized investigation systems for incident and crime reporting. These are the Composite Listing of Incidents and Crimes (CLIC) and the Institution Listing of Incidents and Crimes (ILIC). They provide departmental investigators with a current updated file of all investigations at IDC since 1982. Inquiries can be made into either system. Security regarding access is set by each institution. Both systems have on-line editing, updating, and inquiry capabilities, and several weekly batch reports are available. These are IDMS/R database systems that run on IBM 3090 MVS and IBM 9377 VM computers.

A safety, maintenance, and sanitation system runs on individual PCs, as does an internal communication system using microcomputer technology that assists in communicating information between departments. Systems designed to review the auditing system, referred to as an "audit analyzer" and an "audit tracking system," have fallen into disuse.

The Audit Function

In Illinois, performance auditors and fiscal auditors performed separate functions and were in different units at the time of the study. They are now combined into one unit with expanded responsibilities. American Correctional Association accreditation audits are conducted in Illinois, one of the first states to be involved in correctional accreditation. Performance auditors, however, are not always directly linked to the accreditation process, which is carried out by institutions with accreditation managers. More cooperation in this area might have strengthened the organizational position of the performance audit unit (OPA), which was eventually absorbed into the FIA unit.

The attitude of top administration toward performance audits is critical. In Illinois, as in other states, it has shifted over time, moving from a more disciplinary view to a team approach. The disciplinary approach tends to punish managers who fail internal or external audits. The more constructive approach is seen as one that does not seek to discipline managers who fail to comply with audit (or accreditation) standards. Instead, the purpose is to design methods of corrective action. Problems are viewed as organizational problems to be resolved through a team approach. To make the process a constructive one, however, a commitment from the highest level is needed, preferably the director. In some cases, the director or deputy attends audit exit conferences, which enhances the commitment to corrective action.

Automated Systems

The system has an "EDP auditor," but no one on staff is fully qualified in this area, and it was felt that this function should be improved. Computer personnel recommended that auditors should better understand EDP functions. They also saw the split between performance and fiscal auditing as appropriate. In general, automated systems must be designed according to user needs, whether designed

for managers, auditors, or other personnel. A totally integrated system, one that allows on-line access to all sub-systems, may not be necessary. Transferability of information is the goal. Systems must be compatible to allow aggregation where necessary.

New Jersey Department of Corrections

The New Jersey Department of Corrections (NJ DOC) has two primary computer systems for processing critical inmate and administrative computerized functions: the Offender Based State Correctional Information System (OBSCIS) and the S/36 Corrections Management Information System (CMIS). These systems were designed to serve management functions and provide sufficient data for use in other types of performance review systems. The following is an overview of each system.

Offender Based Correctional Information System

In 1976, the NJ State Systems and Communications Data Center designed, developed and implemented OBSCIS for the then-Division of Corrections and Parole. This system tracks offenders from admission date through the date of discharge from parole supervision in the community. It provides information on the identification, location, and status of 50,000 inmates and parolees. The data is used primarily for planning and budgeting. The Office of Telecommunications and Information Systems, NJ Department of the Treasury, runs OBSCIS on its mainframe system and provides all the support, maintenance and network services for its operations. Presently, there are more than 100 terminals and printers linked to the OBSCIS network, and more than 200 DOC employees regularly use the system. During the 1991 fiscal year, the system completed over one million "look-ups" for identification, location, and status of offenders.

OBSCIS was designed to collect sentencing and characteristic information at the time of admission only and was unable to provide direct support for daily operations of the institution. While admissions and current status data provide sufficient support for long-term planning and budgeting functions, they do not meet staff needs in such critical areas as classification, banking, commissary, and health and pharmacy functions. As a result of these deficiencies, the NJ DOC developed a new Corrections Management Information System (CMIS) in the mid-1980s in order to support institutional operations.

Corrections Management Information System (CMIS)

In February 1985 the NJ DOC implemented a distributive CMIS system. The new system was developed after a six-month planning effort in 1984 which culminated in the NJ DOC's first five-year data processing master plan. CMIS incorporates the use of 20 IBM S/36 minicomputers: one at each of the Department's 15 major correctional facilities, four at central office headquarters, and one at the prison industries office. The primary purpose of the S/36 CMIS system is to provide day-to-day operational support to the institutions in order to increase their productivity and efficiency and to contain costs. Currently, more than 800 NJ DOC employees use the 695 terminals and printers linked to the CMIS network. Presently, 13 applications are being run at each of the Department's 15 institutional sites. They include:

Inmate Information—Tracks data required by correctional staff for terminal display, regular reports, and ad hoc reports. These reports include release date, conviction data, demographic data, work programs, educational programs, aliases and disciplinary information. The system interfaces with the Inmate Banking, Health Care and Pharmacy applications.

Inmate Banking—Records inmate's monetary transactions, separating personal monies from earnings resulting from work-release assignment. It produces monthly statements for each inmate and reports for

internal affairs identifying potential patterns for contraband transactions. This application interfaces closely with the canteen application.

Canteen/Commissary—Tracks inmate requests for canteen purchases. Automatically rejects items that exceed quantity restrictions, location restrictions and items that cause a negative balance in the inmate's account. Maintains a canteen inventory and automatically debits the inmate's account. Provides a list of items purchased by an inmate that are restricted due to dietary assignments.

Custody Officer Scheduling—Provides a complete working roster of all custody officers, including their shift, division, days off, job assignment and leave schedules. Tracks seven overtime lists to ensure fairness of overtime call-ins according to union contract agreements. This application interfaces with the personnel and time and attendance applications.

Personnel Information—Tracks all data that the Department requires to produce personnel reports, such as leave balance reports, late record listings, absence listings and service award listings. Automatically updates employee records for annual leave accruals and percentage cost-of-living adjustments.

Time and Attendance—Integrates data and information from the custody officer scheduling system and the personnel information application to produce time and attendance reports and exception reports for payroll purposes. On a biweekly basis, provides all time worked and leave statistics to institutional timekeepers for payroll processing.

Fixed Assets—Tracks Departmental assets over $300 and meets the requirements of the NJ Treasury Department's directives for each state agency to maintain records of such assets.

Pharmacy—Tracks inmate prescription orders, provides prescription labels, provides drug contraindication data, and maintains inventory control.

Health—Tracks inmate visits with doctors or nurses, symptoms, diagnosis, prescribed treatment, and appointment control.

Financial Management—Provides accounting control over appropriated accounts, purchase orders and accounts payable.

Materials Management—Maintains inventory controls for all institutional goods, products and supplies.

Training History—Provides firearms training records, qualification and requalification statuses and an automated reschedule notification function. This module is integrated with the Officer Scheduling Module.

Networking—As inmates and/or employees are transferred or reassigned from one facility to another, automatically transfers their computerized record through the HUB S/36 at central office. In addition, S/36 terminals provide access to the state's mainframe applications, including the New Jersey Financial Management System (NJFIS), the Personnel Management Information System (PMIS), and the Management Acquisition and Control System (MACS).

Integration of OBSCIS and CMIS Systems

The Department of Corrections' current 1989-1994 Data Processing Business System Plan recommends an electronic interface from CMIS to OBSCIS and from CMIS to the three state mainframe systems: PMIS, NJFIS, and MACS. Through FY1992, the Department has been unable to secure sufficient funding to provide the electronic linkage and integration of these two critical computer systems. The Department's long-term goal is to integrate these two systems in order to reduce redundant data entry, cut operating costs and eliminate database discrepancies resulting from the maintenance of two distinct databases.

MIS Audit/Program Review Support

The S/36 CMIS system provides data processing support to the 15 major correctional institutions, the prison industries unit and the central office headquarters for 13 applications. The system has standardized institutional operations, improved productivity and reduced administrative costs. However, the CMIS system was not designed to monitor institutional performance or program workload. The lack of uniform performance indicators combined with a decentralized audit/review capability seriously inhibits its use in facilitating the integrated review process. In addition, its inability to generate department-wide reports (planned but not done due to budget cutbacks) also makes the S/36 CMIS unsuit-table for auditing purposes.

Summary of Current System

The NJ Department of Corrections has a decentralized audit/programmatic review capability which spans many different bureaus and organizational units cutting across several different divisions. Generally, the organizational unit responsible for a specific function is the primary agency responsible for auditing that function throughout the entire Department. Financial audits and program reviews are conducted by the Division of Administration, the Division of Policy and Planning, the Division of Adult and Juvenile Institutions, and the Office of Institutional Support Services. In addition to the internal review function within the DOC, financial audits are regularly conducted by agencies outside of the Department, including the Office of Legislative Services (State Auditors Office) and the Office of Management and Budget (OMB) of the State Treasurer's Office. Additional external audits are completed by grant award agencies, including the Department of Education and the Department of Community Affairs.

Federal agencies, including the National Institute of Corrections, National Institute of Justice and the Federal Bureau of Investigation, also complete program reviews. The lack of a centralized internal program review capability within the DOC hinders the development of uniform audit guidelines and policies throughout the Department. The internal control process is also affected by the lack of staff and the relatively low priority accorded it and other service functions, such as training and MIS. These have been supplanted by security and control, housing, health services, and transportation services, functions that address severe crowding problems.

The NJ DOC has two management information systems which facilitate the administration and coordination of services to the offender and parolee populations. The first, OBSCIS, was designed primarily to track offender characteristic information to be used for planning, management and budgeting purposes. OBSCIS is also used to identify, track, and locate the 50,000 offenders and parolees. However, it does not provide direct institutional support for the day-to-day management of correctional facilities.

The S/36 CMIS system became operational in 1985 after a six-month planning effort. It was designed primarily to support direct service functions, such as inmate banking, canteen/commissary, health, pharmacy and inmate classification. There are currently more than 13 applications, and all institutions are networked so that when an inmate or employee is transferred so is the computerized record. Neither system was designed to monitor work performance or management "indicators" that support the audit or

internal review function. The implementation of S/36 CMIS has forced standardization and uniformity of many applications throughout the NJ DOC. However, the existing internal review process in the NJ DOC is too decentralized and underfunded to support a comprehensive and integrated program and financial audit capability. The Department's long-term strategic data processing plan is to integrate OBSCIS and S/36 CMIS in order to reduce costs and increase efficiency. This integration project could be enhanced by adding management performance indicators, which would be the first step in the introduction of the management-by-information philosophy.

Implementation of Original Five Year Plan

As indicated, New Jersey had a five-year plan for the implementation of an information processing system (New Jersey, 1984). The plan called for minicomputers to be installed at each institution, a goal which has been achieved. The original goal of the system was to establish an Inmate Trust Fund Accounting system (basically for commissary purchases and business remits). The long term goal, as indicated in the 1989-1994 Data Processing Master Plan, was to integrate the independently serviced OBSCIS into the system.

The costs of implementing the original five-year plan were estimated to be $8 million for hardware, software, maintenance, training, staff, and consumables (New Jersey, 1984). Actual costs were considerably less at $5.6 million. Staffing requirements included a computer operator and a senior data entry operator at each institution to implement additional specifications. However, of 20 sites, 9 (45%) have a full-time, trained computer operator, who became available through the reassignment of work resulting from the automation effort. Data entry operators were not provided. Seven positions were recommended for central office, which appears to have been exceeded based on the information presented below. The pre-CMIS system consisted of six nonintegrated systems for classification/sentencing tracking, trust fund accounting, food service, preventive maintenance, health/pharmacy, corrections officer scheduling, and central office microcomputer applications.

New Jersey DOC hired an outside firm to design the five-year plan. The contractor spent over six months analyzing prison and central office staff needs, visiting institutions, and interviewing key staff and "interfacing agency" personnel. The firm researched available software packages and visited vendors who would provide system software and hardware. Automation guidelines were designated. The desired outcome was to be able to monitor yearly costs associated with each identified task, including inmate information and inmate banking (New Jersey, 1984). Information was to be used to "operate and manage the institutions and provide greater coordination at the departmental level" (New Jersey, 1984:1-9). The use of the system to monitor or audit performance beyond fiscal applications was not stated as a goal, and, as noted elsewhere, is not yet a current goal.

The Current System

According to the Division Deputy Director, "the greatest benefits of the [CMIS] system are being derived from Trust Fund Accounting, Commissary, and Inmate Information (classification): 'These three applications give us the best value in the system.'" (Wilson, 1991). The greatest benefits are seen as reducing the entry (posting) of information to one entry, tracking funds, inventory, sentence credits, and even writing checks for inmate purchases. Clearly these activities provide an audit trail for management review.

Some parts of the system are becoming antiquated due to lack of funding. A second five-year plan that might have improved the system was not done (New Jersey, 1988). On the field visit it was found that the Department's fiscal management system would not run on the state computer system. The corrections system was originally intended to supplement the State treasury system, not replace it. However, the State Treasury system was found more efficient for managing accounts. The Departmental personnel system may also be improved upon by the state system. Management systems that are not allowed to

develop cannot serve either management or auditing functions. This was true in Utah also, which has plans for a state takeover of many DOC information functions. The advisability of this practice is subject to debate.

System Costs

The original five-year plan established the role of funding support in the success of automation. Cost containment was improved by implementing equipment and hardware applications sequentially, so that experience gained could be applied in the next institution. A pilot phase was completed before implementation, and volume purchases were used to achieve discounts, which proved an advantage in a five-year plan. Staff commitment, management, and training support were essential to the success of the plan.

It is difficult to specify implementation costs for management review and audit systems because many systems have used existing personnel and incurred few additional system costs. Estimates for implementation and staffing requirements in July 1992 are shown in Table 6.

The number of staff users at each location varies from 19 (the Juvenile Medium Security Facility) to 153 (Garden State Reception Center). The total number of end users is about 1,600 persons. The most elusive cost item in the 1992 estimate is training. There has been no major training for MIS personnel for almost five years; most training is done internally. Computer coordinators in each institution and a "hot line" advisor in central office provide technical support for the system.

System Security/Audit Functions

Program authorization codes are used to access the system. A security officer in each institution works with the superintendent to determine who should have master security code access or access to specific applications only (Wilson, 1991). Audit trails identify occurrences of unauthorized access to files. Another type of audit trail is produced by the Canteen/ Commissary module, which monitors inmates on restrictive medical or religious diets. Inmates choose items from a computer list coded by item number, cost, and restrictions. Illegal purchases, such as candy by a diabetic are reported to authorities, who can document the incident to protect against a lawsuit. Also, the system will restrict purchases to the amount of money each inmate has available.

One of the most important functions of the system is keeping track of officer overtime with the Custody Officer Scheduling Module. New Jersey was over budget by $40 million in 1991 for overtime. Timekeeping is also done using the Time and Attendance Module, which has increased the accuracy of this function.

Two basic types of audits of the management information system occur. One is of the system itself, and the second is an audit of data entry for the inmate information module.

System Audit

The system audit looks at computer operations, system security, and hardware controls. About 45% of the audit can be done from central office by accessing records and logs at the various computer installations. Site visits are done in which operations are observed. A major concern is whether the local microcomputer is properly connected to the System 36 central processor in Trenton. The auditor reviews the system service log, which is a record of system service calls and unusual events (such as overrides of initial program loads). The system history is evaluated (log of all system jobs, including job control language) as is the system configuration (operating system definition of devices and programming support). Several additional areas are examined, including various types of system logs, physical site layouts, system and application documentation, and training procedures.

Table 6

New Jersey MIS Costs: First Five-Year Plan

Initial Costs	
Hardware	$1,557,783
Software	1,313,471
Training	133,525
Networking	415,664
Commissary/Trust Fund	105,480
SUBTOTAL	3,525,869
Software Enhancements	506,894
SUBTOTAL	4,032,763
Bureau of Management Information Systems Staff	1,640,000
TOTAL COST	$5,672,763
Optimum Staff Requirements	
Application Specialists	6
Technical Research Development	3
Programmers	2
Microcomputers	3
Computer Operations	2
Auditors	1
Secretary	1
Manager and Assistant	2
TOTAL	20

The review of system security examines physical, communications, and resource security. Every user is identified, and violations of the system (or invalid sign-on attempts) are evaluated. Systems designed to detect misuse are reviewed. Particular attention is given to privileged users and to the consistent assignment of limitations to application-level users. Hardware controls are reviewed through a physical inspection and inventory computer equipment. Hardware maintenance logs are also examined for conformance with contractual obligations and to ensure that service procedures are not used to circumvent security. These audits are ideally conducted once per year, depending on the degree to which each institution is observing proper procedures; however, budget and personnel constraints may preclude annual audits. If central office checks raise inconsistencies in the above operations, it will be subject to a site audit.

Inmate Information System Audits

The second major area of information system auditing is the inmate information system application. The CMIS Inmate Information system is not intended to replace OBSCIS, but was designed to supplement it through the use of day-to-day operational applications. The Department's 1989-1994 data processing master plan (1988) recommended the integration of these two systems.

Problems with the System

Unfortunately, the existing system is almost obsolete and the second five-year plan was not funded. The system is now near capacity and is unable to accommodate data needed for future prison population increases. Because of storage and memory limitations, information cannot be brought into a central computer (mainframe) at one time. To aggregate information at the central office, each of the 15 institutions would have to be downloaded and then analyzed. This is not routinely done.

Budgeting is not currently on the system. Budgeting is done through a "wide area network" (WAN) operating system" at each institution and controlled by the DOC accounting office. The microcomputer-based WAN will assist budgeting and fiscal planning staff in the preparation of their quarterly spending plans, which is an OMB requirement. However, thanks to personal computers and the WAN, fiscal analysts will have a standardized and uniform format for the preparation of the quarterly spending plan for each account and obligation. No system financial information is available on the System 36 at the central office location. Each institutional microcomputer uses the financial management package for monitoring institutional accounts, purchase orders, receipt of orders, late payment notices, and obligations.

The question of centralization of the information function is also routinely raised. The New Jersey DOC is decentralized and the superintendents may wish to keep it that way in order to retain control. However, a good information system requires a degree of centralization, for reasons mentioned above. Central office must be able to quickly aggregate information, for example, on inmate sick days for a legislative request. While the current system allows this to be done in about 48 hours, as opposed to four weeks, a centralized system would provide even greater efficiency. At times, it is necessary to produce reports for the 15 different systems more quickly.

The auditing unit is beginning to see the system's potential and is seeking other types of reports from it. Decisions must be made about what will be done in this area in the future. Limitations on aggregating data at a central location will slow the development of both management review and audit systems. Even with these problems, it is important to realize that the existence of the management information system has begun to standardize language (codes) and procedures within the department and to train staff in the use of automated systems. However, future development depends on fiscal support and the continued dedication of top administrators who see the value in management information for both operational and management review purposes.

Utah Department of Corrections

The management information system is maintained by the Division of Technical Services Automated Systems Bureau. A major revision is now being undertaken with respect to the organization of information services. The present system uses somewhat outmoded equipment designed to provide information through a "corrections network" throughout the institutional and field services system. A recent evaluation of information services and needs has been completed and reveals problems in response time, staffing needs, staff relationships, and technical areas, such as data access. Reorganization will probably involve the operation of a new system by the Division of Information Technology (ITS), an agency outside the Department of Corrections.

The proposed restructuring will involve an in-depth survey of user satisfaction and future needs. This will include an analysis of the information needs of users in executive, administrative, and financial

units. Hardware needs will be assessed. Short and long term plans of action would be formulated. Existing UDC MIS staff would be integrated with ITS staff, merging functions, duties, and responsibilities. ITS would assume full management control over DOC MIS operations.

The present MIS system provides data for the Internal Audit Unit but is not directly linked to the audit function. The existing information systems analysis (a departmental document) does not address the specific needs of various units. As the system changes it is anticipated that the needs of the Internal Audit Unit will become part of the new information system.

CHAPTER X

ADVANCED AUDITING APPLICATIONS

As technology improvements and new management techniques are applied to government functions, the importance of maintaining a reliable, highly skilled program review/internal audit staff becomes increasingly important. The program review/internal audit staff should be prepared to assist the organization in evaluating new technologies and techniques for possible application.

Total Quality Management and Ethics

Definitions

Total quality management (TQM) and "ethics" are two of the most vital topics in business and government today. Osborne and Gaebler (1992) give TQM a prominent place in their book on "reinventing" government that emphasizes performance measurement in relation to results. The major forces in the development of the total quality management concept have been the written works of W. Edwards Deming and the work of the American Society of Quality Control. Deming (1986:23-24) identified the "14 points" of TQM as:

1. A complete, company-wide commitment to quality work in products, services, and relationships.
2. Firms must adopt a new management philosophy, congruent with the new economic realities, and lead in their implementation.
3. Cease dependence on inspection to achieve quality, by building in quality in the first place.
4. Cease awarding business solely on the basis of lowest cost.
5. Constantly improve the quality work system.
6. Institute on-the-job training in quality work.
7. Rely on leadership by persuasion, rather than management by rules.
8. Eliminate management by fear.
9. Break down the artificial barriers between departments.
10. Eliminate management by exhortation; manage by persuasion.
11. Eliminate numerical quotas and management by objective.
12. Remove the barriers that rob personnel of their right to pride of workmanship.
13. Institute a genuine program of education and self-improvement.
14. The transformation to total quality work is everybody's job.

TQM may be described as a management style, a mode of behavior, or an attitude. It is a cultural element deeply ingrained in an organization. It focuses on the process and benefits of continual organizational improvements, from decisionmaking and problem-solving to enhanced communication. It translates into "quality management practices," which represent the effort to develop management practices that will proactively and systematically lead to continuous improvement throughout the full range of organizational activity. Outcome measures are important to this improvement process, as outlined in the research and evaluation sections of this report. They must support the development and application of improved management practices.

Hart (1992:1) addressed both total quality management and ethics issues, indicating that they are based upon "individual beliefs, and require attitude changes in management that are not currently

fashionable. It is interesting to note, however, that the two subjects are not independent to one another but are intimately related."

Deming (1986:97-98) appeared to address both in stressing the importance of avoiding the "Seven Deadly Diseases" that affect organizations:

1. The lack of commitment—genuine commitment—to total quality work.
2. The emphasis upon short-term profits and short-term thinking.
3. The reliance upon performance evaluations, merit ratings, and annual reviews.
4. Management job-hopping.
5. Management's overreliance on visible figures.
6. Excessive medical costs.
7. Excessive costs of liability.

Some of these ideas are not "fashionable," as described by Hart (1992) and may also be contrary to some personnel rules, as with the requirement in some organizations for performance evaluations, merit ratings, and annual reviews.

Applicability of TQM to Government Auditing

Quality certification is a current movement in Europe where ". . . quality certification is becoming an essential condition for doing business with large private enterprises and all sorts of government entities" (Grossi, 1992:33). Stern (1992:22) has summarized the concept by asking the question, ". . . if all employees left tomorrow, would your existing procedures enable the company to meet quality standards?" With direct applicability to government organizations, Stern (1992:24) identified the critical components necessary for obtaining quality certification including:

Documentation. When many companies started investigating compliance they learned many of their procedures were not written down, but executed by individual staff members without proper documentation.

Objective Criteria. Everything must have objective evidence and management must "own up" to operational weaknesses. This is a cultural change for most organizations.

Leadership. Direction from the top of the organization is necessary, as meeting quality standards will encounter resistance if staff felt they were being asked to do too much, were frustrated by paperwork, and were reluctant to make changes.

Internal Audit. One key to gaining quality certification is establishing and maintaining an organizationally independent internal audit function. Vigilant management review ensures that quality processes remain consistent.

Proactive Management. A change in traditional problem-solving techniques is needed. For example, when a certain employee lacked training, the manager would see to it that the situation was remedied. Now if a problem arises with training, the supervisor will put a mechanism in place to ensure that all of his or her employees receive training.

Mission, Goals, and Objectives. Quality is everyone's responsibility within an organization, from the CEO to secretaries. Supervisors ensure that procedures are in place, but everyone plays a role. The employee must know his or her job, be able to describe it, and document

exactly what is accomplished. Managers must know how replacements are trained. Staff should be involved in writing procedures rather than just following instructions.

Grossi (1992:33) has warned that much that is written about TQM is not useful, noting that "Too often, TQM is depicted as some sort of magical, instantaneous remedy for all kinds of 'corporate sickness.'" While quality certification itself is performed by professional organizations, officially empowered by their respective national governments, program review/internal audit staff must acquire a fundamental understanding of total quality management, assess the role and function of program review/internal audit staff as it relates to total quality management, and develop knowledge of the quality certification process. Program review/internal audit staff have a responsibility to assess management's progress toward creating a total quality environment that uses the tools of communication, training, empowerment, team-building, measurement, and benchmarking.

Construction Auditing

Scope of New Prison Construction

Corrections has become a big business nationally. A 1989 survey, with 100% response, found prison construction in the U.S. up 73% from 1987-88; 128,000 new beds were projected for 1989-90 at a cost of over $6.7 billion (Corrections Compendium, 1989:10). Forty-four states were planning or building new prisons, with average costs per bed rising 23.8% from $42,000 in 1987-88 to $52,900 in 1989. The highest reported costs were for California at $1.29 billion for 15,030 beds (Corrections Compendium, 1989). Construction has not slowed down. Just over $2 billion has been set aside for new prison construction in the U.S. in 1993, an average of $43 million per system, with about 83 new facilities to be constructed (Corrections Compendium, 1993). The high rate of correctional facility construction in the United States promises to expand as rapid increases in prison and jail populations cause crowding that can lead to unconstitutional housing practices (Innes, 1986). Operational costs for 49 states, the District of Columbia, and the Federal Bureau of Prisons totaled $21.9 billion for the 1993-94 fiscal year, $10 billion more than five years ago (Corrections Compendium, 1993).

Construction costs must be part of the internal controls program for departments of correction. According to Courtney Thompson (1992), "Overcharges on construction contracts typically run from 1% to 2% of the total job cost. Flaws, waste, and abuse can escalate overcharges to 30% of the total cost or . . . more."

Methods of Controlling Construction Costs

For years private sector corporations and government organizations have controlled construction costs by means of implementing various controls, including audit methodologies. The basic components of effective cost control include an aggressive audit function and, according to Townsend (1992), include the following:

Cost Control Objectives During Various Phases of a Construction Project

Project planning phase
Contract document development phase
Bid/contract award phase
Construction phase
Contract closeout phase

A Multi-Step Approach to Effectively Controlling Construction Costs
Cost Control Roles and Responsibilities-The Owner's Team

Project manager/purchasing authority
Field engineer(s)
Cost analyst/construction accountant
Contract administrator
Outside architect/engineer
Construction auditor

Preventing and/or Detecting Typical Overcharges in Lump-Sum Contracts

Specified construction materials or products not installed
Specified services not rendered
Overstatement of change order proposal
Overstatement of contractor claims

Preventing and/or Detecting Typical Overcharges in Cost-Plus Contracts

Payroll burden overcharges
Labor hours and/or wage rates overstated
Material overcharges
Back charges not handled properly
Equipment rental overcharges
Equipment purchase overcharges
Insurance overcharges
Overcharges by contractors
Accounting errors, duplicate charges, etc.

Bid Document Formal Language to Enhance Cost Controls

Non-collusive bidder certification
Acknowledgment of owner's business ethics policy
Value engineering provisions
Overhead markups on changes

General Contract Language/Provisions to Enhance Cost Controls

Tailoring the contract
Definition of reimbursable costs
Address overtime, delays, and other impact costs
Change order administration

Special Considerations for Time-and-Material Contracts

Establishing proper rates for labor, equipment, etc.
Obtaining adequate documentation on a timely basis

Special Considerations for Unit Price Contracts

Adequate definition of how units will be measured
Monitoring work in progress and/or work in place
Accurately determining quantities

Using Computer Database Applications as Part of the Operational Control System for Cost-Plus and/or Time-and-Material Contracts

Special Cost Control Considerations with Change Orders to Lump-Sum or Guaranteed-Maximum Contracts

Field administration of changes
Obtaining proper documentation
Special contract provisions
Monitoring change order work
Analyzing/auditing change orders

Special Cost Control Considerations with Contractor "Claims"

General claims
Differing site condition claims
Delay and impact claims

The implementation of methods to control construction costs is essential as governmental organizations encounter critical external scrutiny related to expenditures, face shrinking budgets, and experience an increased demand for services.

Fraud Auditing

Both the Comptroller General (1988) and the Institute of Internal Auditors (1989) say that auditors must recognize the characteristics and types of vulnerabilities and potential illegal acts associated with the audit area. Further, auditors should anticipate conditions and activities where irregularities are most likely to occur. "In addition, they should identify inadequate controls and recommend improvements to promote compliance with acceptable procedures and practices" (IIA, 1989:19).

Scope of Fraud and Consequences to the Organization

Fraud is always a concern in external and internal audits, as found in the many recent accounts of fraud in governmental and private sectors. According to Thompson (1992:19-20), "Government entities are exposed to fraud in contracts and grants, and fraud by program recipients, providers, and administrators." Government entities are also influenced by cost overruns on construction projects, as noted earlier. Fraud and the resulting attention by the media and regulators jeopardize the credibility of the organization and its leaders (Thompson, 1992:20).

Organizational Strategies for Fighting Fraud

Two factors are critical to the battle against fraud: an environment that does not tolerate it and executives, managers, operating personnel, and internal auditors who are trained to identify and expose it (Thompson, 1992: 20). In addition to establishing a fraud policy, Thompson (1992: 22) identifies five

steps for fraud detection and four steps for fraud prevention:

FIVE STEPS FOR FRAUD DETECTION

1. Know fraud exposures in specific terms.
2. Know where exposure to fraud may be potentially greatest (e.g., inmate accounts).
3. Be alert for fraud symptoms.
4. Incorporate into routine audits program steps that are likely to reveal fraud symptoms.
5. Follow through on all observed symptoms.

FOUR STEPS FOR FRAUD PREVENTION

1. Improve screening of job applicants, vendors, and contractors.
2. Reduce fraud opportunities.
3. Create an environment where people believe that dishonest acts will be detected—by management, monitoring techniques, other employees, or the auditors.
4. Create an environment where dishonest acts are not tolerated and are punished.

Thompson (1992:23) reports that some internal auditing departments work with management to develop procedures for controlling fraud and its results. This is done by involving management in conducting vulnerability assessments, control self-assessments, or risk assessments. Further:

> Some internal auditors have reported dramatic results from helping management discharge their responsibilities related to fraud...By increasing internal auditing effectiveness, internal auditors can make a positive difference in the fight against fraud.

The best method for educating management on how to prevent and detect fraud may be the use of program review/internal audit staff.

Automation

The use of information technology to support the internal audit function is no longer optional. It is imperative. According to the IIA Research Foundation (1991:3-2):

> Not only is much of the data that the auditor must obtain in electronic format, but data volume and complexity preclude effective review through manual techniques. Furthermore, the overall information systems (IS) environment is rapidly changing.

Internal auditing departments are integrating internal audit and information skills, obtaining assistance from consultants and staff with IS skills, and focusing on training and certification of internal audit staff.

The Role of Reviewers/Auditors

Reviewers/internal auditors should also play a key role in information system development. According to the IIA Research Foundation (1991:1-21):

> Internal auditors should review the systems planning process to ensure the integration of organization and information system objectives. In addition, they should address the process and procedures used to develop and maintain the organization's systems and data. Auditor

involvement in the system development process helps to assure that appropriate controls and security requirements are incorporated during development; that data integrity is maintained throughout the implementation process; and that the resulting system meets management's objectives.

Within the Bureau of Prisons, the Program Analysis Branch (PAB) coordinates analyses of reviews to determine trends and patterns that are both discipline-specific and cross-disciplinary. The PAB is also responsible for assisting program administrators and managers at all levels with the use of information from the Key Indicator Strategic Support System (KI/SSS), the PC-based management tool discussed earlier. Much of the information used in the management assessment process is provided by the PAB.

Within the Illinois Department of Corrections (IDOC), Fiscal Internal Audit (FIA) staff do information system (IS) pre-implementation reviews. The State of Illinois' Fiscal Control and Internal Auditing Act requires internal auditors to conduct pre-implementation reviews for new electronic data processing (EDP) systems and major revisions to existing systems. Reviews ascertain that systems provide adequate audit trails and accountability.

IDOC is currently involved in a project to download the inmate trust fund system from the State's central computer mainframe to PC-based local area networks (LANs) at each correctional center. This new system will also automate commissary operations and accounting, including point of sale inventory control. The scope of the FIA review includes assessing compliance with the IDOC system development standards, the efficiency and effectiveness of the development and change control methodology, and the internal controls of the system itself.

IDOC has purchased the software and is working with the vendor to identify required modifications, establish the hardware configurations, and develop the implementation plan. FIA staff attend weekly status meetings held by the project team, which consists of IS and accounting personnel. An initial version of the software has been installed on a test LAN, and various staff have performed unstructured examinations of the system's functionality and internal controls. A new version of the software incorporating recommended modifications will be installed, and FIA will conduct structured reviews of the functionality and controls before installation of the system at a pilot facility.

The FIA staff doing the pre-implementation review have little EDP expertise. Most of the work involves internal control issues, and auditors use information from the IIA Research Foundation's *Systems Auditability and Control* as audit criteria. Reviewing program code will require the use of a consultant or an IDOC data processing employee not associated with implementation. While the latter option would not guarantee total objectivity, it may be the only economical option. The FIA Chief Internal Auditor stressed that all financial and compliance auditors must understand systems auditability and control concepts. No auditor can function effectively in an automated environment without a basic understanding of how internal controls are implemented in a PC, LAN, or mainframe application.

New Jersey Department of Corrections (NJ DOC) EDP audits are conducted by staff of the Division of Policy and Planning, MIS Bureau. These audits address NJ DOC training and inmate classification, as well as management information systems. The MIS Bureau conducts audits of the S/36 CMIS system at each institution to ensure that the system is being used efficiently and that the proper security precautions are in compliance with DOC guidelines.

When the Utah Department of Corrections contracted to implement an automated system for staff scheduling, management, and personnel cost control the system was reviewed by BIA staff from its inception. BIA staff were involved in the initial training provided by the consultant. Narrow scope audits were conducted on five elements: 1) the specificity and adequacy of the contract with the consultant; 2) the consultant's compliance with the contract; 3) the cost-benefit of implementing the automated staff management system; 4) the sufficiency of implementation efforts within the department, including changes necessitated by establishing and operating a centralized, automated system where there had been decentralization; and 5) the quality of the actual operation of the system in the early phases.

A sample audit program questionnaire pertaining to implementation of an automated system for staff scheduling, management, and personnel cost control is shown in Exhibit 3. It addresses database integrity and related policies and procedures. Exhibit 4 shows audit program questions designed to determine if department policies and procedures pertaining to implementation of the new system have been prepared and are sufficient. These examples are part of the audit of a system installation associated with the purchase of a personnel management and staffing package by the Utah DOC. This system, which was developed by an experienced corrections professional, promised to reduce overtime expenditures based on the following requirements: 1) that personnel deployment be centralized at the division level; 2) that personnel work schedules be developed, operated, and maintained by an automated system that provides a year-to-date relief factor; (3) that control and revisions of staffing patterns be centralized and approved

Exhibit 3

Audit Program Questionnaire

REQUIREMENTS	AUDIT TESTS
Written policy and procedure: 1. Progress toward policy and procedure development.	Documents to be examined: 1. Examine the Division Coordinator's project log.
Other applicable standards: 1. Division database must be established.	Practices to be observed: 1. Is the Division database in place in the Division Coordinators office? 2. Has the information in the database been verified? 3. Do only those authorized make changes in the division database? 4. How often is the database changed? 5. How do changes affect the facility Coordinators? 6. Is the division coordinator receiving reports from the facilities (i.e., data disks to storage)? 7. Can the Division Coordinator manipulate the data files?
Expert opinion: 1. Contractor's guidelines for implementation. 2. Opinion of staff of agencies where implementation has occurred.	Personnel to be interviewed: 1. Division Coordinator

Exhibit 4

Audit Program Questionnaire

REQUIREMENTS	AUDIT TESTS
Written policy and procedure: 1. Department policy and procedure requires that all major areas of operation are addressed in comprehensive, written formal policies and procedures. Also the Steering Committee (agency) is required by the implementation plan developed by the contractor to approve policies and procedures, the facilities users manual and the technical reference manual. Approval was to occur by March 5, 1992. It was then to be forwarded to the consultant for review.	Documents to be examined: 1. Policies and procedures in a general order by March 5, 1992. 2. Review content with contractor to determine if all necessary operations are documented in the General Order.
Other applicable standards: 1. Consultant's guidelines for system implementation, focusing on Steering Committee's responsibility to approve new policy and procedure.	Practices to be observed: 1. Attend Steering Committee and system coordinators meetings as deemed appropriate.
Expert opinion: 1. Implementation plan program requires that all major areas be described in policy and procedure.	Personnel to be interviewed: 1. Institutional Support Services Director to ascertain status; 2. Institutions Director to verify issuance. If not, determine why. 3. Contractor to assist in determining if content of policies and procedures is adequate. 4. Assess whether coordinators are sufficiently familiar with system concepts.

at the division rather than at the facility level; 4) that control and revision of the master roster be centralized and approved at the division level; 5) that the system be used as a budget and planning tool (not required, but strongly recommended); and 6) that relief factor management be centralized and approved for each facility at the division level with the actual relief factor not to exceed a specified level.

Auditors of the Utah Bureau of Internal Audit have also conducted audits of information system functions department-wide. These audits have assessed: 1) short and long-term planning, 2) data processing product purchasing, 3) EDP training, 4) mainframe security, 5) operating logs, 6) tape libraries,

7) disaster recovery planning, 8) software documentation standards, 9) hardware and software inventory procedures, and 10) surplus practices.

In most work environments today completed work products and massive amounts of vital information are stored on computers. The Utah Department of Corrections Audit Bureau of Internal Audit recognizes this and has been increasing its use of computer-assisted audit techniques (or CAATs). The Bureau uses standard tools, such as word processing and spreadsheets. It also employs a commercially developed PC-based application that analyzes and processes data from databases stored on any size computer, even a mainframe. All that is needed is "read only" access to the data files. The program provides the necessary tools to produce reports directly from the application. Where the data can be written to a file, an auditor can export the data to a spreadsheet, database, or word processing program.

Auditors are not just limited to the existing fields in the database. The application can calculate new fields or create auditor-defined fields based on existing information. It can join two files where there is a common identifier so information can be compared across both files. Even files from two different databases can be joined or compared. This capability has allowed the Bureau of Internal Audit to do audits that compare databases on vendors and victims receiving payments from the Department of Corrections with databases containing information on staff and offenders. Further examples of what the program can do include:

- Counting the number of records in a file or the number of items that meet a particular test. For example, auditors could determine the number of inmates who are housed in a unit who have filed grievances of a certain type within a specified period of time.
- Totalling a field or a number of fields in a file.
- Determining the age of a transaction compared to a specified reference date. This could be used to determine whether inmate disciplinary hearings have occurred in a timely manner.
- Checking sequential order of records and detecting and reporting on gaps, duplicates, or missing numbers. This is important for any items where sequential numbering is a control, including checks, receipts, and transactions records.
- Classifying data based on the value of character or text fields.
- Completing several types of statistical analyses on a file.
- Selecting samples from a population for field testing. This population can be based on an exception condition, such as offenders who have not had file action since a particular point in time.

Conclusions

This report has addressed the importance of program review/internal audit systems for U.S. correctional agencies and facilities. Findings have applicability to all government organizations. A model program review/internal audit system has been presented in order to provide a reference for administrators who plan to incorporate the review/audit process into their overall system of internal controls. Program review/internal audit procedures from several correctional agencies have been documented, including the Federal Bureau of Prisons, Illinois, New Jersey and Utah. A multi-state audit procedure used in Oregon, Washington, and Idaho was also documented. An overview of evaluation procedures that can be used to monitor the success of the review process has been provided. A major component of the project has been to provide methods by which corrections managers can identify and assess risk, including

a method for scoring correctional system performance and setting priorities for improvement. The final chapter has presented advanced audit applications, including total quality management, fraud auditing, and the role of automation in the future of program review. These program review/audit procedures can be adapted to various correctional operations and contribute to a general improvement in performance.

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APPENDIX A

Statutes

The Institute of Internal Auditors, August 1992 Draft of Model Internal Audit Legislation for State Governments

New Jersey Statute for State Auditor

THE INSTITUTE OF INTERNAL AUDITORS

AUGUST 1992 DRAFT OF

MODEL INTERNAL AUDIT LEGISLATION FOR STATE GOVERNMENTS

This model internal audit legislation, authored by Sam M. McCall, Deputy Auditor General of Florida, was developed to assist states in considering and implementing an internal audit function, thereby enhancing audit effectiveness and accountability in state government. It is patterned after comprehensive legislation enacted in Florida, Illinois, and Texas; and is designed to provide each state the flexibility to structure an internal audit function that meets its individual needs. This draft was developed and then enhanced with survey results from all members of the National State Auditors Association, internal audit directors, and others in each state that would have a direct interest in the proposed legislation. It has been approved by the Government Relations Committee and is currently being reviewed by the Professional Issues Committee and the Internal Auditing Standards Board. If any changes are to be made, a final version of the model legislation will be made available in November 1992.

Citation of the Act

This Act shall be known and may be cited as the (name of State) internal Audit Act.

Purpose

The purpose of the Act is to establish a full-time program of internal auditing to assist in improving agency operations. The agency internal audit director shall furnish independent analyses, appraisals, and recommendations concerning the adequacy of each state agency's system of internal control, and the efficiency and effectiveness of agency management in carrying out assigned responsibilities in accordance with applicable laws, rules, and regulations. The internal auditing program shall promote the establishment of controls necessary to accomplish agency goals and objectives at reasonable costs. The agency internal audit director shall be alert to the possibility of abuse or illegal acts, errors and omissions, and conflicts of interest.

Definitions

(a) "State agency" means each executive or judicial branch agency, board, or commission created pursuant to law, and also includes each state university.

(b) "Agency head" means the Governor, a Cabinet officer, an elected official, an agency secretary, an executive director, or a governing board or commission.

(c) "Agency internal audit director" means the person appointed by the agency head to direct the internal audit function for the state agency. Where consistent with responsibilities described in this Act, the term agency internal audit director may also be referred to as inspector general, audit director, chief auditor, or similar internal audit administrator descriptions.

Note: The above is an example definition of the term "agency" and "agency head." Each state should define these terms to comply with law and the organizational structure in the affected state.

Applicability of the Act

Any Agency meeting one or more of the following criteria shall establish an ongoing program of internal auditing:

(a) The agency has an operating budget exceeding (Ex. $10-$50) million annually.

(b) The agency has a staff of more than (Ex. 100-500) employees.

(c) The agency receives and processes collections in excess of (Ex. $3-25) million annually.

(d) The agency administers programs that the agency head considers high risk and essential to the safety, health, and welfare of the state, and which can therefore justify an ongoing program of internal auditing.

Note: Each state should set its own threshold for establishing a required internal audit function.

Appointment of Agency Internal Audit Director, Staffing, and Location of Audit Organization

Each state agency shall employ an agency internal audit director who shall be appointed by the agency head. The agency head shall ensure that the Director is allowed to employ a sufficient number of professional and support staff to implement an effective program of internal auditing. Compensation, training, job tenure, and advancement of internal auditing staff shall be based upon merit. The internal audit organization shall be located outside the agency's staff or line management functions or units subject to audit, and shall be free of operational and management responsibilities that would impair the ability to make independent audits of any aspects of the agency's operations.

Note: As an alternative, a state may prefer to structure an internal audit function under one central internal audit organization. The central internal audit organization could also provide internal auditing services to smaller agency organizations that have a need for internal auditing services, but are not large enough to support a full-time audit staff. A centralized internal audit function may be more efficient and may be more consistent in providing broad audit coverage for the state as a whole. However, such structure may not promote a detailed understanding of each agency program or be responsive to the needs of the agency head or the agency. The benefits of a central internal audit organization for the state as a whole versus an internal audit function for each agency should be carefully considered. Additional state internal audit organizational structures are possible. For example, some states may want to establish a central internal audit organization to meet the oversight needs of the Governor, and may also want to allow individual agencies to employ an agency internal audit director. Care should be taken to ensure that the structure of the internal audit function provides adequate audit coverage and is responsive to the needs of the organization.

Professional Qualifications

The agency internal audit director shall possess the following qualifications:

(a) A bachelor's degree from an accredited college or university and (Ex. 5 to 8) years of progressively responsible professional auditing experience as an internal auditor or independent postauditor, electronic data processing auditor, or any combination thereof. The auditing experience shall be at a minimum consist of audits of units of government or private business enterprises, operating for profit or not for profit; or

(b) A master's degree from an accredited college or university and EX. 4-7) years of progressively responsible professional auditing experience as an internal auditor or independent postauditor, electronic data processing auditor, or any combination therefor; or

(c) A certified internal audit certificate issued by the Institute of Internal Auditors and (Ex. 4-7) years of progressively responsible professional auditing experience as internal auditor or independent postauditor, electronic data processing auditor, or any combination thereof.

Note: Some states may consider allowing one or more of the following:

1. A certificate as a certified public accountant,
2. A certificate as a certified information systems auditor, or
3. A certificate as a certified management accountant.

Duties of the Agency Internal Audit Director

The agency internal audit director shall:

(a) Report directly to the agency head or deputy agency head through the audit committee.

Note: A state may prefer the Director report only to the agency head. Government Auditing Standards allow the Director to also report to the deputy agency head; however, a state may require a higher level of reporting.

(b) Conduct financial, compliance, electronic data processing, and performance audits of agency programs, activities, and functions and prepare audit reports of findings.

(c) Review and evaluate internal controls over the agency's accounting systems, administrative systems, electronic data processing systems, and all other major systems necessary to ensure the fiscal and administrative accountability of the state agency.

(d) Develop long-term and annual audit plans to be based on the findings of periodic documented risk assessments. The plan shall show the individual audits to be conducted during each year, and the related resources to be devoted to each of the respective audits. The audit plan shall ensure that internal controls are reviewed on a periodic basis. The plan shall be submitted to the agency head and the audit committee for comment. A copy of the approved plan shall be available upon request to the state auditor and/or legislative auditor or other appropriate external auditor to assist in planing and coordination of any external financial, compliance, electronic data processing, or performance audit.

(e) The scope and assignment of the audits shall be determined by the agency internal audit director; however, the head of the agency may at any time request the agency internal audit director to perform an audit of a special program, activity, function, or organizational unit.

Applicable Professional Standards

(a) Audits shall be conducted in accordance with the Standards for the Professional Practice of Internal Auditing published by the Institute of Internal Auditors, Inc., and, when required by law, regulation, agreement, contract, or policy, in accordance with Government Auditing Standards issued by the Comptroller General of the United States. All audit reports issued by internal audit staff shall include a statement that the audit was conducted pursuant to the appropriate standards.

Working Papers

(a) Audit working papers and reports shall be public records to the extent that they do not include information which has been made confidential pursuant to law.

Note: Some states may prefer that working papers not be a public records, or at least, not be a public record until the audit report is released. Each state should consider the needs of the internal audit function and its public records law requirements.

(b) When the agency internal audit director or a member of his/her staff receives from an individual a complaint or information protected by whistleblower or other legislation, the name or identity of the individual shall not be disclosed without the written consent of the individual, or unless required by law or judicial processes.

(c) The director and the internal audit staff shall have access to all personnel and any records, data, and other information of the state agency deemed necessary to carry out assigned duties. The agency internal audit director shall maintain the confidentiality of any public records that are made confidential by law, and shall be subject to the same penalties as the custodian of those public records for violating confidentiality statutes.

Reporting

(a) At the conclusion of each audit, the agency internal audit director shall submit preliminary findings and recommendations to the person responsible for supervision of the program, activity, function, or operational unit being audited who shall respond in writing to any findings of the agency internal audit director within (Ex. 15-45) working days after receipt of the findings. Such response and, if necessary, the agency internal audit director's response shall be included in the final audit report.

(b) The agency internal audit director shall submit the final report to the head of the agency and the audit committee. The report shall be provided upon request to any applicable legislative, executive, or judicial branch oversight body, appropriate state and/or legislative auditor, or other external auditor. The report shall be distributed to the extent authorized by law.

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Follow-Up on Issued Reports

(a) No later than EX. 4-12) months after a financial, compliance, electronic data processing, or performance audit is issued, the agency internal audit director shall issue a follow-up report to the agency head and audit committee. The follow-up report shall address the status of corrective actions reported to the director by the agency manager responsible for supervision of the program activity, function, or organizational unit audited.

(b) The agency internal audit director shall submit the follow-up report to the head of the agency and the audit committee. The follow-up report shall be provided upon request to any legislative, executive, or judicial branch oversight body, appropriate state and/or legislative auditor, or other external auditor.

Action on Findings

(a) The state and/or legislative auditor or other external auditor, in connection with independent postaudits of the same agency, shall give appropriate consideration to internal audit reports and the resolution of findings therein.

(b) Appropriate legislative committees may inquire into the reasons or justifications for failure of the agency to correct the deficiencies reported in internal audits.

Professional Development

(a) The agency head shall make available to the director adequate resources to ensure the professional development and continuing professional education of internal audit staff.

(b) The internal audit director and the state and/or legislative auditor shall cooperate in the exchange of technical assistance and access to current information concerning audit techniques, policies and procedures.

Quality Control

(a) Each agency internal audit organization shall have an external quality control review at least once every three years to determine compliance of issued reports with current Standards for the Professional Practice of Internal Auditing and/or, if appropriate, Government Auditing Standards. The review shall be performed by qualified persons who are independent of the organization and who do not have a real or apparent conflict of interest. The report issued on the external quality control review shall be a public record to the extent authorized by law.

Audit Committee

(a) An audit committee shall be established to monitor the activities of the agency internal audit organization. The internal audit director shall report to the agency head through the audit committee, and has freedom of access to the agency head to be responsive to specific request, direction, and needs.

Note: In some states it may not be feasible to have an audit committee for every agency. Alternatives would be to have: (1) one audit committee to serve all state agencies; (2) one audit committee to serve agencies whose head is appointed by the Governor, one audit committee to serve the agency of each elected officer (Treasurer, Attorney General, etc.), and one audit committee to serve agencies whose head is appointed by the Governor and Cabinet; or (3) some other audit committee arrangement based upon each states' unique organizational structure.

(b) The audit committee shall:

(1) Be composed of individuals who are external to the organization's management structure, and who have the program and/or management expertise to perform the review function effectively.

(2) Carry out oversight responsibilities relating to financial compliance, electronic data processing, performance, and other reporting practices.

(3) Concur in the appointment or removal of the director of internal auditing.

(4) Review the annual internal audit plan and budget, internal and external audit reports, follow-up reports, and quality assurance reviews.

(5) Periodically meet with the agency internal audit director to discuss pertinent matters, including whether there are any restrictions on the scope of audits.

(6) Not be compensated for services provided. However, they shall be reimbursed for travel expenses in accordance with authorizing law.

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State Interagency Internal Audit Forum

(a) A State interagency internal Audit Forum shall be established and composed of agency internal audit directors. The purpose of the Forum will be to promote the exchange of communication, to develop training programs, to share audit techniques and approaches, and to address ways to improve agency operations and systems of internal control. The Forum will elect officers from its membership and shall meet periodically throughout the year.

Annual Report

(a) Within (Ex. 60-180) days after the end of each fiscal year, the agency internal audit director shall issue an annual report which separately lists audit reports issued, and other activities completed or in progress at of the end of the fiscal year. The annual report shall describe accomplishments of the internal audit activities. Copies of the report shall be provided to the Governor, the agency head, and the audit committee. The annual report shall be provided upon request to any legislative, executive, or judicial branch oversight body, and to the appropriate state and/or legislative auditor, or other external auditor.

New Jersey Statute for State Auditor

52:24–4. Auditing accounts and reports of "accounting agencies"; assistance

It shall be the duty of the State Auditor to conduct post-audits of all transactions and accounts kept by or for all departments, offices and agencies of the State Government, to report to the Legislature or to any committee thereof and to the Governor, and to the Executive Director of the Office of Legislative Services, as provided by this chapter and as shall be required by law, and to perform such other similar or related duties as shall, from time to time, be required of him by law.

The State Auditor shall personally or by any of his duly authorized assistants, or by contract with independent public accountant firms, examine and post-audit all the accounts, reports and statements and make independent verifications of all assets, liabilities, revenues and expenditures of the State, its departments, institutions, boards, commissions, officers, and any and all other State agencies, now in existence or hereafter created, hereinafter in this chapter called "accounting agencies." The officers and employees of each accounting agency shall assist the State Auditor, when and as required by him, for the purpose of carrying out the provisions of this chapter.

Amended by L.1948, c. 29, p. 90, § 2; L.1971, c. 211, § 14; L.1979, c. 8, § 29.

Historical Note

Source: L.1933, c. 295, § 4, p. 793.

The 1948 amendment added first paragraph; and, in first sentence of second paragraph, substituted "post-audit" for "audit".

The 1971 amendment inserted "and to the executive director of the Office of Fiscal Affairs" in first paragraph; and inserted "or by contract with independent public accountant firms" in second paragraph in first sentence.

Supersedure of inconsistent acts and effective date of L.1971, c. 211, see Historical Note under § 52:11–43.

The 1979 amendment, in the first paragraph, substituted "Office of Legislative Services" for "Office of Fiscal Affairs"; and, in the second paragraph, twice substituted "chapter" for "article".

Effective date of 1979 amendment, see Historical Note under § 52:11–54.

Cross References

Additional duties of state auditor, see §§ 52:11–62, 52:11–63.

Library References

States ⇐73 et seq., 121 et seq.
C.J.S. States §§ 130 to 136, 140, 203, 223.

Notes of Decisions

1. Construction and application

The conduct and examination of post-audits of the office of State Treasurer is under the exclusive supervision and control of state auditor. Atty.Gen.F.O. 1949, No. 12.

52:24–4.1. Hazardous discharge fund; annual audit

The State Auditor shall conduct an annual audit of the "Hazardous Discharge Fund" created pursuant to the "Hazardous Discharge Bond Act," P.L.1981, c. 275. This audit, together with any recommendations on practices or procedures to promote or guarantee the fiscal integrity of the "Hazardous Discharge Fund," shall be submitted to the Governor and the Legislature, and to the Assembly Agriculture and Environment Committee and the Senate Energy and Environment Committee, or their designated successors. The audit shall be due on or before December 31 of each year.

L.1982, c. 30, § 1, eff. April 30, 1982.

Historical Note

Title of Act:

An Act concerning certain State audits and supplementing chapter 24 of Title 52 of the Revised Statutes. L.1982, c. 30.

Library References

States ⇐73, 127.
C.J.S. States §§ 130 to 136, 140, 228.

52:24–4.2. Annual audit; submission; due date

The State Auditor shall conduct an annual audit of the fund, pursuant to the provisions of chapter 24 of Title 52 of the Revised Statutes. This audit, together with any recommendations on practices or procedures to promote or guarantee the fiscal integrity of the fund, shall be submitted to the Governor and the Legislature, and to the General Assembly Agriculture and Environment Committee and the Senate Energy and Environment Committee, or their designated successors. The audit for fiscal year 1981 shall be due within 60 days of the effective date of this act, and each successive annual audit shall be due on or before December 31.

L.1982, c. 32, § 1, eff. April 30, 1982.

Historical Note

Title of Act:

A Supplement to the "Spill Compensation and Control Act," approved January 6, 1977 (P.L.1976, c. 141; C. 58:10–23.11 et seq.). L.1982, c. 32.

APPENDIX B

Audit Standards

Summary of "STANDARDS FOR AUDIT OF GOVERNMENT ORGANIZATIONS, PROGRAMS, ACTIVITIES AND FUNCTIONS," 1988 Revision, General Accounting Office (GAO)
[Attachment B to Bureau of Prisons Program Statement 1210.12]

Summary of General and Specific Standards for the Professional Practice of Internal Auditing, Institute of Internal Auditors

Summary of
"STANDARDS FOR AUDIT OF
GOVERNMENT ORGANIZATIONS, PROGRAMS,
ACTIVITIES AND FUNCTIONS"
1988 Revision
General Accounting Office (GAO)

GAO auditing standards are divided into five categories. Bureau of Prisons program review procedures shall comply with these standards. General standards apply to program and financial program reviews. The American Institute of Certified Public Accountants (AICPA) has issued standards that are applicable to and generally accepted for financial audits. The AICPA standards for field work and reporting have been incorporated into GAO standards.

General Standards (A - D)

Field Work Standards for Financial Audits (E - G)

Reporting Standards for Financial Audits (H - M)

Field Work Standards for Performance Audits (N - R)

Reporting Standards for Performance Audits (S - W)

General Standards:

A. Qualifications - The staff assigned to conduct the audit should collectively possess adequate professional proficiency for the tasks required. The audit organization must ensure that the audit is conducted by staff who collectively have the knowledge and skills necessary for the audit to be conducted. These qualifications apply to the knowledge and skills of the audit organization as a whole and not necessarily to every individual auditor. To meet this standard, the audit organization should have a continuing education and training program. Auditors should have a knowledge of auditing techniques, government organizations, appropriate communication skills, and for financial audits, proficiency in accounting principles.

B. Independence - In all matters relating to the audit work, the audit organization and the individual auditors, whether government or public, should be free from personal and external impairments to independence, should be organizationally independent, and should maintain an independent attitude and appearance. Independence must be maintained so that opinions, conclusions, judgments, and recommendations will be impartial and will be viewed as impartial by knowledgeable third parties.

C. Due Professional Care - Due professional care should be used in conducting the audit and in preparing related reports. Applicable auditing standards must be followed to the extent possible. When standards are not able to be followed, reasons must be documented in the scope section of the audit report.

Good professional judgment must be used when conducting the audit, assessing findings, and preparing the audit report. Appropriate follow-up on findings from previous audits must be accomplished to determine whether corrective actions have been taken. Timeliness must be followed as required by policy, and sensitive information must be safeguarded. Auditors should attempt to remove any audit scope impairments which restrict the ability to render objective opinions and conclusions. Failing that, auditors should disclose the impairment in the scope section of the report.

D. Quality Control - Audit organizations conducting government audits should have an appropriate internal quality control system in place and participate in an external quality control review program. The internal quality control system should provide reasonable assurance that the organization has established and is following adequate audit policies and procedures and is following applicable auditing standards. An external quality control review of the organization conducting audits should be completed at least once every three years by an organization not affiliated with the audit organization.

Field Work Standards for Financial Audits - AICPA standards of field work for financial audits are incorporated herein. AICPA standards are not restated. This section prescribes supplemental standards of field work needed to satisfy the unique needs of government financial audits.

E. Planning - All levels of government planning should include consideration of the audit requirements. Audit objectives should satisfy legal and regulatory needs of potential users. A test of compliance should be accomplished with applicable laws and regulations. Audit steps and procedures should be designed to provide reasonable assurance of detecting errors, irregularities and illegal acts that could have a direct and material effect on the financial statement amounts or the results of financial related audits. The auditor should also be aware of the possibility of illegal acts that could have an indirect and material effect on the financial statements or results of financial related audits. Due professional care and caution should be exercised in audit steps and procedures relative to illegal acts, so not to interfere with potential future investigations.

F. Evidence - A record of the auditor's work shall be retained in the form of working papers. Working papers are the link between field work and the auditors' report.

Financial audit working papers should:

* contain a written audit program cross-referenced to the working papers;

* contain the objective, scope, methodology and results of the audit;

* contain sufficient information so that supplementary oral explanations are not required;

* be legible with adequate indexing and cross-referencing, and include summaries and lead schedules, as appropriate;

* restrict information included to matters that are materially important and relevant to the objectives of the audit;

* contain evidence of supervisory reviews of the work conducted.

G. Internal Control - A sufficient understanding of the internal control structure is to be obtained to plan the audit and to determine the nature, timing and extent of tests to be performed.

Reporting Standards for Financial Audits: AICPA reporting standards are incorporated herein. They are not restated. Supplemental standards of reporting are prescribed to satisfy the unique needs of government financial audits.

H. Statement on Auditing Standards - A statement should be included in the auditor's report that the audit was conducted in accordance with generally accepted government auditing standards. This statement should be qualified in situations where an auditor did not follow an applicable standard (unless the standard was not applicable to the audit and therefore not followed). In these situations, auditors should modify the statement to disclose, in the scope section of the report, the applicable standard that was not followed, the reason therefor and the known effect not following the standard had on the results of the audit.

I. Report on Compliance - Auditors should prepare a written report on their tests of compliance with applicable laws and regulations. This report, which may be included in either the report on the financial audit or a separate report, should contain a statement of positive assurance on those items which were tested for compliance and negative assurance on those items not tested. It should include all material instances of noncompliance, and all instances or indications of illegal acts which could result in criminal prosecution.

J. Report on Internal Controls - Auditors should prepare a written report on their understanding of the entity's internal control structure and the assessment of control risk made as part of a financial statement audit, or a financial related audit. This report may be included in either the auditor's report on the financial audit or a separate report. The auditor's report shall include at a minimum: (1) the scope of the auditor's work in obtaining an understanding of the internal control structure and in assessing the control risk, (2) the entity's significant internal controls or control structure, including the controls established to ensure compliance with laws and regulations that have a material impact on the financial statements and results of the financial related audit; and (3) the reportable conditions,

including the identification of material weaknesses, identified as a result of the auditor's work in understanding and assessing the control risk.

K. Reporting on Financial Related Audits - Written audit reports are to be prepared giving the results of each financial related audit.

L. Privileged and Confidential Information - If certain information is prohibited from general disclosure, the report should state the nature of the information omitted and the requirement that makes the omission necessary.

M. Report Distribution - Written audit reports are to be submitted by the audit organization to the appropriate officials of the organization audited and to the appropriate officials of the organizations requiring or arranging for the audits, including external funding organizations, unless legal restrictions, ethical considerations, or other arrangements prevent it. Copies of the reports should also be sent to other officials who have legal oversight authority or who may be responsible for taking action and to others authorized to receive such reports. Unless restricted by law or regulation, copies should be made available for public inspection.

Field Work Standards for Performance Audits:

N. Planning - Work is to be adequately planned. This includes defining audit objectives and planning how they can be attained while establishing a balance between audit scope, time frames and staff-days to be spent to ensure optimum use of audit resources. Planning is important in performance audits because the methodology and implementing steps and procedures employed are varied and complex. Staff planning should include assigning staff with appropriate skills and knowledge, assigning an adequate number of experienced staff and supervisors and provisions for on-the-job training. Written audit programs should be prepared which provide a description of the methodology and audit steps and procedures to be accomplished, a systematic basis for assigning work to supervisors and staff, and the basis for a summary record of work.

O. Supervision - Staff are to be properly supervised. Assigning and use of staff is important to satisfactory achievement of objectives. Since skills and knowledge vary among auditors, work assignments must be commensurate with abilities. Proper supervision provides for effective on-the-job training. Staff should be informed not only of the work to be performed, but how they are to proceed, why the work is to be conducted and what it is expected to accomplish. The level of supervision may vary with the level of auditor staff experience. Supervisor review of work performed should be documented in working papers.

P. Legal and Regulatory Requirements - An assessment of compliance with applicable requirements of laws and regulations is required when necessary to satisfy the audit objectives.

Auditors should design the audit to provide reasonable assurance of detecting abuse or illegal acts that could significantly affect the audit objectives. Auditors should be alert to situations or transactions that could be indicative of abuse or illegal acts.

Q. Internal Control - An assessment should be made of applicable internal controls when necessary to satisfy the audit objectives.

R. Evidence - Sufficient, competent, and relevant evidence is to be obtained to afford a reasonable basis for the auditors' judgments and conclusions regarding the organization, program, activity, or function under audit. A record of the auditors' work is to be retained in the form of working papers. Working papers may include tapes, films, and discs and should:

* contain a written audit program cross-referenced to the working papers,
* contain adequate indexing and cross-referencing, schedules and summaries,
* be dated and signed by the preparer,
* be reviewed by a supervisor,
* be complete and accurate to provide proper support for findings, judgments and conclusions, and to enable demonstration of the nature and scope of work conducted,
* be understandable without oral explanations. They should also be complete and concise. Anyone using them should be able to readily determine their purpose, data sources, the nature and scope of the work conducted, and the preparers conclusions.
* be as legible and neat as practicable,
* be restricted to matters that are significant and relevant to the objectives of the assignment.

Reporting Standards for Performance Audits:

S. Form - Written audit reports are to be prepared communicating the results of each government audit. They are necessary to communicate results to officials at all levels of government. Written reports make the results less susceptible to misunderstanding and should be available for public inspection. They also help to facilitate follow-up and determine whether appropriate corrective actions have been taken.

T. Timeliness - Reports are to be issued promptly to make the information available for timely use by management and legislative officials and by other interested parties.

U. Report Contents - The report should:

* include a statement of the audit objectives and a description of the audit scope and methodology;
* include a full discussion of the audit findings, and where applicable, the auditor's conclusions;
* include the cause of problem areas noted in the audit, and recommendations for actions to correct the problem areas and to improve operations, when called for by the audit objectives;
* include a statement that the audit was conducted in accordance with generally accepted government auditing standards, and disclose when applicable standards were not followed;
* identify the significant internal controls that were assessed, the scope of the auditor's assessed work, and any significant weaknesses found during the audit;
* include all significant instances of noncompliance, abuse and all indications or instances of illegal acts that could result in criminal prosecution that were found during or in connection with the audit;
* include the pertinent views of responsible officials of the organization, program, activity, or function audited concerning the auditors' findings, conclusions and recommendations, and what corrective action is planned;
* include a description of any significant noteworthy accomplishments, particularly when management improvements in one area may be applicable elsewhere;
* include a listing of any significant issues needing further study and consideration; and

  include a statement about any pertinent information that was omitted because it is deemed privileged or confidential. The nature of such information should be described, and the basis under which it is withheld should be stated.

V. Report Presentation - The report should be complete, accurate, objective, and convincing, and as clear and concise as the subject matter permits.

W. Report Distribution - Written audit reports are to be submitted by the audit organization to the appropriate officials of the organization audited, and to the appropriate officials of the organizations requiring or arranging for the audits, including external funding organizations, unless legal restrictions, ethical considerations, or other arrangements

prevent it. Copies of the reports should also be sent to other officials who may be responsible for taking action on audit findings and recommendations and to others authorized to receive such reports. Unless restricted by law or regulation, copies should be made available for public inspection.

The Institute of Internal Auditors

SUMMARY OF GENERAL AND SPECIFIC

STANDARDS FOR THE PROFESSIONAL PRACTICE OF

INTERNAL AUDITING

100 INDEPENDENCE - INTERNAL AUDITORS SHOULD BE INDEPENDENT OF THE ACTIVITIES THEY AUDIT.

110 Organizational Status - The organizational status of the internal auditing department should be sufficient to permit the accomplishment of its audit responsibilities.

120 Objectivity - Internal auditors should be objective in performing audits.

200 PROFESSIONAL PROFICIENCY - INTERNAL AUDITS SHOULD BE PERFORMED WITH PROFICIENCY AND DUE PROFESSIONAL CARE.

The Internal Auditing Department

210 Staffing - The internal auditing department should provide assurance that the technical proficiency and educational background of internal auditors are appropriate for the audits to be performed.

220 Knowledge, Skills, and Disciplines - The internal auditing department should possess or should obtain the knowledge, skills, and disciplines needed to carry out its audit responsibilities.

230 Supervision - The internal auditing department should provide assurance that internal audits are properly supervised.

The Institute of Internal Auditors

Summary of General and Specific Standards for the Professional Practice of Internal Auditing

The Internal Auditor

240 Compliance with Standards of Conduct - Internal Auditors should comply with professional standards of conduct.

250 Knowledge, Skills, and Disciplines - Internal auditors should possess the knowledge, skills, and disciplines essential to the performance of internal audits.

260 Human Relations and Communications - Internal auditors should be skilled in dealing with people and in communicating effectively.

270 Continuing Education - Internal auditors should maintain their technical competence through continuing education.

280 Due Professional Care - Internal auditors should exercise due professional care in performing internal audits.

Summary of General and Specific Standards for the Professional Practice of Internal Auditing

300 SCOPE OF WORK - THE SCOPE OF THE INTERNAL AUDIT SHOULD ENCOMPASS THE EXAMINATION AND EVALUATION OF THE ADEQUACY AND EFFECTIVENESS OF THE ORGANIZATION'S SYSTEM OF INTERNAL CONTROL AND THE QUALITY OF PERFORMANCE IN CARRYING OUT ASSIGNED RESPONSIBILITIES.

310 Reliability and Integrity of Information - Internal auditors should review the reliability and integrity of financial and operating information and the means used to identify, measure, classify, and report such information.

320 Compliance with Policies, Plans, Procedures, Laws, and Regulations - Internal auditors should review the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations and reports and should determine whether the organization is in compliance.

330 Safeguarding of Assets - Internal auditors should review the means of safeguarding assets and, as appropriate, verify the existence of such assets.

340 Economical and Efficient Use of Resources - Internal auditors should appraise the economy and efficiency with which resources are employed.

350 Accomplishment of Established Objectives and Goals for Operations or Programs - Internal auditors should review operations or programs to ascertain whether results are consistent with established objectives and goals and whether the operations or programs are being carried out as planned.

The Institute of Internal Auditors

Summary of General and Specific Standards for the Professional Practice of Internal Auditing

400 PERFORMANCE OF AUDIT WORK - AUDIT WORK SHOULD INCLUDE PLANNING THE AUDIT, EXAMINING AND EVALUATING INFORMATION, COMMUNICATING RESULTS, AND FOLLOWING UP.

410 Planning the Audit - Internal auditors should plan each audit.

420 Examining and Evaluating Information - Internal auditors should collect, analyze, interpret, and document information to support audit results.

430 Communicating Results - Internal auditors should report the results of their audit work.

440 Following Up - Internal auditors should follow up to ascertain that appropriate action is taken on reported audit findings.

The Institute of Internal Auditors

Summary of General and Specific Standards for the Professional Practice of Internal Auditing

500 MANAGEMENT OF THE INTERNAL AUDITING DEPARTMENT - THE DIRECTOR OF INTERNAL AUDITING SHOULD PROPERLY MANAGE THE INTERNAL AUDITING DEPARTMENT.

510 Purpose, Authority, and Responsibility - The director of internal auditing should have a statement of purpose, authority, and responsibility for the internal auditing department.

520 Planning - The director of internal auditing should establish plans to carry out the responsibilities of the internal auditing department.

530 Policies and Procedures - The director of internal auditing should provide written policies and procedures to guide the audit staff.

540 Personnel Management and Development - The director of internal auditing should establish a program for selecting and developing the human resources of the internal auditing department.

550 External Auditors - The director of internal auditing should coordinate internal and external audit efforts.

560 Quality Assurance - The director of internal auditing should establish and maintain a quality assurance program to evaluate the operations of the internal auditing department.

APPENDIX C

Audit Policies and Procedures

Federal Bureau of Prisons Program Statement 1210.12, Program Review with Attachment A, Definition of Terms Used in Program Statement (September 14, 1993)

State of Utah Department of Corrections ACr13, Departmental Audits (June 1, 1994)

Illinois Department of Corrections Administrative Directive 01.11.102, Fiscal Internal Audits (October 1, 1991)

U.S. Department of Justice
Federal Bureau of Prisons

Program Statement

OPI: PRD
NUMBER: 1210.12
DATE: September 14, 1993
SUBJECT: Management Control and Program Review Manual

1. PURPOSE AND SCOPE. This Program Statement defines the policies, standards, and procedures the Bureau of Prisons follows in establishing, maintaining, evaluating, and improving its internal systems of control, including program reviews.

This Program Statement's provisions apply to all Bureau of Prisons' (BOP) organizational components and installations including divisions, regions, institutions, and BOP functional areas such as Federal Prison Industries, Inc. (FPI), and the National Institute of Corrections (NIC). This Program Statement affects department heads, community corrections managers, training center directors, associate wardens, wardens, regional administrators, Central Office administrators, regional directors, and assistant directors. For this Program Statement's purpose, references will be made to institution level personnel.

2. DIRECTIVES AFFECTED

a. Directive Rescinded

P.S. 1210.10 Management Control and Program Review (12/23/91)

b. Directives Referenced

P.S. 1210.5 Inspections (06/23/83)
P.S. 1210.9 Liaison with External Audit Authorities (02/11/91)
P.S. 1353.1 Release of Records (05/29/75)
DOJ Order 2860.3A Implementation of the Federal Managers' Financial Integrity Act (P.L. 97-255), 1986
DOJ Order 2900.5A Responsibilities for the Detection of Waste, Fraud, and Error in Department of Justice Programs, 1986
DOJ Order 2900.6a Audit Follow-Up and Resolution Policy, 1989
OMB Circular A-50, Audit Follow-up, 1982
OMB Circular A-73, Audit of Federal Operations and Programs, 1983
OMB Circular A-76, Performance of Commercial Activities, 1983

OMB Circular A-123, Internal Control Systems, 1986
GAO, Government Auditing Standards, 1988
GAO, Standards for Internal Controls in the Federal Government, 1983
GAO, Internal Auditing in Federal Agencies, 1974

3. STANDARDS REFERENCED

a. American Correctional Association Foundation/Core Standards For Adult Correctional Institutions: FC2-4002, FC2-4030, FC2-4065, FC2-4093, C2-4021, and C2-4031.

b. American Correctional Association 3rd Edition Standards For Adult Correctional Institutions: 3-4018, 3-4036, 3-4053, 3-4104, 3-4199, 3-4310, and 3-4401.

c. American Correctional Association Foundation/Core Standards For Adult Local Detention Facilities: FC2- 5032, FC2-5070, C2-5028, C2-5014.

d. American Correctional Association 3rd Edition Standards for Adult Local Detention Facilities: 3-ALDF: 1A-17, 1B-09, 1C-07, 3B-01, 4D-01, and 5A-13.

4. DEFINITIONS. Attachment A contains the definitions for terms used in this program statement.

5. BACKGROUND. In accordance with 31 U.S.C. 3512(b)(1), Executive Agency Accounting Systems, and OMB Circular A-123, Internal Control Systems, each federal government agency is required to establish a continuous process for evaluating and improving the agency's internal control systems.

Each Department of Justice agency head must annually submit an assurance statement to the Attorney General certifying that the agency is operating effectively, efficiently, and in compliance with applicable regulations; and that existing systems of internal control adequately protect the agency's resources against fraud, waste, abuse, and mismanagement. The assurance statement must also identify any system-wide control weaknesses and actions taken or planned to correct the weaknesses in an appropriate and timely manner.

In order for the agency head to make this certification, there must be a systematic approach to assessing operations and programs at all organizational levels. This is achieved through a management control program which includes a system for assessing risks and testing the adequacy of internal controls for all program and administrative areas. This program statement outlines the requirements and responsibilities for implementing an effective management control program. It also establishes, for all levels of the organization, a system of assurance which, taken as a whole, permits the Director to submit the required annual certification to the Attorney General.

6. REQUIREMENTS

a. Management Controls. The BOP shall maintain a system of management controls that enables managers to regularly assess program performance, determine the degree of risk, test the adequacy of internal controls, and adjust operations to conform with requirements and achieve desired results. Program review is an essential management control tool because it provides timely and essential information on program performance.

b. Program Review. The BOP subjects each of its programs to a thorough examination by organizationally independent, trained Bureau reviewers who are specialists in the program area being reviewed. Each program/operation at each Bureau component shall ordinarily be reviewed at least once every three years. The review cycle is based on need and determined by the disciplines' level of program performance at the review site. Generally, newly established facilities should be reviewed between 12 and 16 months following activation.

c. General Program Review Objectives

(1) Provide assistance to management by recommending solutions to problems;

(2) Ensure conformity with applicable laws, regulations, policies and procedures;

(3) Identify weaknesses in financial and/or administrative controls;

(4) Determine if programs are achieving desired results;

(5) Promote efficient management practices;

(6) Ensure that performance is reliably reflected in management and statistical reports;

(7) Improve quality;

(8) Prevent, detect, and report on situations involving fraud, waste, abuse, mismanagement, or illegal acts;

(9) Identify programs or components of programs that have noteworthy accomplishments and promote their recognition and replication (internal benchmarking); and

(10) Establish usable management indicators for vital functions to monitor program/operation performance.

d. Standards for Program Review. The General Accounting Office (GAO) has issued standards for all government audits, which are referred to as "generally accepted government auditing standards." These standards cover the following areas:

(1) Auditor qualifications;

(2) Auditor independence;

(3) Due professional care or audit quality, including sound professional judgment and standards relating to examination, evaluation, and reporting; and

(4) Quality control, including internal and external reviews.

The BOP shall adhere to the Standards for Audit of Government Organizations, Programs, Activities, and Functions (see Attachment B). To ensure compliance with these standards, the Bureau has developed a quality assurance program. The program provides for continuous evaluation of the program review process. Results are utilized in the preparation of the report to the Attorney General. This provides assurance that the Bureau has achieved consistent and effective implementation of the Federal Managers' Financial Integrity Act and OMB Circular A-123, Internal Control Systems.

Bureau reviewers are required to assign an overall program performance rating based upon the review's results. This assists the Executive Staff to make individual and system-wide resource needs determinations.

7. MANAGEMENT CONTROL SYSTEM. The basic components of management control are: assessing, planning, testing (program review), monitoring, analyzing, and correcting or adjusting. The following is a brief overview of these components, including the "system of assurance" requirements incorporated into each level of the organization and at each stage of the process.

a. Assessing. For a system of management control to be effective, an in-depth and realistic assessment of all programs is required. This is needed to determine the degree of "risk" or the need for improvement and to plan a program review system for each specific program or functional area. This is accomplished by means of a management assessment (described in Chapter 1), whereby program managers examine each important process or activity cycle of the program from start to finish.

b. Planning. Periodic management assessments provide a forum for program managers to view their program's strengths and weaknesses. Areas of weakness are discussed and action plans are

developed to implement good internal controls and ensure improvement. Assistant and regional directors certify through their annual assurance letter to the Director that examination of those processes considered most at risk are included in the program review guidelines and strategic plans have been developed to bring about needed improvement.

c. Testing/Program Review. Bureau reviewers will normally conduct their reviews, studies, etc., based on the semiannual program review schedule and within the scope of the program review guidelines. However, if the review is in response to a specific event or special emphasis issue, it may require the development of new program review objectives and instructions. In any event, all program reviews must conform to generally accepted government auditing standards and the provisions of this program statement. The Reviewer-in-Charge for each program review certifies that, within the scope of the review and except for deficiencies cited, there is reasonable assurance that programs are in compliance with applicable regulations and policies, and internal control systems are effective (detailed procedures for conducting a program review are covered in Chapter 2).

d. Monitoring. Program monitoring is an extension of the Testing/Program Review component (see above). Monitoring on a continuous or periodic basis (weekly, quarterly, etc.) allows staff to correct problems before they get out of hand, track strategic goal accomplishments, communicate to other Bureau staff, follow-up on actions called for in past program reviews, and prepare for upcoming reviews.

Bureau staff at each level of the organization (institution, regional office, Central Office, etc.) establish ways of monitoring the well-being of their respective programs and, in particular, the program's vital functions (see Attachment A for definitions). Management indicators for vital functions (see Attachment A) help define for the manager the information sources and criteria used for this monitoring.

e. Analyzing Program Review Findings. At least annually, program managers will analyze the results of all reviews, special studies, and management indicators. Based on this analysis, the program review guidelines may be updated and reissued. Additionally, each regional and assistant director will prepare a certification letter to the Director stating that control systems for those programs, functional areas, or installations under his/her jurisdiction are operating effectively, except as noted. The Director, in turn, provides such assurance to the Attorney General no later than October 31 of each year.

. Correcting. The essence of management control is the :ion that adjusts operations to conform with requirements. ior to a program review's closure, the CEO must give assurance :nat internal control systems are in place to prevent recurrence of the problems. Such assurance can be obtained through various reviews and monitoring systems (see Chapter 2 for details). In addition, actions to correct system-wide problems must be tracked by the appropriate program managers to ensure that the scheduled corrective action is being taken, and that the corrective action is appropriate and will, in fact, improve the situation. Corrective actions may include development of new or modified program review guidelines; plans for special studies or reviews; improvement in training programs; changes in policy, monitoring the accomplishment of strategic action plans, etc.

g. Strategic Management Cycle. A "holistic" approach has been incorporated into the Bureau's system of management wherein information from the following sources is utilized:

(1) Strategic Plans/Goals,
(2) Management Assessments,
(3) Program Reviews,
(4) Operational Reviews,
(5) Social Climate Surveys,
(6) Institution Character Profiles,
(7) Management Indicators,
(8) Policy Development, and
(9) Other Information Sources (external agency reviews, etc.)

All of these areas are interdependent and collectively form what is known as a "strategic management cycle." It is intended that strategic planning be a continuous process, and the use of review findings, management indicators, and strategic planning objectives/action steps be closely interrelated. By identifying issues through the program review process, strategic issues are developed to ensure that long-term corrective action is fully implemented. Further, analysis of a program review's results aids program administrators to develop program review guidelines to ensure quality program evaluations.

8. RESPONSIBILITIES. The following is an outline of the responsibilities involved in the management control and program review system. Specific internal control reporting requirements can be found in the program statement on Internal Control Reporting Requirements.

a. Director. The Director submits an assurance statement to th: ttorney General at the end of each fiscal year certifying th. Bureau programs are operating effectively and in accordance wi:. applicable law, and that systems of internal control are adequate to protect resources. Material weaknesses and

significant concerns in the Bureau's systems of controls will be identified in the Management Control Plan with a plan for correcting them included.

b. Assistant Directors. The assistant directors' responsibilities shall include the following:

(1) Ensure that management assessments of all division programs are conducted and that the results of these assessments are incorporated into program review guidelines for each program;

(2) Determine the need for special reviews or studies in program areas and ensure that necessary reviews are conducted accordingly;

(3) Ensure that the results of program reviews, management indicators, management assessments, and other reviews and studies throughout the year are analyzed to determine if there is a pattern of noncompliance or lack of controls in division programs;

(4) Ensure appropriate strategic plans are developed to address and correct weaknesses;

(5) Update and reissue program review guidelines with the Assistant Director, Program Review Division, annually for division programs based on the analysis mentioned above to include the program area's management indicators for vital functions; and

(6) Prepare a certification letter to the Director annually, attesting to the adequacy of internal controls in division programs and summarizing major system-wide concerns or weaknesses needing corrective action (see Attachment C-1 for sample).

c. Assistant Director, Program Review Division. The Assistant Director, Program Review Division, is the designated Internal Control Officer for the Bureau of Prisons. OMB directs that a senior official be given responsibility for coordinating the agency-wide effort to comply with the Financial Integrity Act (P.L. 97-255). The official should also ensure that the agency's methods of assessing the adequacy of internal controls are in accordance with the provisions of this Act.

The Assistant Director, Program Review Division, not only has oversight authority for the Bureau's program review program, but also:

(1) Serves as Program Review Authority for all centralized Bureau of Prisons program reviews;

(2) Issues a compiled semi-annual program review schedule for all programs and ensures timeliness of program review schedules;

(3) Develops and updates program review policy;

(4) Provides program and operational review skills training and technical assistance to reviewers;

(5) Monitors all reviews and review materials related to the conduct of program reviews, conducts on-site evaluations of reviewers, and provides assistance to ensure program reviews are conducted in compliance with program review policy and auditing standards;

(6) Reviews program review objectives and guidelines for completeness and general adherence to accepted formats prescribed in policy;

(7) Provides systematic analysis and feedback to all levels of the agency related to program reviews;

(8) Assesses the overall effectiveness of the program review program; and

(9) Makes recommendations to the Director for improvements in Management Control and Program Review;

d. Regional Directors. Regional directors shall have the following responsibilities:

(1) Ensure that chief executive officers and regional administrators are fully responsive to program review findings and that institutions close program reviews in a timely manner;

(2) Determine the need for special reviews or studies in specific program areas and ensure that necessary reviews are conducted;

(3) Prepare an annual certification letter to the Director attesting to the adequacy of internal controls in regional programs (see Attachment C-2 for sample); and

(4) Ensure strategic issues are developed for regional strategic plans and develop corrective actions to address noncompliance and lack of controls.

e. Wardens and Superintendents. The wardens' responsibilities shall include the following:

(1) Provide full support and cooperation to the reviewers, including freedom of access to all property, records, employees, and inmates;

(2) Ensure operational reviews of each functional area in the institution are conducted within the time frames established in Chapter 2;

(3) Provide timely initiation and completion of appropriate corrective action to enable the program review's closure within prescribed time frames;

(4) Certify that adequate controls have been implemented or improved to avoid recurrence of deficiencies (see Attachment C-3 for sample);

(5) Provide feedback to the regional administrators on their respective discipline guidelines to ensure that the guidelines adequately measure the performance of the program and its vital functions;

(6) Identify issues to be incorporated into the institution's strategic planning process; and where appropriate, establish action plans to address operational and program review findings; and

(7) Annually prepare a certification letter to the regional director attesting to the adequacy of institution internal controls (see Attachment C-3 for sample).

f. Central/Regional Office Administrators. Central/regional office administrators have the following responsibilities:

(1) Ensure annual management assessments are completed within time frames specified in the program statement on Internal Control Reporting Requirements;

(2) Monitor for trends and develop strategic plans to address emerging problem areas as part of the program evaluation and guideline development process;

(3) Issue Operations Memorandum for program review guidelines which identify their respective discipline's management indicators for vital functions;

(4) Ensure that the information from program reviews, management indicators, management assessments, and other studies are analyzed to determine if there is a pattern of noncompliance or lack of controls in regional programs;

(5) Mentor and train institution department heads in conducting high quality operational review programs and provide feedback on the results of those reviews; and

(6) Identifies strategic issues for regional strategic plans and develops corrective actions to address noncompliance and lack of controls as discussed in subsection (3) above.

g. Program Review Branch (PRB). The PRB has the responsibility to conduct program reviews for all centralized disciplines.

h. Program Analysis Branch (PAB). PAB coordinates an in-depth analysis of reviews to determine trends and patterns that are both discipline-specific and cross-discipline in nature. This branch is also charged with the responsibility of assisting program administrators and managers at all levels with the development and use of vital functions and management indicators, program reviews, and other Bureau tools.

i. Strategic Management Branch (SMB). SMB evaluators coordinate the annual management assessments of each discipline, assist with the identification of vital functions, coordinate the Bureau's strategic planning process, coordinate the Year-end Assurance Statement Report from the Director to the Attorney General, and serve as liaison between the BOP and external audit authorities (DOJ, GAO, ACA). They also conduct a program review quality assurance program to assure that program reviews are conducted in accordance with government auditing standards and that the program review policy is implemented throughout the agency.

9. DISTRIBUTION. The head of each organizational component shall ensure that a copy of this Program Statement is provided to and maintained by each manager for ready reference in preparing for and responding to a program review and in conducting operational reviews.

Kathleen M. Hawk
Director

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ATTACHMENTS

CHAPTER 1 - DEVELOPING AN INTERNAL CONTROL PROGRAM

1. INTRODUCTION

The Federal Managers' Financial Integrity Act (P.L. 97-255) was passed in 1982 and mandated that all federal agencies develop an internal control program to prevent waste, loss, unauthorized use, or misappropriation. This Act reinforces the requirement that individual managers are responsible for the successful operation of controls in the programs they manage.

OMB Circular A-123 prescribes the policies and standards to be followed in establishing, maintaining, reviewing and reporting on internal controls. Additionally, GAO has provided standards to be followed in carrying out the internal control process.

In practical terms, this Act requires the Bureau of Prisons to apply and review its methods of internal control and report the results annually to the Attorney General.

2. STRATEGIC MANAGEMENT CYCLE

A strategic management cycle has been developed which envelopes the concept of continuous planning through management assessments, operational reviews, program reviews, social climate surveys, institution character profiles, other information sources (GAO, OIG, new legislative regulations, etc.), information synthesis (Program Summary Reports, etc.), policy development, and the formulation of strategic plans and goals. Information derived from these events is gathered, monitored, analyzed, and synthesized to assist managers in assessing their respective programs.

3. MANAGEMENT ASSESSMENT

A management assessment is a systematic method of assessing the strengths and weaknesses of a particular program/activity and developing monitoring tools to improve those areas. Furthermore, it provides the opportunity for the identification of strategic issues that may ultimately become part of the program's or Bureau's strategic plan.

a. Participants

Suggested participants at management assessments could include the Central Office administrator, the regional administrators, and representatives from the Program Review Division to facilitate the management assessment process. Field staff are informed of the management assessment event in advance and are urged to present their views through the regional administrator of the specific discipline program. Additional field input is obtained through the responses of wardens to the Program Review Division survey following program reviews.

b. Methods

Management assessments are conducted using a variety of methods (i.e., teleconference, in-person conference, or a combination of both) dependant upon:

* changes in the discipline's program
* thoroughness of the risk assessment
* clarity of program review guidelines.

c. Preparation

Prior to the management assessment, the Central Office administrator and an evaluation specialist from the Strategic Management Branch, Program Review Division, gather, analyze and collate documents into a packet to be distributed to all participants. Some of the documents to be included in the packet are:

* mission statement of the program
* strategic plans and update
* prior year's risk assessment
* current program review guidelines
* criteria for a material weakness or significant concern
* GAO/OIG information
* PRD survey data
* management indicator exercise
* AIS data reflecting deficiency trend information

d. Products

The products of a management assessment are as follows:

(1) Risk Analysis - The management assessment process involves a risk analysis of the many components which comprise the work of each program area. During the analysis, management controls (regulations, policies, etc.) are identified, weighed and rated.

(2) Program Review Guidelines - Soon after the management assessment, program review guidelines are drafted by the discipline staff and reviewed by program review staff. If a management assessment produces no changes to the guidelines, the prior year's operations memorandum may be reissued.

Following the review of the guidelines by program review staff, the operations memorandum is returned to the Central Office discipline administrator for finalizing. The final operations memorandum is prepared with signature blocks for the assistant director of the respective discipline and the Assistant Director, Program Review Division.

Guidelines are most effective if developed immediately following the management assessment. Additionally, it is important to stagger distribution to balance workloads. Therefore, all operations memoranda containing program review guidelines for FY 19XX should have an

effective date of October 1, 19XX, and a cancellation date of September 30, 19XX.

(a) Development of Guidelines - Guideline steps are required for all high risk processes (as identified in the risk analysis) and recommended for all medium risk processes. Guidelines should be written clearly, granting the reviewer the opportunity to observe a program activity, review pertinent documentation and interview appropriate staff. Guidelines should not be written as survey questions, but should be direct and substantial, relating to exactly what the reviewer should do and what the reviewer should find as an acceptable practice. It is equally important to indicate the sample number of items to be reviewed. To facilitate the use of guidelines for operational and program reviews, a policy citation or regulation with the appropriate page number shall be ascribed following each review step.

The following is an example format to be used in developing review guidelines: Look at ...(a specific activity, program, or program component) to determine ...(specific objectives are being met or policy requirements complied with...). Three examples of guidelines follow which involve a reviewer observing a program first-hand, reviewing documentation and interviewing staff.

Observe an actual team meeting to determine whether staff are developing a financial responsibility plan at initial classification and program reviews. (P.S. 5380.2, p. 2, sec.6a; p. 6 sec.6c).

Examine 5 percent (or up to 25) of the central files of cases identified as participating in the Inmate Financial Responsibility Program (IFRP) and review Attachments A and B to determine if they are completed and in the central file. (P.S. 5380.2, p. 8, sec.7c; p. 4, sec. 6a; p. 5 sec. 6b).

Interview the Inmate Financial Responsibility Coordinator to determine whether it can be demonstrated that monthly IFRP reports are submitted to the regional office by the 15th of each month. (P.S. 5380.2, p. 9-10, para. 8).

(b) Operations Memorandum - The cover sheet of each operations memorandum should include the following standard statements regarding vital functions, management indicators and ACA Foundation Core Standards:

During the management assessment, vital functions for (name the discipline) were identified as follows: (list the vital functions and number them). The guideline steps in support of each of these vital functions are identified in the left margin with the notation: (V1), (V2), (V3), etc.

Management indicators in support of each vital function are attached at the end of the guidelines. Each indicator lists proposed source(s) and user(s) of the information. When possible, the indicators also list the acceptable level of performance or standard for a particular area. These management indicators should be used by the identified staff to continuously monitor program efficiency, to react proactively to potential hot spots or program weaknesses, and in the operational review process to measure program outcomes. Because these indicators are directly linked to the vital functions, when properly used, they are also effective in monitoring the overall health of the program before a program review.

"The following ACA Foundation Core Standards are referenced in the attached program review guidelines: (list the ACA standard numbers). Review guidelines in support of ACA Foundation Core Standards are identified with the notation (FC2-xxxx) following any policy citations. Additional ACA standards may be referenced in the Background or Regulations section of any review objective as a result of the management assessment, but are not necessarily linked to the reaccreditation process."

4. MANAGEMENT INDICATORS FOR VITAL FUNCTIONS

During the management assessment process, the mission statement and vital functions are reviewed. Management indicators are then developed to help program managers monitor their program's vital functions.

At all levels, management indicators for vital functions can be used by managers to track vital functions. At the institution level, they can be used by department heads and associate wardens to monitor the health of programs between, and in anticipation of, operational and program reviews. A new department head may use them as an extension of the program review process to help determine the operational level of their department.

Central and regional office staff can use management indicators for vital functions to monitor trends and patterns across institutions. They can be used prior to the management assessment to identify strengths and weaknesses within an area. This monitoring can assist staff in identifying needs for resources and staff assistance. They can also be incorporated into strategic planning as a means of tracking goal progress and attainment.

Program Review Division staff may use management indicators for vital functions as an extension of the review process. As they are refined, reviewers may use them to conduct "long-distance reviews" of at least some aspect of a program scheduled for an upcoming program review.

5. STRATEGIC ISSUES

During the course of the management assessment, strategic issues emerge. Issues not resolved during the management assessment may be included in the discipline's or Bureau's strategic plan. Executive Staff will determine which Bureau issues, if any, will be reported to the Department of Justice as a material weakness or significant concern (refer to section 7 below for an explanation of material weakness and significant concern).

Strategic planning is continuous planning; thus, strategic issues arise throughout the year and not just during management assessments. At any time objectives may be developed and recommended to the Executive Staff for inclusion in the BOP's planning process. Similarly, issues that do not have national impact may be incorporated into local strategic plans.

6. MATERIAL WEAKNESSES/SIGNIFICANT CONCERN

Strategic issues which have impact outside the agency may be referred to the Executive Staff for review. If the Executive Staff agrees, the issue will be reported to the Department of Justice through the management control plan. The management control plan identifies material weaknesses and significant concerns, and details the corrective actions and target dates for completion of those actions. The criteria for material weaknesses and significant concerns are as follow:

a. Material Weakness Criteria

(1) significantly impairs the fulfillment of an agency or component's mission;

(2) deprives the public of needed services;

(3) violates statutory and regulatory requirements;

(4) significantly weakens safeguards against waste, loss, unauthorized use or misappropriation of funds, property or other assets;

(5) results in a conflict of interest;

(6) merits the attention of the agency head/senior management, the Executive Office of the President, or the relevant Congressional oversight committee; or

(7) their omission from the report could reflect adversely on the management integrity of the agency.

b. Significant Concern

(1) is a control deficiency of significant importance having Bureau-wide impact to be reported to the Attorney General,

(2) if the deficiency is not corrected could develop into a material weakness.

CHAPTER 2 - CONDUCTING A PROGRAM REVIEW

1. OVERVIEW

All Bureau program reviews must conform to the standards for auditing established in the Government Auditing Standards and the provisions of this program statement. Planning, conducting, and analyzing the results of program reviews should be done within the context of a system of management control.

a. Requirements (Extent, Frequency)

Each program or operation at each Bureau installation shall be comprehensively reviewed in accordance with published program review guidelines by reviewers based on need. Programs that receive a good or superior rating are eligible to have their review deferred by one year. This determination will be based on management indicators for vital functions, operational review results and input from CEOs and program administrators. Programs that receive acceptable ratings will be reviewed on a two year basis, and programs receiving deficient ratings will be reviewed at 12-18 months. At-risk programs will be reviewed upon request for closure. If circumstances dictate, newly established facilities may be reviewed beginning 120 days from the point they begin receiving inmates. The decision to conduct formal reviews will be made after consultation with the regional director and will focus on one or more of the following disciplines: Correctional Services, Human Resource Management, Financial Management, Facilities, and Health Services. All other disciplines will be reviewed 12-16 months after activation.

b. Program Review Types

The provisions of this program statement apply to Bureau reviews conducted in a variety of situations. The types of program reviews include, but are not limited to, the following:

(1) Program Reviews - to determine compliance with applicable regulations and policies, adequacy of internal controls or safeguards, and the effectiveness, efficiency, and quality of programs and operations (also referred to as management, centralized, operational, or expanded scope reviews).

(2) Operational Reviews - Operational reviews are conducted under the authority of the CEO of each installation or organizational component. At the institution level the review authority is the warden or superintendent. At the region or division level, the regional director or the assistant director are designated as the review authority. An operational review is a self-evaluation conducted by the program staff that enables them to closely evaluate the strengths and weaknesses of their program and to take corrective action.

c. Reviewer-in-Charge

Each program review must have one Reviewer-in-Charge (RIC) who is appointed by or approved by the Assistant Director, Program Review Division, and will report the findings directly to the Review Authority. The RIC shall ensure that:

(1) Reviews are conducted in accordance with the provisions of this program statement;

(2) Program review objectives are met within the scope of the review plan;

(3) Findings and recommendations are presented in a written report;

(4) Working papers adequately support review findings;

(5) Review team members (reviewers) receive appropriate guidance and supervision;

(6) An overall rating is provided as a part of each Program Review Report.

(7) Appropriate management officials are kept fully advised of the results of the review.

d. Due Professional Care

Due professional care is to be used in conducting the review and in preparing related reports. This includes:

(1) Using good judgment in conducting the review, assessing the findings, and preparing the report;

(2) Following-up on findings from previous reviews to determine whether appropriate corrective actions have been taken;

(3) Adhering to timeliness prescribed by policy;

(4) Ensuring the safeguard of sensitive information.

e. Scope of the Review

The extent and focus of the review, as well as reporting any impairments to the effectiveness and integrity of the review, are governed by the following provisions:

(1) No Constraints: Reviewers should attempt to remain within the scope of the specific review objectives for efficient use of resources and to help focus their attention. However, they are not constrained from examining other areas, if the evidence leads them in other directions.

(2) Reviewer Access: Personnel at the review site must grant reviewers access to all documents that need to be examined, permit reviewers to interview employees and inmates who are reasonably available, and allow reviewers to inspect all areas and items of government property.

(3) Scope Impairments: If factors restrict the scope of the review, limit the reviewer's access, or interfere with the reviewer's ability to form objective opinions and conclusions, the Reviewer-in-Charge should attempt to informally resolve the problem. Failing that, the Reviewer-in-Charge shall report the problem to the Assistant Director, Program Review Division. Any such impediment shall be documented by the Reviewer-in-Charge in the working papers.

f. Technical Assistance

Bureau reviews have three purposes: to determine whether corrective action or improvement is needed, to identify noteworthy programs or program components, and to provide assistance to staff members who are responsible for implementing noted corrections and improving operations. Reviewers should attempt to adequately explain how a problem should be corrected or a procedure implemented, and they should be alert to give assistance when indicated.

g. Phases of the Program Review

There are five interrelated phases to any review: preparation, examination, evaluation, reporting, and follow-up. There are standards, principles, and procedures for each phase, and all Bureau reviewers must have a complete understanding of these. The five phases are not mutually exclusive, nor does one phase follow directly after another.

(1) Preparation - Data collection and assessment prior to arrival at the review site in order to help focus on the program review objectives;

(2) Examination - The evidence collection phase, usually at the review site, which includes determining whether the evidence is sufficient, reliable, and relevant;

(3) Evaluation - Assessing the evidence for patterns of deficiencies or need for improvement, and organizing the evidence into the elements of a finding;

(4) Reporting - Development of findings for presentation at closeout and in writing via the formal report;

(5) Follow-up - Evaluating the facility's response, monitoring corrective action, seeking resolution of any disagreements, and obtaining closure of the review.

PREPARATION FOR THE REVIEW

This section describes the requirements of the preparation phase of the review. It encompasses all the work and data gathering prior to arrival at the review site(s). Adequate preparation is important to ensure that the program review results will satisfy the review objectives (Chapter 1). The following represents the steps involved in preparing for the on-site examination.

a. Data Collection and Preassessment

The reviewer should assess the situation at the specific review site prior to arrival at the site by obtaining and reviewing all pertinent data including management indicators. This information and the reviewer's written assessment of it represent the first working papers collected or prepared for the program review. These papers (or a synopsis) should be placed in the review file for reference. Results of this pre-assessment may necessitate adjustments to the program review objectives. This assessment should include the following:

(1) Events - Recent events, such as a major incident, new department head, change in mission, etc., should be taken into consideration in assessing the situation at the review site.

(2) Trends - Workload and performance data should be reviewed to determine any recent trends suggested in that data. The data might include number and nature of inmate incidents, staff vacancies and turnover, minority hiring, recognition awards, accidents, staff and inmate grievances, investigations, inmate disciplinary actions, class waiting lists, course completions, inmates employed, medical duty status, custody levels, security level versus crowding and staffing.

(3) Other Significant Data - Other information such as KI/SSS, external agency reports, (GAO, OIG, ACA, etc.) should be reviewed.

(4) Past Program/Operational Reviews - Review any recent program/operational reviews of the specific review site and the status of pending corrective actions.

b. Developing a Site Plan for the Review Site

Based on the steps, the reviewer shall develop a brief, written Program Review Site Plan for the specific review site (see Attachment D-1 for a site plan sample).

(1) Contents: The site plan shall include:

(a) a summary of the pre-assessment and where deficiencies might be expected based on what has been found in similar situations;

(b) the general scope of the program review;

(c) review dates, suggested team members, reviewer days, cost containment information, and other logistical information.

(d) comments from the CEO, regional administrator and Central Office administrator

(2) Approval: The site plan will be placed in the form of a memorandum from the Reviewer-in-Charge to the Review Authority or designee for approval. If unusual conditions exist, the Reviewer-in-Charge should meet with the Review Authority to discuss the planned review.

c. Notifying the CEO

The Chief Executive Officer (CEO) of the review site shall be officially notified of the review in writing by the Review Authority at least 30 days prior to the review (see Attachment D-2 for a notification memorandum sample).

(1) Contents: The notification shall contain the following information: dates of the review; names, titles, and duty stations of the Reviewer-in-Charge and reviewers; scope of the review - program area(s), type of review, special focus areas if any, program review objectives if different than those published for the program; requests for any specific information from officials at the review site (requests for such information should be limited to those pieces of information not available from any central data base or central information location);requests for advance materials should be kept to a minimum and should not incur substantial copying costs and staff time; a request that the CEO respond if there are any additional special concerns or areas which the CEO would like examined.

(2) Unannounced Program Reviews: The Review Authority reserves the right to conduct reviews without prior notification if deemed necessary to achieve reasonable assurance that a site/program is operating in accordance with applicable law and policy, and property and resources are efficiently utilized and adequately safeguarded.

3. EXAMINATION

The examination phase involves all the data collection, interviews, and observations conducted at the review site(s). The following section outlines the steps, procedures, principles, and tools required in this phase of the review.

a. Organization and Supervision

(1) Organizing the Program Review Work: Prior to beginning the work, the Reviewer-in-Charge (RIC) shall meet with the

program review team members and brief them on the plan, including the division of labor, time frames, objectives, and review and sampling techniques. The review shall be organized to ensure that no unnecessary demands are placed on institution staff.

(2) Giving Due Consideration: The department head should be afforded the opportunity to be fully involved in the review activities. The Reviewer-in-Charge shall inform the department head and staff that all comments that might alter findings and recommendations or that provide information concerning the cause of a deficiency will be fully investigated and given due consideration. The reviewer shall work with the department head and staff to find causes and solutions.

(3) Lines of Communication: The Reviewer-in-Charge should arrange with the department head precisely how reviewer requests for information and feedback on concerns will be handled throughout the review. The Reviewer-in-Charge shall meet daily with the appropriate management staff such as the department head and associate warden to discuss progress and preliminary findings. The CEO is encouraged to participate in the daily closeouts in order to be fully appraised of the findings of the review. A record of these interim meetings is to be placed with the working papers.

(4) Supervising the Program Review Team: Proper supervision of team members must be exercised from the beginning of the review through the closeout and preparation of the report.

b. Evidence

During the examination phase, information is discovered and gathered. This is considered evidence which will support the conclusions contained in the final report.

(1) Types of Evidence: Evidence may be categorized as one of the following:

(a) Physical (direct observation of people, property or processes). This is considered to be the most dependable type of evidence, and is essential in determining the adequacy of internal controls. Reviewers should allow sufficient time during the review to observe all important procedures actually in operation and determine both the efficiency and effectiveness of the operations.

(b) Testimonial (interviews). While extremely valuable, this is considered to be the least dependable type of evidence, and information thus obtained requires corroboration before it can be used in support of a finding.

(c) Documentary (files, records, invoices, etc.). This is an excellent method of verifying the reliability of evidence gained through other methods; however, reviewers should not spend an inordinate amount of time reviewing files and records to the exclusion of observation, interviews, and analysis.

(d) Analytical (developed by making judgments about other forms of evidence through computations, reasoning, comparison, etc.). This is used to conduct staff complement analyses, figure vacancy rates, compare the situation of one review site with other institutions, etc. Reviewers should allow sufficient time to conduct such analyses. A well developed finding and a well written Program Review Report should contain the results of numerous analyses to give the reader a better perspective.

(2) Standards of Evidence: Evidence must meet three standards in order to be considered in the program review findings. It must be sufficient, competent, and relevant.

(a) Sufficient - There must be enough factual, sufficient, and convincing evidence to lead a knowledgeable, reasonable person who is not an expert in the program area to the same conclusion as the reviewer. Determining the adequacy of evidence requires judgment, especially when there is conflicting evidence. Sufficient evidence is needed to back-up the conclusion. Sampling sizes for examinations, observations, and interviews should be sufficient to give the reviewer reasonable assurance that adequate controls are in place.

(b) Competent/Reliable - The evidence must be reliable and the best that can be obtained through the use of reasonable program review methods. If there is any reason to question its validity or completeness, additional measures must be taken to authenticate the evidence.

(c) Relevant - The evidence must be linked to the program review objectives and have a logical, sensible relationship to the issue being proved or disproved.

c. Serious or Unusual Problems

There may be situations where problems are so pervasive or serious that reviewers will find it necessary to halt the review or drastically redirect the program review work.

(1) Approval: The Reviewer-in-Charge shall discuss the matter with the CEO and the Review Authority. The Review Authority has final authority on whether the program review should be halted or redirected.

(2) Sufficient Evidence for Report: Before a review can be halted, the Reviewer-in-Charge shall ensure that sufficient evidence has been gathered to prepare a report of the major findings. Ending a review or redirecting it prior to completion of the entire scope of the review does not relieve the Reviewer-in-Charge from preparing a Program Review Report and documenting the reasons in accordance with the provisions of this program statement.

(3) Assistance: The Reviewer-in-Charge will discuss the next course of action with the Review Authority. Courses of action might include: providing technical assistance for the remainder of the review period, rescheduling a technical assistance visit at the review site, or naming a special staff assistance team comprised of program experts.

d. Fraud, Abuse, and Illegal Acts

Reviewers shal. be alert to situations or transactions that could be indicative of fraud, abuse, and illegal acts. Any such evidence or information should be reported to the CEO and Review Authority immediately for possible referral to the Office of Internal Affairs and follow-up investigation. Similar accusations concerning the CEO shall be reported directly to the Review Authority. The Review Authority shall determine whether the review team should continue with the program review or suspend the review until the investigation is completed.

e. Working Papers

(1) Standard: A written record of the reviewers' work shall be retained in the form of working papers. It should be possible for a knowledgeable person, not involved with the program review, to review the working papers and management indicators and arrive at the same general conclusions as the reviewers.

(2) Purpose: Working papers provide a systematic record of the work done by a reviewer or team of reviewers and contain the information and evidence necessary to support the findings and recommendations presented in the Program Review Report. They serve as evidence if the program review conclusions are challenged.

(3) Types: Working papers are of various types. Technically, all the information reviewed in preparation for the program review are considered to be working papers, as are notes taken during interviews, observations, photographs, and reviews of documents. This includes computer printouts, logs, files,

etc. In addition, any analyses or computations done to support findings are part of the working papers. All preprinted program review checklists and interview sheets are considered to be working papers.

(4) Program Review File: A file shall be established for each program review with the original working papers placed in the file. The department head and/or associate warden will initial each deficiency and advised item marked in the working papers acknowledging their review of the evidence. The working papers should be placed in a file which would facilitate their use and prevent loss or mutilation. The file's contents shall be clearly identified (official program review, review site, program area, dates).

(5) Retention: Program Review working papers shall be retained by the Review Authority for at least eight years from the date of the review. Documents for one complete review cycle will be retained in the Program Review Division files, and the remaining records will be archived in accordance with government regulations. Working papers will be destroyed at the end of this time period unless there are specific reasons presented for their retention.

(6) Team Members' Papers: Only one program review file and set of supporting documents will be maintained. The Reviewer-in-Charge will collect all working papers from the review team members for inclusion. If a team member wishes to retain a particular working paper, it will be necessary to make a copy of the document with the approval of the RIC.

(7) Format: Each reviewer has a personal style of recording and collecting information. This program statement is not intended to impose a rigid, standard format for working papers, nor should the development of working papers impose extra work for the reviewer disproportional to the value of the evidence obtained. However, at a minimum, working papers shall be:

(a) complete and accurate to provide proper support for the program review conclusions;
(b) clear, concise, and understandable;
(c) legible and neat, even though usually hand written;
(d) restricted to matters that are materially important and relevant to the program review objectives.

(8) Forms: In addition to the preprinted checklists and interview sheets that reviewers normally use, it is suggested that each reviewer have a supply of working paper forms to record information collected during the program review. There is an official working paper form which is used by staff of the Program Review Division (see Attachment D-3 for a working paper sample).

form is printed on pads of 100 pages each and is available in packages of five pads per package (500 pages). A supply of these packages can be ordered from UNICOR.

f. Program Review Interviews

This is a crucial part of the examination phase of a program review. There are three types of program review interviews: entrance interview with CEO, discovery/confirmation interviews with staff and inmates, and exit interview/closeout with CEO.

(1) Entrance Interview: Upon arrival at the review site, the reviewers shall meet with the CEO and any other personnel the CEO may wish to have present.

(a) Purpose - At this meeting, the Reviewer-in-Charge will define the scope of the review, and briefly describe how it will be organized to cause as little disruption to the operation of the facility as possible.

(b) Cluster - If the review is being conducted in conjunction with other discipline reviews, each Reviewer-in-Charge will attend the entrance interview.

(c) Closeout Schedule - A date and time for the closeout may be established during this meeting.

(2) Discovery/Confirmation Interview: Reviewers will normally be interviewing large numbers of staff and, depending upon the discipline, inmates during the course of the program review, based on the program review objectives as well as on discovery of evidence during the course of the review.

(a) Adjusting Outline - Reviewers should not expect that any interview outlines provided with the official system-wide program review objectives will completely cover the situation at every review site; therefore, in developing the program review plan for the specific site, the reviewer should prepare various interview outlines or checklists based on the information. In addition, as evidence is collected during the review, new questions may need to be added to the interview outline.

(b) Notes and Summaries - It is inappropriate to use recording equipment in a program review interview setting. The reviewer will make a record of the significant information gathered based on the notes taken and impressions. The interview outline and the notes are considered to be part of the official working papers. The actual interview

notes are considered confidential and should not be disclosed. If a request is received for interview information, the Reviewer-in-Charge can prepare a summary of the information obtained through the interviews for discussion with program staff or managers.

(3) Exit Close-outs: At the conclusion of the program review, the reviewers shall meet with the CEO and any staff the CEO wishes to have present to apprise them of the results of the review to include any significant findings, deficiencies or significant lack of administrative controls. A draft of the findings and a preliminary overall rating of the program will be given to the CEO prior to the conclusion of the close-out.

If other major deficiencies are later discovered through a review of working papers or additional discussions with other team members, the Reviewer-in-Charge will discuss the deficiencies with the Review Authority and CEO prior to release of the Program Review Report. If the final overall rating is different than the preliminary overall rating provided to the CEO during the close-out, the RIC will discuss this with the CEO prior to the release of the Program Review Report.

4. EVALUATION

The evaluation phase of a program review is ongoing from the time pre-assessment information is collected prior to arrival at the review site, through the examination and closeout, to the preparation of the Program Review Report. The reviewers are making judgments about every document examined, every interview conducted, and every observation made to determine if a piece of evidence may link or relate to other evidence gathered.

To emphasize its importance, the evaluation phase is presented as a separate phase and is focused on the work of the reviewers as they begin organizing evidence into findings, where appropriate. The evidence should have been assessed for its sufficiency, reliability, and relevance.

a. Purpose

During the evaluation phase, the reviewers analyze the evidence for indications of patterns, trends, interrelationships, common causes and effects of the problems on the program, and innovative methods of improving operations.

b. Organizing Evidence into Findings

To ensure that evidence is presented in a manner that will be most useful to management, the evidence collected, if indicative of a serious problem, must be organized into a "finding" or series of findings.

c. Materiality

Materiality of deficiencies and whether or not they need to be placed in the official report (rather than handled verbally or placed on the advised list) is a matter of individual reviewer's judgment with the concurrence of the RIC based on all available evidence, extent of the problem, the risk to the efficient and effective management of the program, the program review objectives, etc.

The following represents some guidance in making a determination of the materiality of a significant finding:

(1) Importance to the accomplishment of the mission and vital functions of the program, the institution, or the Bureau;

(2) Pervasiveness of the condition - isolated or widespread (a single example of a deficiency is normally not sufficient to support a broad conclusion or a related recommendation);

(3) Indication of fraud, waste, abuse or illegal acts (or anything that might warrant adverse personnel action);

(4) Extent of the deficiency (based on allowable deviation from what is expected);

(5) Importance to the maintenance of adequate controls, such as a pattern of small, related discrepancies, which by themselves, would not warrant mention, but taken together could be detrimental to the program;

(6) Dollar amount involved (if any) compared to allocation for program at this review site;

d. Deficiencies

Reviewers may investigate and report on any significant problems, failings, weaknesses, and need for improvement. The term "deficiency" is used to describe any such concern and includes, but is not limited to, the following:

* deviations from policy or regulation;
* weaknesses in internal controls;
* lack of quality controls;
* failure to observe accepted standards of practice for a particular profession;
* lack of operating efficiency;
* failure to meet program objectives;

e. Noteworthy Accomplishments

Reviewers are encouraged to investigate and report significant solutions, successes, strengths, and program ideas or capacities that are noteworthy.

f. Elements of a Significant Finding

A well-developed significant finding contains the following elements:

(1) Condition: What was found, the extent of the problem related to the number of cases examined, interviews conducted, etc. There can be only one condition in a significant finding; however, a significant finding may be based on one or more deficiency or need for improvement. These deficiencies can be combined into a single significant finding, if they are all related to the same activity and program review objective or if the cause and effect for each is approximately the same. The intent is to ensure that deficiencies are not listed as isolated, unprioritized events, one after the other.

EXAMPLE: Evidence (documentary, testimonial, physical, analytical can include many noted problems, etc.): "Observed two unauthorized staff members enter the mail room, door left open on one occasion, mail delivery not within 24 hours based on inmate interviews, unusually large number of lost mail claims, high staff turnover in the mail room."

Condition (only one): "Lack of adequate controls in the operation of the mail room."

(2) Criteria: What should be, based on policy, regulation, law, generally accepted practice, desirable administrative or internal controls, quality controls, program objectives, efficient operations, etc. The reviewer should be aware of policy compliance exemptions granted to the review site.

(3) Effect: What effect the condition is already having or what will probably happen if the condition is not corrected; that is, how significant is the finding in terms of attainment of the objectives of the program and the mission of the review site. This is also known as the "materiality" of the condition.

EXAMPLE (based on previous example above): Result of Condition: "unauthorized access, late delivery of mail, lost mail."

Potential Result if not Corrected: "fraud involving inmate monies, loss of confidentiality of sensitive materials."

(4) Cause: Why the condition happened, if known. The condition is only the symptom; the reviewer must determine the underlying cause(s) for the condition, or at least determine some probable causes, in order to be of most benefit to management.

EXAMPLE (based on previous example above): Why did Condition happen? "probably because of high staff turnover, lack of adequate training, lack of adequate, detailed local procedures."

5. OVERALL RATING

Because of the great amount of information derived from program review findings, the Executive Staff determined that there was a need for a shorthand system of summarizing information from the Program Review Reports. The assignment of an overall rating meets this need. The rating reflects the overall judgment of the Reviewer-in-Charge (RIC) as to how well the mission and objectives of the program area are accomplished. The rating is determined by a careful evaluation of how well the vital functions identified in the discipline guidelines are being carried out. Further, the rating is a measure of the performance of the program and is not directly related to the performance of the program manager. The assignment of the rating is also intended to measure the performance of the program over time. The following terms and definitions are used:

* Superior - The program is performing all of its functions in an exceptional manner and has excellent internal controls. Deficiencies are limited in number and not serious in nature. The program performance exceeds expectations and demonstrates initiative and exceptional effort.

* Good - The program is performing all of its vital functions, and there are few deficient procedures within any of its functions. Internal controls are such that there are limited procedural deficiencies. Overall program performance is above an acceptable level.

* Acceptable - This is the "baseline" for the rating system. The vital functions of the discipline are being adequately performed. Although numerous deficiencies may exist, they do not detract from the acceptable accomplishment of the vital functions of the program area. The internal controls are such that there are no performance breakdowns which would keep the program from continuing to accomplish its mission.

* Deficient - One or more vital functions of the program are not being performed at an acceptable level. Internal controls are weak thus allowing for serious deficiencies in one or more program areas.

* At Risk - The program is impaired to the point that it is not presently accomplishing its overall mission. Internal controls are not sufficient to reasonably assure that acceptable performance can be expected in the future.

In arriving at these ratings, the discipline's mission complexity or degree of difficulty is taken into consideration. What constitutes vital functions is determined by the regional and Central Office administrators during the management assessment.

6. THE PROGRAM REVIEW REPORT

Written Program Review Reports are required. The only official report to which the CEO must respond and take action is the one written and presented to the Review Authority for review and transmission to the CEO. Because the system allows for the challenging of deficiencies and significant findings, the Program Review Report will only be considered final upon review Closure. The timetables for this process are established within the program statement (see Attachment D-4 for a Program Review Report sample).

a. Fairness and Accuracy

The reviewer should place the deficiencies and/or noteworthy accomplishments into perspective and avoid exaggeration. Only information which is adequately supported by sufficient evidence in the working papers can be included in the report. Critical comments should be presented in a balanced perspective, taking into consideration any unusual difficulties or circumstances faced by the reviewed officials.

b. Clarity

Reports shall be clear, concise, and substantive. Conclusions should be specific, not left to inference. Aside from department heads and relevant program administrators, readers will have varying perspectives (institutional, regional, system-wide) and may not have a background in the program area being reviewed. Therefore, technical terminology is avoided whenever possible.

c. Persuasiveness

The information in the Program Review Report must substantiate the findings and the recommendations. This information must be reliable, sufficient and logically presented to illustrate the impact or potential impact of the deficiency.

d. Credit

The reviewer should give credit where institution management has already noted a problem and is taking steps to correct the situation or is actively searching for solutions. Often, the reviewer merely performs the role of highlighting known problems. It should be noted that problems identified by technical assistance visits and recently conducted operational reviews may be listed as findings and or/deficiencies within the Program Review Report. This is done because identified problems should have a sufficient system of controls in place for a specified period of time, ordinarily six months.

e. Quality Assurance

The Reviewer-in-Charge shall establish and maintain a quality assurance program for the purpose of providing reasonable assurance that program review work conforms with the GAO auditing standards and with this program statement.

(1) Quality Control Review: The reviewer shall conduct a quality control review prior to submitting the final report to the Review Authority and must document for the file that the review was conducted (see Attachment H-5 for Quality Assurance Review sample).

(2) Components: The Reviewer-in-Charge will ensure that:

(a) review findings are fully supported by sufficient, reliable, and relevant evidence rather than by evidence of minor deficiencies or examination of irrelevant or insignificant matters;

(b) program review objectives have been met;

(c) review team members are properly supervised and their work reviewed;

(d) review findings can be traced to the working papers to ensure that they are fully supported and documented and that figures used in the report are accurate;

(e) interim meetings have been held regularly with the department head and/or associate warden to keep them apprised.

f. Timeliness

Program Review Reports must be issued promptly.

(1) To the Review Authority: The written report of findings will be prepared by the Reviewer-in-Charge and submitted to the Review Authority within twenty business days after the end of the review (close-out). Any exceptions to this requirement must be approved by the Review Authority.

(2) Review by Review Authority: The Review Authority shall review the report to ensure compliance with the provisions of this program statement and standards of auditing. Within ten business days after receipt by the Review Authority, the review report shall be forwarded to the Chief Executive Officer of the review site, under cover memorandum signed by the Review Authority.

g. Distribution

Copies of the Program Review Report and cover memorandum shall be sent to the respective assistant director, regional director, and CEO. In addition, a copy of the report shall be distributed to the regional and Central Office program administrator of the discipline responsible for the program area. A copy of the report may also be distributed to other assistant directors or regional directors who may have an interest in one or more of the findings.

h. Retention

The Program Review Report shall be retained by the Review Authority for eight years, in accordance with the provisions of the National Archives and Records Administration, General Records Schedules (Number 22).

i. Release Provisions

The appropriate method for an outside party to request a Program Review Report and/or related working papers, management assessment/risk analysis documentation, program review guidelines, or any other agency record of the Bureau of Prisons is to make a request in writing to the Director, Bureau of Prisons, Attention: Office of General Counsel, Freedom of Information Act/Privacy (FOIA/PA) Section. The FOIA/PA Section shall coordinate responses to requests for Program Review Reports and related papers with the Program Review Division.

j. Separate Reports

If a separate report containing confidential information is being issued, this should be so stated in the report and/or cover memorandum.

k. Reviewing by Exception

Reporting the results of a program review is governed by the principle of "reviewing by exception". This principle is used throughout the auditing community. It means that, if an area, component, or issue is within the scope of the program review and it is not mentioned in the report, the reader can assume that no serious or significant deficiencies or need for improvement were found in that area. It is not necessary for the reviewer to recap every area examined during the program review.

l. Program Review Report Format

The following Program Review Report format shall be used for the Review Report (see Attachment D-4 for a sample).

(1) Cover Memorandum: Each report must be accompanied by a memorandum from the Review Authority to the CEO of the review

site. The memorandum, usually no more than one or two pages, should briefly describe: the scope of the program review, the overall assessment, and any significant findings (including significant exemplary findings) and will include a description of the repeat deficiencies, if any. The memorandum shall indicate specific response instructions concerning time requirements and repeat deficiencies.

(2) Data Sheet: This is a list of items covering the basic facts of the program review (i.e., review site, dates, reviewers, rating, gender of population, operational review dates, etc.).

(3) Program Reviewer Assurance Statement and Signature: This is a statement signed by the Reviewer-in-Charge that he/she has reasonable assurance (see Attachment D-5 for Assurance Statement sample) that:

(a) the review was conducted in accordance with generally accepted government auditing standards;

(b) the findings of noncompliance with policy or inadequate controls which are contained in the Program Review Report are supported by evidence that is sufficient and reliable;

(c) findings of noteworthy accomplishments are supported by sufficient and reliable evidence; and

(d) within the scope of the program review, the program is operating in accordance with applicable law and policy, and property and resources are efficiently utilized and adequately safeguarded, except for the deficiencies noted in the report and in the list of advised items which are supported and documented in the working papers.

(e) The date the Program Review Report was prepared and the name, title, and duty station of the other members of the review team shall be placed directly under the assurance statement.

(4) Lack of Assurance: If conditions found during the review indicate widespread lack of policy compliance and/or inadequate administrative controls, thus preventing the Reviewer-in-Charge from making the assurance statement, this must be clearly stated and explained by the Reviewer-in-Charge in this section of the report. It must also be emphasized in the Review Authority's cover memorandum and special follow-up measures should be outlined.

The Reviewer-in-Charge may also be prevented from making the assurance statement because the scope of the review was impaired, unlimited access was not granted, or some event caused the review team to leave the review incomplete, through no fault of the program reviewer or individuals under review. This must be explained in this section and in the cover memorandum.

(5) Background: This is a brief statement of facts describing the staffing pattern, program description, personnel in charge, recent events, findings from last program review, etc. This information should reflect the current information available during the review week.

(6) General Comments: This section is open-ended and can be used for different purposes. This section is not intended to be used for long lists of recommendations or suggestions to correct less important deficiencies which are not related to a significant finding. Such recommendations should be handled by giving the department head a separate list of items needing attention. Some purposes of this section include but are not limited to the following:

(a) discussion of any issues and questions needing further study and consideration on a broader-based scale, such as possible changes to BOP policy or training courses, etc.;

(b) observation of areas not directly related to the program being reviewed;

(c) summary of specific issues the Review Authority wants covered in every program review or in certain program reviews;

(d) response to the CEO's request that a specific issue be examined;

(e) discussion of innovative or complex ideas for improvement not specifically related to a finding.

(7) Significant Findings: This section describes any significant findings based on the evidence gathered. The reader must be able to determine how the various deficiencies relate to one another and precisely what impact the deficiencies are having or will have on the program.

(a) Findings Format: Significant findings must be numbered and normally relate to a specific program review objective. Significant findings must follow the following format:

* Heading - describes the program area or topic involved. It must be meaningful to the reader.

EXAMPLES: "Tool Control", "Staff Training", etc.

* Condition and Effect - is a brief one or two sentence opening labeled, "Condition and Effect," that informs the reader what the basic condition is and what basic effect it is having on the operation (or probable effect it will have if not corrected):

EXAMPLE: "There is a lack of adequate controls in the operation of the mail room, resulting in misplaced mail, slow delivery of mail, inappropriate access to the mail room, and a potential for fraud and lack of confidentiality."

* Evidence Section - This is the heart of the finding and is labeled, "Evidence and Criteria." It is a brief but persuasive presentation of the pertinent, more important evidence. It shall note the extent and significance of problems and shall be measured against what should be - the criteria. It must be concise but informative, giving the reader the facts supporting the finding in an organized manner.

Any deviations from policy/regulation that have a direct relationship to the problem may be listed within this section or in the "Other Deficiencies" section.

* Cause - This is the underlying reason that the Condition exists. Common causes include lack of training, lack of resources, inattention or negligence, inadequate or unclear guidance/policy, poor physical arrangement of facility, etc. In some cases, the reviewer may be unable to determine the cause, and further study may be required. If the cause is related to staff shortages or other lack of resources, the reviewer should so state. Budget constraints do not mitigate against the identification of significant problems caused by the constraints. Previous efforts to obtain funding to correct the problems should also be mentioned so responsibility for future action can be properly placed.

Also, the reviewer should keep in mind that the policy may be the problem. In other words, the criteria used may need correcting rather than the condition at the review site. Perhaps the policy isn't written clearly, is outdated, or its requirements aren't needed. If the reviewer believes this to be the problem or part of the problem, this must be stated, and the Review Authority should request review of the policy in a separate memo to the appropriate assistant director. Additionally, this information should be considered during the management assessment process.

* Recommendations: These are the actions the reviewer presents to the CEO to correct, eliminate, improve, or lessen the impact of the conditions noted in the significant finding. This constitutes the main purpose of program reviews in the Bureau which is to help management adjust operations to improve programs. All significant findings shall be subjects of corresponding recommendations. Reviewers should take the time needed to present well thought out recommendations that are clear, helpful, realistic, and cost-effective.

(b) Further Study - Every significant finding shall have a corresponding recommendation; however, there may be situations where neither the cause nor the solution/recommendation is clearly apparent. In that case, the "recommendation" may be to study the problem further, perhaps at the regional or national level.

(c) Workable Solutions - Various possible solutions will be discussed with the department head, regional administrator and associate warden to ensure that the solution (or series of options) eventually presented to the CEO at the closeout and in the written Program Review Report will be truly workable.

(d) Interim Solutions - The reviewer should be alert to innovative procedures or ways to improve operations that can correct or at least partially correct the situation - even if the basic cause is lack of resources, staff, or space.

(e) Deviations from Policy/Regulation - Although recommendations that require compliance with policy or regulations are generally considered non-negotiable, a simple statement of compliance with policy is not adequate. The reviewer will specify the measures that are required to fully correct or improve the condition stated in the finding.

(f) Other Departments - If the staff member responsible for taking the corrective action, or a portion of the action, is not the department head of the program being reviewed, this should be clearly stated. The responsible party (department head, warden, etc.) must be named. Prior to preparing the final Program Review Report, the reviewer should discuss the matter with the appropriate regional or Central Office administrator. The reviewer will provide a copy of the Program Review Report to that administrator, highlighting in a cover memorandum the finding and action involved. The Review Authority, in consultation with the assistant director for the respective discipline, will resolve disagreements between administrators.

(8) Repeat Significant Finding: A repeat significant finding is a finding listed on the current review that was also listed during a previous formal review. While a repeat significant finding occurs infrequently, it should be noted that it does not have to be a mirror image of the previous finding. Different evidence may be utilized to indicate a component

weakness that was found during the previous review. Repeat significant findings will be developed from program reviews and not operational reviews.

(9) Repeat Deficiencies: This is a list of those current deficiencies which were also listed as problems during the last program review (give date of last program review). Any significant risk of allowing them to remain uncorrected must be included (unless this is covered in the Significant Findings section). The CEO shall be instructed, in the Review Authority's cover memorandum, to explain why corrective action was not taken or was not effective prior to the review and what specific controls will be implemented to ensure the deficiencies do not appear again.

(10) Noteworthy Accomplishments: Programs, procedures, or management practices identified as innovative, which involve cost-effective utilization of existing resources and have potential applicability in other BOP settings, shall be addressed through significant findings. The inclusion of significant exemplary findings, however, is not intended to be a routine feature of review reports.

(11) Commendations: This is a description of exceptional performance of an individual, group or program. Such descriptions should be brief and should be reserved for truly innovative or praiseworthy performance related to the program being reviewed.

(12) Other Deficiencies: This section is an attachment to the review report listing problems or weaknesses noted by the reviewer which are in need of correction. The reviewer should include a one or two sentence summary of the problem and, if applicable, a reference number of policy or regulation. Deficiencies that contributed to a significant finding may be listed either in the Significant Finding section or under the Other Deficiencies section. Those deficiencies supporting significant findings but are located in the Other Deficiencies section will be identified as part of the evidence for the significant finding (SF-1, SF-2, etc.)

During discussions with the department head, the reviewer must ensure that the department head has an understanding of what action is required to remedy the situation, and these discussions must be noted in the reviewer's working papers.

Deficiencies or need for improvement not considered significant enough to be included in the Program Review Report will be conveyed to the department head and will be documented in the reviewer's working papers. The Reviewer-in-Charge shall ensure that the department head initials the working papers to verify advisement. The Reviewer-in-Charge shall prepare a separate memorandum known as the Advised List, listing the deficiencies not considered significant enough to warrant

inclusion in any part of the Program Review Report. This memorandum will be distributed to the CEO, regional administrator, and department head; and a copy will be placed in the official program review file with the working papers. Corrective action is expected to be taken to resolve the deficiencies; however, these minor deficiencies will not be addressed in a Program Review Report nor shall any response be necessary.

7. PROGRAM REVIEW FOLLOW-UP

The program review follow-up phase begins immediately after the review report is distributed and continues until the review is officially closed by the Review Authority.

a. Responsibilities

The responsibilities for program review follow-up are divided between the reviewer and the institution, as follows:

(1) Responsibilities of Reviewer: It is the responsibility of the Reviewer -in-Charge to keep the Review Authority informed as to the adequacy of the response and corrective actions taken by the institution. It is also the RIC's responsibility to ensure that review closure is warranted and that a monitoring system is in place to follow-up on "post-closure" long-term actions through the strategic planning process when applicable.

(2) Responsibilities of Reviewed: It is the responsibility of the Chief Executive Officer of the review site to respond to the review report in a timely manner, take the necessary, appropriate actions to correct deficiencies and improve operations in a timely manner, and ensure that adequate administrative controls and monitoring systems are in place to prevent the deficiencies from recurring. If the review report contains a significant exemplary finding, the CEO may implement incentive awards as appropriate. When applicable, long term corrective action should be monitored through the strategic planning process.

(3) Responsibilities of Regional Program Administrator: It is the responsibility of the regional program administrator of each discipline to monitor the implementation of corrective actions and the placement of internal controls outlined by the CEO in response to program review findings. Further, the regional administrator should work closely with the institution to develop strategic initiatives to address issues that are noted during the program review and the operational review. Through the effective use of management indicators for vital functions and the strategic planning documents, the regional administrator should be able to assess the level of program performance from a distance and advise the department head on potential corrective action.

b. Response to Program Review Report

The CEO shall respond to the Review Authority (with copies to the appropriate assistant/regional director and Assistant Director, Program Review Division) no later than 20 business days after receipt of the report. Any exceptions to this requirement must be approved by the Review Authority (see Attachment D-6 for a Response sample). The CEO's response shall address the following:

(1) Repeat Significant Findings: The CEO must provide a separate response to the Director through the regional director with a copy to the Assistant Director, Program Review Division. The CEO must describe the measures and internal controls which will be implemented to ensure that the problem will not occur again as well as explain why the problem was not corrected prior to the program review.

(2) Repeat Deficiencies: The CEO must describe the measures and internal controls which will be implemented to ensure that the problem will not occur again, as well as explain why the problem was not corrected prior to the program review.

(3) Other Deficiencies: The CEO must certify that all deficiencies listed in the Program Review Report (including those involving significant findings) have been corrected. This can be a blanket statement with exceptions noted.

Normally, any deficiencies from policy or regulation are not negotiable. They must be corrected immediately, unless budget constraints or other justifiable constraints preclude timely compliance. Any constraints must be explained and a realistic time frame for correction must be specified using the strategic planning process. A formal action plan shall be developed for each area that requires prolonged corrective action. A copy of these action plans will be attached to the CEO response to the Program Review Report (see Attachment D-7 for Action Plans sample).

If there are constraints in resolution of deficiencies involving a significant finding, the response to that finding should be referenced and the constraints discussed therein.

(4) Significant Findings and Recommendations: The CEO is required to respond to recommendations relating to significant findings cited by the reviewer, declaring agreement or disagreement.

(a) Agreement: If the CEO is in agreement, the steps taken or planned to comply will be listed with a time frame for resolution specified.

(b) Disagreement: Through discussions during the program review between the reviewer, the department head, and associate warden, the potential for disagreement with findings and/or recommendations should be reduced. However, the CEO may wish to present in the review response justification as to why the recommended action cannot or should not be taken, or alternative methods of correcting the problem or improving the program can be taken. The Review Authority will make the final decision to accept or reject the CEO's response. If necessary, the Assistant Director, Program Review Division, may consult with the assistant director for the respective discipline in regard to policy issues.

(c) Non-Policy Based Criteria: A Bureau reviewer is an official representative of, and reports directly to, the Review Authority (Assistant Director, Program Review Division). If the reviewer has determined that, in his/her professional judgment, an action should be taken to correct a problem or improve a situation (even if the criteria against which the condition was measured is not contained in policy or regulation), and if the Review Authority has agreed with this judgment, it is incumbent upon the CEO to take such action or present adequate justification as stated above under "Disagreement".

(5) Other Sections: The CEO should also review other sections of the Program Review Report (the Cover Memorandum, Background, General Comments, etc.) to determine if issues have been raised which require a response. Issues that have been identified in the General Comments section of the report must be responded to by the CEO. The CEO has the option to disagree with the General Comment item but a response is still required.

c. Review of Response

The Reviewer-in-Charge will review the CEO's response to ensure that it is complete and that all deficiencies have been corrected or the action plan contains an acceptable time frame for corrections. If there is a disagreement between the reviewer and the CEO regarding any finding and/or recommendation, the matter will be presented to the Review Authority for decision.

d. Notification

The Review Authority will notify the CEO in writing of the acceptance or rejection of the response within 10 business days of receipt (see Attachment D-8 for sample).

e. Follow-up Reporting

Included in the Review Authority's response may be the requirement for any follow-up reporting measures (progress reports, plans of action) to be taken on the part of the CEO. The requirement for these reports is on a case-by-case basis and may be used when the time frame for corrective action is over a long period of time or the implementation of adequate internal controls is of concern.

f. Closure of the Program Review

Before a program review can be closed by the Review Authority, several actions are required by the reviewer and institution. These actions provide the Review Authority with the assurance needed to close the program review.

(1) Follow-up Review by Institution: Prior to seeking closure of the program review, the CEO shall ensure that a follow-up review is conducted to determine if adequate internal controls are in place to prevent the problems from recurring.

(a) Responsibility: The appropriate associate warden (AW) or appropriate management official is responsible for the follow-up review being conducted.

(b) Review Team: The AW may either conduct the review personally or may head a review team. A local option might include appointing other institution department heads as members of the review team to provide cross-discipline training. Another local option is to include the department head and/or staff of the department in question on the review team.

(c) Time Frame: The follow-up review should be conducted approximately 90-120 business days after the closing date of the program review. This allows for a sufficient period of time for internal controls that have been put in place as a result of the review to begin working.

(d) Method: Each deficiency mentioned in the review report shall be examined through the published program review guidelines. The intent is to determine not only whether the deficiency has been corrected, but whether adequate, cost-effective controls have been instituted, where appropriate, to lessen the likelihood of a recurrence of the deficiency. Such controls might include: an additional level of review, more frequent inspections, cross-checking systems, new written procedures, improved training, etc. The review

team shall ensure that both the "condition" as well as the "cause" have been addressed and that staff have implemented the reviewer's "recommendations".

(e) Report: A report of the review team's findings will be prepared by the associate warden within 10 business days from the date of the review, and shall be sent to the Review Authority (with copies to the assistant director for the discipline reviewed and the regional director) under cover memorandum from the CEO. The report should address all repeat deficiencies and significant findings to include whether or not the controls put in place to correct weaknesses or deficiencies have been effective (see Attachment D-9 for Follow-up Review Report sample). This memorandum can also be used to request closure of the program review (see "Request for Closure").

(f) Certification: The associate warden's certification of correction of the deficiencies and adequacy of controls will be included in or attached to the report.

(g) Additional Reviews: On a case-by-case basis, the Review Authority will determine whether additional follow-up reviews are needed and, if so, at what intervals. This should include a complete assessment as to the performance of the vital functions.

(2) Request for Closure: When the CEO is confident that all necessary actions have been taken, he/she must request closure of the program review (see Attachment D-10 for Request for Closure sample).

(a) Time Frame: Normally, closure of program reviews shall be within 120 business days from the date the review report was received by the CEO. If the CEO is unable to request closure of the review within the prescribed time frame due to extraordinary circumstances, he/she may request an extension from the Review Authority.

(b) Requirements: In the cover memorandum to the Review Authority, the CEO will certify that he/she has reasonable assurance that all deficiencies noted in the Program Review Report have been corrected and needed improvements have been made (except where noted elsewhere in the response) and that adequate controls are in place to prevent a recurrence of the deficiencies.

(3) Assurance/Closure: When the Review Authority has obtained reasonable assurance that the deficiencies have been corrected, the Review Authority shall notify the CEO that the program review is considered closed. A copy of this notification will be sent to the appropriate assistant and regional director and Central Office administrator (see Attachment D-11 for Closure memo sample).

(a) Exceptions: There are instances where limited resources or other restrictions will preclude achieving full compliance within 120 business days. The Review Authority shall consider such situations on a case-by-case basis. In the event the program is rated at-risk, the CEO will determine when he or she is prepared to request closure. At that point, the CEO will request closure of the review through the regional director. If the regional director concurs, then the request for closure is forwarded to the Director with a copy delivered to the Assistant Director, Program Review Division. At that point, a return review is scheduled. If the situation is fully resolved or if the stated strategic plan to correct the problem over the long term is realistic and fully responsive to the review finding, the review can be closed. The Review Authority and regional administrator, however, should continue to monitor the CEO's progress against the established action plan through the strategic planning reporting system.

(b) Assurance Methods: These include the written assurance by the CEO that the follow-up review confirmed correction of all deficiencies, an on-site visit by the reviewer or member of the review team, or by a knowledgeable third party from the regional office or another facility, or a follow-up review directed by the Review Authority.

(4) Unclosed Program Reviews: At the end of each quarter, the Program Review Branch will prepare and submit to the Review Authority a summary report of unclosed program reviews that have gone beyond the 120 business days deadline. The summary shall briefly state which program reviews are overdue for closure and precisely why they have not been closed. Information regarding unclosed reviews that have not been granted extensions will be conveyed to the respective regional director for follow-up and resolution.

8. OPERATIONAL REVIEW

An operational review is to be conducted of each program at all levels 10-14 months from the week the previous program review was conducted. For newly activated facilities, an operational review should be conducted 6-8 months after formal activation with the exception of the 5 disciplines which will be reviewed 120 days following activation. Apart from the requirement stated above, an operational review may be conducted at any time to determine program effectiveness. Through the effective use of this process, weaknesses can be identified and corrected quickly through the effective use of strategic planning. Action plans can be developed that will ensure correction over time and the strengthening of the program. Further, the operational review process enables program managers to establish strong internal controls to ensure that corrective action continues to be effective.

a. Conducting an Operational Review

The conduct of an operational review includes the five phases of the program review process (preparation, examination, evaluation, reporting, and follow-up) discussed earlier in this chapter (see Attachment E for Operational Review Guide).

b. Operational Review and Review by Need

The operational review required by this program statement will be used by the Program Review Division staff as a key management indicator to aid in determining whether or not a program which received a superior or good rating as a result of their last program review is still operating effectively. Under the concept of reviewing based on need, programs that receive good or superior ratings can be considered for deferment from the two year cycle. In addition to a variety of management indicators, the Review Authority will closely consider the information contained in the Operational Review Report. The timeliness of this operational review will have a bearing on the final decision to defer a program review. The decision to defer a review is a clear demonstration of the strength of the program's internal controls. If a program is deferred, another operational review is required 22-26 months following the last program review.

(1) Responsibility: Responsibility for ensuring that the operational review is conducted in accordance with policy rests with the appropriate associate warden, assistant superintendent, deputy regional director or deputy assistant director. The CEO is the Review Authority for all operational reviews.

(2) Members of Review Team: The head of the review team and its membership are left to the discretion of the CEO. The entire team can be comprised of staff of the department being reviewed.

(3) Preparation: Department staff and/or review team members shall review the national program review guidelines and adjust them as necessary based on concerns and high risk areas of the program, as perceived by institution staff.

Staff from related departments should be included in a meeting(s) to enable the review team to take a "big picture" approach to the review - that is, looking at areas outside their own department which may affect, and may be affected by, the program being reviewed. Coordination for this inter-departmental meeting shall be the responsibility of the associate warden, deputy regional director or deputy assistant director. A brief memo announcing the upcoming operational review should be prepared and forwarded to the CEO (see Attachment I-12 for a sample).

(4) Report: Complete results of this review will be submitted by the associate warden, deputy regional director, or deputy assistant director to the CEO who acts as the Review Authority with a copy to the regional director (institution review) and Assistant Director, Program Review Division, within 10 business days after the review is completed (see Attachment I-13 for Operational Review Report sample).

(5) Certification: The associate warden should provide certification that the operational review was comprehensive and conducted in accordance with policy. The certification should also include that findings and conclusions are supported by working papers which will be retained for review by the program review team during the next program review.

(6) Working Papers: The department head or administrator shall retain the working papers for operational reviews as well as the report in an appropriately labeled file until a subsequent program review of the program has been conducted and a final report has been issued. During the official Bureau program review, the program reviewers will examine working papers from the operational review to determine the review was comprehensive and that the adequacy of controls was assessed.

(7) Exemptions: The Assistant Director, Program Review Division, may grant an exemption to the operational review process when justified by the CEO and respective regional director.

(8) Closure/Corrective Action: The process of establishing corrective action through sound strategic planning and closure of the operational review is essential. Each CEO should ensure that adequate action plans are developed to correct deficiencies and that the operational review is closed within 120 business days of the completion of the operational review.

(9) Corresponding Requirements: Annual/operational reviews required by discipline program statements may be combined with the operational reviews required by this program statement. However, these conjunctive operational reviews must be in compliance with provisions outlined within this program statement.

CHAPTER 3 - PROGRAM REVIEW DIVISION QUALITY ASSURANCE PROGRAM

1. OVERVIEW

The Bureau's Management Control and Review Program is an acceptable method of internal control review, provided there is reasonable assurance that the program operates within government auditing standards (see Attachment B for summary). The GAO general auditing standard for quality control requires an internal quality assurance program and a means to ensure that the program review policy is fully implemented throughout the agency.

The Strategic Management Branch, Program Review Division, is designated to conduct the quality assurance program and to report all findings to the Review Authority. The quality assurance program utilizes the following measurement and review tools to develop the assurance that program reviews continue to meet government auditing standards: Program Review Division Survey, Program Review Critique, Post-Review Evaluation, Limited Compliance Review, and the Program Review Cycle Case Study.

2. PROGRAM REVIEW DIVISION SURVEY

Prior to the date of each program review, the Program Review Division will forward a survey (see Attachment F for a sample) to the CEO. The CEO should return the completed survey to the Deputy Assistant Director, Program Review Division, within ten days after the program review team leaves the institution.

Evaluation specialists from the Strategic Management Branch will compile results from the Program Review Division survey into comparative data that is made available through periodic reports for use by Bureau Executive Staff, program administrators, and Program Review Division staff. The intent is to improve the quality of program reviews, identify the need to revise program review guidelines, develop strategic issues, and report on trends that warrant further consideration within the Program Review Division and the strategic planning process.

3. PROGRAM REVIEW CRITIQUES

Evaluation specialists will complete a minimum of one program review critique per quarter for each assigned centralized review team (see Attachment G for the format). Results of each critique will be forwarded to the Branch Chief and Section Chief, Program Review Branch, and the Deputy Assistant Director, PRD.

4. POST-REVIEW EVALUATIONS

The Strategic Management Branch, at the request of a Program Review Branch Chief, will assist in an in-depth evaluation of program reviews. The depth and scope of the evaluation will vary, depending on whether specific auditing standards are

included in the request. The post-review evaluation is considered an internal tool within the Program Review Division to assist in the improvement of the program review process.

5. LIMITED COMPLIANCE REVIEWS

Limited compliance reviews are in-depth reviews of program review activity conducted only at the request and under the authority of the Assistant Director, Program Review Division. Limited compliance reviews include a field work component for the evaluation specialist (see Attachment H for guidelines).

6. PROGRAM REVIEW CYCLE CASE STUDY

Periodic case studies documenting implementation of the Bureau's program review system are conducted as assigned by the Branch Chief, Strategic Management Branch. Case studies take a long-term approach to determine whether program review follow-up and closure plans are implemented, corrections actually made, and whether they were effective. Operational reviews and subsequent program review findings are also reviewed to determine that the Bureau's review program is fully implemented (see Attachment I for guideline sample followed during the case study).

DEFINITIONS OF TERMS
USED IN PROGRAM STATEMENT

Advised Item - A weakness in a program/operation which indicates a problem may be developing but does not totally meet the standards of evidence for it to be a deficiency, i.e., sufficient, reliable, and a sensible relationship to the review objective. While not included in the Program Review Report, an advised item should be brought into full compliance during the follow-up review phase.

Audit Standards - General measures of the quality and adequacy of the work performed. They also relate to the reviewer's professional qualities. Standards referred to as "Generally Accepted Government Auditing Standards" are those set forth in the publication "Government Auditing Standards" issued by the General Accounting Office (GAO). The GAO standards are divided into General, Field Work, and Reporting standards.

Compliance Review - A review conducted with the sole purpose of determining whether programs are being carried out in conformity with laws regulations and agency written policy and procedures. (For financial reviews this also includes a determination of compliance with laws and regulations that could materially affect the entity's financial position and statements.)

Conclusions - Interpretations of the evidence stated in relationship to the objectives of the review.

Deficiency - Problems or weaknesses noted by the reviewer which are in need of correction. In its broadest sense, a deficiency includes any condition needing improvement. A deficiency can include: deviation from policy/regulation, lack of adequate internal controls, poor or unprofessional practice, inefficient practice, ineffective results, poor quality, etc. A finding is usually based on several related deficiencies.

Elements of a Significant Finding - The five components of a well developed significant finding:

* Condition - What exists (the situation the reviewer finds).
* Criteria - What should be - what the condition is measured against.
* Effect - What impact the condition is having or could have.
* Recommendation - Action needed to correct problems noted in the Program Review Report.
* Cause - What is creating or permitting the condition.

Evidence - Information gathered that is adequately sufficient, reliable or relevant to afford a reasonable basis for the judgments and conclusions regarding the organization, program,

activity, or function. The types of evidence include: documentary, testimonial, physical/observation, and analytical. Evidence is recorded in the working papers.

Expanded Scope Program Review - The concept that requires that reviews go beyond the traditional financial and/or compliance program audits. The reviewer bases his findings on sources in addition to law, regulation and policy. This might include examining the adequacy of systems of administrative and quality control, assessing conformance with professional standards of practice, determining the need for improvement, determining the achievement of productivity goals, determining the achievement of program objectives, etc. (see "Program Review Scope").

General Accounting Office (GAO) - The auditing arm of the Legislative Branch of the Federal government given responsibility for monitoring the Executive Branch's implementation of Congressional requirements. The GAO also sets minimum standards to be met in implementing Congressional mandates (e.g., internal control standards). The GAO is headed by the Comptroller General of the United States; however, its monitoring/auditing function encompasses programs as well as financial areas.

Impairments - Impediments to conducting a program review in accordance with standards, specifically GAO Standards relating to independence. These impediments can restrict the program review or interfere with a reviewer's ability to form independent and objective opinions and conclusions. The impairment can be external, organizational, or personal.

* External impairments - includes interference which limits or modifies the scope of a program review, restricts funds or other resources dedicated to the review organization, interferes with the assignment of personnel, overrules or influences the reviewer's judgment as to the appropriate content of a report or selection of what is to be examined, and jeopardizes the reviewer's continued employment with the agency or career advancement within the agency for reasons other than level of competence.

* Organizational impairments - Review organizations should report results of the reviews and be accountable to the head of the agencies; reviewers should be removed from political pressures.

* Personal impairments - include official, professional, personal, or financial relationships that might cause the reviewers to limit the extent of the inquiry, to limit disclosure, or to weaken findings in any way; preconceived ideas toward individuals or program objectives that could bias the review; previous involvement in a decision-making or management capacity that would affect current operations of the entity or program; biases that result from employment in, or loyalty to, a

particular group or organization; and subsequent performance of a review by the same individual who, for example, had previously approved actions now under review or who maintained the official records now under review.

Internal Program Reviewer - A qualified, trained employee who conducts program reviews on behalf of the Assistant Director, Program Review Division.

Internal Review - A program review conducted of BOP programs by staff or contract consultants of the Bureau (whereas, review by GAO, OPM, DOJ, etc., would be considered an "External Audit"). Internal reviews are performed under the direct authority of a member of the Bureau's Executive Staff. Review work accomplished under the authority of an institution Chief Executive Officer or his/her designee is referred to as an operational review.

Management Assessment - A management assessment is a systematic method of assessing the strengths and weaknesses of a particular program. The primary results of this process are the program review guidelines and management control plans.

Management Control - One of the three basic components of managing (planning, directing, controlling) which consists of a system of monitoring programs and taking corrective action to conform with prescribed requirements and improved management. Program reviews and other methods of reviewing programs and operations exist within a well-designed system of management control.

Management Control Plan - A Management Control Plan is a brief planning document in which each program area identifies weaknesses, develops corrective actions and monitors their progress.

Management Indicators for Vital Functions - A management indicator is a program performance measure that is designed and used by program managers to monitor each vital function. Management indicators for vital functions are attached to institution-based program review guidelines and are a product of the management assessment. These indicators are tracked by department heads, associate wardens, and at times by regional and Central Office staff to:

* routinely monitor and communicate program efficiency,
* react proactively to potential hot spots or program weaknesses,
* measure program outcomes, and
* anticipate the findings of operational and program reviews.

Management Studies - Reviews conducted in addition to routine program reviews used to assess the effectiveness of a program or program component.

Materiality - The significance of an item of information, given the circumstances, that allows a decision to be made.

Objectives - A program review management concept of which the principal goals are to achieve better application of scarce resources, better results, better objectivity and gain perspectives in reports. The key to the concept is the focusing on objectives throughout the cycle - from development of the program review objectives, through preparation of individual review reports, to following up on systemic corrective actions.

Office of Management and Budget (OMB) - A function within the Executive Office of the President with responsibility for coordination of all management and budget activities of the Executive Branch of the Federal Government. OMB issues circulares which give guidance to other departments and agencies as to how Congressional acts are to be implemented and GAO Standards complied with (e.g., A-123 for internal controls, A-127 for accounting systems, A-130 for ADP systems, A-76 for contracting out activities, etc.).

Operational Review - A review conducted ten to fourteen months or twenty-two to twenty-six months (in the case of a deferred review) from the week the previous program review was conducted, under the authority of an institution Chief Executive Officer, to ensure that all programs are operating in compliance with policy and regulations and that systems of internal control are adequate. A review of progress on required corrective actions is included.

Oversight Authority - The BOP review function which is reserved for the Director, Bureau of Prisons, and is delegated to the Assistant Director, Program Review Division (PRD). Oversight includes the determination of whether reviews are conducted in accordance with the provisions of this program statement and government auditing standards.

Program - A major activity or functional area of the Federal Prison System, such as staffing, dental care, prisoner transportation, staff training. These are also referred to as assessable units in internal control terminology. Several similar programs may be grouped to form a branch (in the Central Office) or a department (in the institution).

Program Review - Work done in reviewing compliance with laws, regulations and policy, adequacy of controls, efficiency of operations, and effectiveness in achieving program results - also referred to as a review, test, inspection and includes exploring and developing all pertinent and significant information necessary to properly consider, support, and present findings, conclusions, and recommendations. Work can go beyond determining compliance with regulation and policy (expanded scope review).

Program Review Authority - The Bureau official under whom the program review is carried out and to whom the Reviewer-in-Charge reports. This official must be a member of the Bureau's

Executive Staff. In its broadest sense, the term Program Review Authority encompasses the official program review function of the Bureau of Prisons delegated by the Director to assistant directors and regional directors.

Program Review Automated Information System - An ADP tracking system maintained by the Program Analysis Branch which contains pertinent information on each review conducted in the BOP, including date, closure, program reviewer's name, and pattern and trend information concerning deficiencies, significant findings, causes, etc.

Program Review Closure - The act of formally closing the file on a program review, requiring reasonable assurance on the Review Authority's part that any improvements and corrective actions recommended by the reviewers have been taken.

Program Review Guidelines - The program review guidelines are the road map developed for the review. Guidelines are developed via a management assessment and are issued under operations memorandum by the appropriate assistant director. The guidelines contain all the information required to successfully prepare for and conduct the review. Its major components are: General Instructions, Program Review Objectives, and Program Review Steps.

* General Instructions - Provide information to the reviewers as to how the program is to be examined. They can include: frequency, minimum days required, suggested composition of team, required indicator information needed, general sampling techniques, suggestions as to materiality and extent of observed problems that are needed to warrant a significant finding, and any other assistance that can be given to the reviewers to ensure that the review is conducted in accordance with this program statement and generally accepted government auditing standards.

* Program Review Objectives - The major part of the guidelines document which outlines the focus of the review for a particular program or activity during the review cycle. The general objectives set forth the main questions the reviewers will pursue and specific objectives describe the areas or issues with which reviewers will be working.

* General Program Review Objective - The general objective for a review is usually to evaluate accomplishments of a program's mission or assess how well a function under review is being performed. The general objective is uniform throughout the Bureau and would normally not be changed, except for special reviews. The general objective for the Bureau is described in this program statement under POLICY. It does not need to be repeated in each set of program review guidelines or report.

* Specific Program Review Objective - Specific objectives follow from the general objective and relate to the major components of the program under review or to major program issues under review (which may cut across several or all program

components). From the specific objective, steps can be designed to outline the work required to reach conclusions on the stated objectives.

* Program Review Steps - These are the instructions placed directly under each specific objective which outline, in detail, the specific documents to be examined, sampling techniques to be used, span of time to be reviewed, analytical work to be done, observations to be made, persons to be interviewed, interview questions to be asked, etc. These steps must be detailed enough that they will be understandable by assistant or trainee reviewers who are included on the team primarily for on-the-job training purposes.

Program Review Phases - The stages of the review, from preparation through follow up, to closure.

* Preparation - The first phase involving collection of all pertinent facts concerning the review site and the program, prior to arrival at the site. Assessments of these facts may lead to an adjustment in the focus of the review (program review objectives).

* Examination - The phase of the program review where evidence is collected and assessed for reliability, sufficiency and relevance, and working papers are prepared.

* Evaluation - The analysis phase where the collected evidence is analyzed to discern exemplary programs or patterns of deficiencies, their effects, and causes. From this analysis, (on-going throughout the review), the evidence is organized into elements of a finding.

* Report - The presentation phase, beginning with an oral report of findings to the Chief Executive Officer at the closeout, to filing of the written report, receipt of the response, and, if changes are necessary, the filing of an amended, final report.

* Follow-up - The final phase of the review, where the reviewer monitors the progress of corrective action. This stage ends with the closure of the review.

Program Review Plan - The document prepared for each specific site and program review which includes such information as the purpose and scope of the review, background information needed to understand the objectives as well as the logistics, division of labor, etc.

Program Review Report - The medium through which a Reviewer-in-Charge communicates the results of the review.

Program Review Schedule - A semi-annual schedule of individual reviews to be conducted during a fiscal year.

Program Review Scope - A section in the Program Review Report which indicates the type of review conducted, the extent of the review, and the specific programs, activities, and functions covered (in the BOP, this is presented in the Cover memorandum from the Program Review Authority).

Recommendations - The courses of action specified in the report to correct problem areas and to improve operations. The suggested course of action can be based on deviations from policy as well as other deficiencies or need for improvement.

Reviewer - See internal program reviewer.

Reviewer Access - The assurance that the reviewers will have complete access to all records, property, operations, personnel and inmates during a program review.

Reviewer-in-Charge - The reviewer that heads the program review team and reports directly to the Program Review Authority.

Risk Analysis - An intensive review of each component's vulnerability in carrying out its mission or stated goals. This is accomplished by balancing the probability of failure against controls in place, thus rating the actual risk or potential damage which could occur.

Significant Exemplary Program/Procedures -

- exhibits an innovative approach to a problem;
- makes efficient, cost effective use of available resources;
- impacts effectively on the targeted problem; and
- has potential applicability in other Bureau settings.

Significant Finding - A pattern of events or single event normally linked to a program review objective that indicates a deficiency or strength in an organization or organizational element. This determination is based on the sound professional judgment of the Reviewer-in-Charge. The event(s) must be supported by information which meets required standards of evidence and could:

- impair or enhance the fulfillment of the program, institution or agency mission;
- violate statutory or regulatory requirements;
- weaken or strengthen safeguards against fraud, waste, abuse and/or mismanagement.

Special Review - The examination of a particular subject area in more depth than accorded in a routine review. It may involve several different disciplines or programs (suicide prevention controls; crisis intervention effectiveness; SENTRY training,

coordination and accuracy; A&O program effectiveness; etc.). This is still considered to be a program review and provisions of this program statement apply. This type of review usually requires a special set of objectives.

Strategic Management Cycle - Is the dynamic process of improving programs through gathering, analyzing, and using information which leads to timely, effective, and continuous planning . The strategy is to merge the present with the future and knowledge with the commitment to improve.

The elements of the strategic management cycle are: management assessment, operational review, program review, social climate sources, institution character profile, other information sources (GAO, OIG, etc.), information synthesis, policy development, key indicators, and strategic management goals.

Conducting a program review is a good example of how specific elements of the cycle interact. Before a program review, the examiner gathers information from the operational review, social climate survey, institution character profile, key indicators, and other sources. Following the review, the examiner informs the institution staff of its strengths and weaknesses in a specific program area; and institution staff develop a strategy for corrective action (strategic plan). Afterward the information is collected and synthesized into a database for assessing the overall effectiveness of a program. This data is used to conduct the program/operation's periodic management assessment and to assist the administrators throughout the year in determining program/operation effectiveness and developing policy.

Strategic Planning - The process the Bureau of Prisons uses to identify local, regional, and national objectives that are critical to the accomplishment of the mission of the Bureau. This process also calls for the development of action plans and steps which identify required resources, set completion time limits, and specifies individuals responsible for completion of the task.

Technical Assistance - In its broadest sense, technical assistance is a component of any review and the purpose is to improve operations. However, in the Bureau, program experts often visit institutions or offices solely to provide expert guidance in a specific, complex program area or a team of experts may be called in to assist institution staff after program reviewers have discovered serious deficiencies.

For the purpose of this program statement, technical assistance refers to a visit conducted for purposes other than a program review. Any summary reports of such a visit are prepared at the discretion of the regional or assistant director responsible for the visit.

Vital Functions - Areas within a program/operation, determined by the Regional and Central Office Administrator during the management assessment, which are critical to a discipline's performance.

Working Papers - Documents that provide support for opinions, conclusions, and judgments. They aid in the conduct and review of the reviewer's work. Include the collection of schedules, papers, analyses, correspondence, and other material prepared or obtained prior to and during the program review. They are to be retained a period of eight years from the date of the review.

STATE OF UTAH
DEPARTMENT OF CORRECTIONS

DEPARTMENT MANUAL

Volume: Administrative Procedures

Chapter: ACr13 DEPARTMENTAL AUDITS

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Authorized By:
Executive Director, Department of Corrections

ACr13/01.00 GENERAL

ACr13/01.01 Purpose of Chapter

A. The purpose of this chapter is to set forth the duties, responsibilities and audit procedures of the Bureau of Internal Audit of the Deputy Director's Office in conjunction with the various divisions in the Department of Corrections.

B. The elements and scope of authority, command and supervision are presented to aid divisions in complying with audit requests.

ACr13/01.02 Cross Reference

TMA 03/05.00 Bureau of Internal Audit
TME 03/00.00 Records Management

ACr13/01.03 Policy

A. It is the policy of the Department that all Departmental programs shall be audited by or under the authority of the Bureau of Internal Audit of the Deputy Director's Office, using the following steps:

1. analysis of compliance of actual practice with existing laws, rules, regulations, standards, and policies;

2. assessment of the efficiency and effectiveness of operations in the utilization of resources;

3. determination of whether mandated program results are consistent with established objectives and goals and operations and programs are being carried out as planned;

4. examination of financial records and operations to determine compliance with Generally Accepted Accounting Principles, laws, regulations and policies; and

5. assessment of the reliability and integrity of financial and operational information and the means used to identify, measure, classify and report such information.

B. The Director of the Bureau of Internal Audit shall coordinate all external audits and

provide assistance to the external auditors if requested.

C. The Bureau of Internal Audit shall also provide technical assistance and training to audit liaisons and other Department staff to encourage compliance and promote improved internal controls.

ACr13/01.04 Definitions

audit exemption — the authorized removal by the Executive Director of a specific policy or objective from the scope of an audit.

audit finding — a conclusion made by the auditors which may include:

1. criteria (measurement standards);
2. condition (the problem);
3. cause (reason why the condition exists);
4. effect (potential or actual result of condition); and
5. recommendation (possible corrective action)

audit liaison — a person designated at each facility, program site, or office to:

1. assist BIA, as a coordinator between BIA and entity management, when audits are performed; while performing this function, the person shall be referred to as a "Coordinating Audit Liaison";
2. function as an auditor (ten working days per year) on various audits within the Department but not related to the liaison's immediate assigned work area; while performing this function, the person shall be referred to as an "Assisting Audit Liaison"; and
3. perform local internal audits in the liaison's immediate area to identify weaknesses in internal control systems and initiate corrective action through the preparation of a report to management or a management letter

audit scope — a description of the extent of the work to be completed by auditors in examining:

1. compliance with applicable laws, regulations, policy and procedure;
2. economy and efficiency of operations;
3. effectiveness in achieving program results;
4. financial statements and operations; and
5. reliability and integrity of information.

audit variance — an approved exemption which may be authorized only by the Executive Director

auditor-in-charge (AIC) — BIA member assigned to plan, implement and report audit findings

BIA — Bureau of Internal Audit

CIB — Corrections Investigative Bureau

closure of an audit report — satisfactory resolution of all actions agreed upon at the exit conference or alternatives to these actions

	approved by the Executive Director, documented in the form of a follow-up report
entity manager	the designated administrator of any regional office, community center, prison facility, individual program, or contracted private provider
entity response	documentation indicating agreement/disagreement to an audit finding; clarification and plan of action
exit conference	a meeting scheduled by the Executive Director with BIA staff and appropriate division personnel to review the working draft report, obtain an entity response and develop action plans to address audit findings
management letter	a report by an audit liaison to an entity manager or division director describing the nature of any weaknesses in internal controls or other problems which are discovered by the audit liaison while doing local internal audits and including recommendations for corrective action
negative assurance	a statement made in audit reports indicating that nothing came to the attention of auditors regarding items not tested which would cause them to believe that untested items are not in compliance with applicable policies, procedures, regulations or laws
positive assurance	tested items appear to be in compliance with applicable policies, procedures or regulations
risk assessment	a methodology devised by BIA to assist the Deputy Director in identifying audit priorities
tested items	items specifically tested by auditors and audit liaisons to determine the degree of compliance with law, regulations, standards and, policies and procedures and effectiveness of operations
vulnerability assessment	a narrow-scope audit looking at the management controls and operations of an entity to determine: 1. susceptibility to loss or unauthorized use of resources, errors in reports and information, illegal or unauthorized acts and/or possible undue external scrutiny; 2. whether specific analysis should be made for purpose of improving controls; and 3. whether a broader scope audit should be performed.

Revised 12/1/92 ACr13/01.04

ACr13/02.00 GENERAL REQUIREMENTS AND INFORMATION

ACr13/02.01 Audit Plan

A. The BIA shall prepare and submit a long-term audit plan based on a risk assessment to the Deputy Director by May 15 before the commencement of each three-year audit cycle.

B. The long-term audit plan shall be divided into individual three-month plans which shall be submitted to the Deputy Director prior to implementation.

C. The audit plan shall include:

1. what/who is to be audited;

2. when the audit shall be performed;

3. estimated time required; and

4. who shall supervise the audit.

ACr13/02.02 Appointment of Division Audit Liaisons

A. Each division director shall ensure that audit liaisons are appointed to adequately represent each entity and function within the division. This includes, for example, each Community Correctional Center, each region, each major institutional housing unit and each bureau.

B. Upon request of the Deputy Director, a division director shall review audit liaison assignments to take into consideration transfers, promotions, etc., in order to maintain adequate division representation.

C. Audit liaisons shall be responsible for:

1. attending training as scheduled and provided by the staff of the Bureau of Internal Audit as ordered by the Deputy Director;

2. coordinating all audits at their work location;

3. assisting BIA in audits at locations other than their work place; and

4. conducting local internal audits and reporting results in management letters under the authority of the Bureau of Internal Audit (see ACr13/02.09).

ACr13/02.03 Auditor/Audit Liaison Training Plan

A. An annual audit training plan shall be prepared by the Bureau Director/designee on or before June 15 of each year for the subsequent fiscal year.

B. Training for BIA and audit liaison staff shall include formal classroom and on-the-job training to meet the requirements of the Department and to enhance professional skills.

ACr13/02.04 Technical Assistance/Training

Technical assistance/training assignments shall be provided by BIA at the direction of the Deputy Director.

ACr13/02.05 Auditing Standards

BIA shall audit to the following standards:

A. laws, rules, regulations, and policies of the United States Government, State of Utah and Department;

B. Government Auditing Standards, published by the United States General Accounting Office;

C. Codification of standards for the professional practice of internal audit, Institute of Internal Auditors, Inc.; and/or

D. other requirements established by the Executive Director for a particular audit.

ACr13/02.06 Right of Access

A. BIA shall be given right of access to all members, offenders, sites, files and other requested information except for confidential legal materials.

B. Adequate secure working space shall be made available to the auditors while on site and copies of documents shall be provided upon request.

C. Requests from the BIA during an audit carry the authority of the Executive Director.

D. Technical manuals issued to the BIA Director shall remain in his custody but may be reviewed by auditors and audit liaisons when necessary to conduct an authorized audit.

E. Auditors are also authorized to review technical manuals in the custody of an auditee while the auditors are conducting an authorized audit.

ACr13/02.07 Internal/External Resources

BIA may use resources within the Department and from other agencies or individuals when technical expertise is required.

ACr13/02.08 Independence

BIA staff shall be free from personal or external impairments to the exercise of independent judgement, maintain organizational independence, and display an independent attitude and appearance.

ACr13/02.09 Management Letter

A. Under the direction and authority of the BIA, audit liaisons shall be used by division directors to perform local internal audits:

1. of entities within the division based on priorities resulting from formalized risk assessment tool; and

2. based on a schedule established by the division director and entity manager in coordination with the BIA and approved by the Deputy Director.

B. Under the supervision and direction of BIA staff, audit liaisons shall develop audit questionnaires to be used in assessing operations during local internal audits;

C. Local internal audit reports and/or management letters documenting deficiencies found during internal audits of entities shall be prepared by the audit liaison and reviewed by BIA staff before being forwarded to the entity manager for review and preparation of an action plan.

D. The Audit Report or letter and action plan shall be forwarded through the chain of command to the division director to ensure that plans are implemented.

E. An exit conference shall be scheduled and attended by the entity manager; appropriate management staff, the division director, if that person elects to attend; and a representative of the Bureau of Internal Audit.

F. All local internal audit reports and related working papers are classified as confidential under Utah Code Ann. Section 64-13-25 and are available at the discretion of the Executive Director, or the governor, or upon court order.

ACr13/03.00 AUDIT PROCEDURE NARRATIVE

ACr13/03.01 Planning

A. The AIC shall provide written notification to the entity manager and division director six weeks prior to the on-site phase.

B. The Audit Announcement includes:

1. a statement of preliminary audit scope and objectives; and

2. a request for pre-audit survey information.

C. If the entity manager is of the opinion a portion of the audit or the entire audit should not be conducted, a written request shall be made to the Executive Director with a copy to the BIA Director within two working days after receiving the Audit Announcement, stating the reason for the requested audit variance and requesting a determination.

D. The AIC shall:

1. conduct a pre-audit survey;

2. collect information relative to the scheduled audit from all relevant sources;

3. request documents and information from the entity to be audited which shall be forwarded to BIA no later than four weeks from the date of the request;

4. interview the division director, entity manager, entity staff and other appropriate individuals to determine what weaknesses in internal controls exist and incorporate these issues and other relevant operational concerns into the scope of the audit;

5. review all external and local internal audit reports and management letters concerning the entity to be audited; and

6. consult with staff of the Attorney General's Office to identify all pertinent legal issues pertaining to the audit. Portions of the audit scope or the entire audit scope may be classified as attorney work product.

E. The AIC shall prepare an audit program detailing audit areas and objectives to be addressed during the on-site phase.

F. The audit program shall define the audit scope which may include one or more of the following:

1. compliance with laws, rules, regulations, or policies;

2. economy and efficiency of resources and staff;

3. program results;

4. examination of financial records and operations; and

5. the reliability and validity of administrative and financial information.

ACr13/03.02 Verification

A. The AIC should schedule and conduct an entrance conference at the beginning of or prior to the first day of the on-site verification phase.

1. The entrance conference should include the division director/designee, entity manager/designee, audit team and coordinating audit liaisons, and other individuals as determined by the division director.

2. The Audit Program and the audit on-site schedule shall be reviewed.

3. The entity shall be provided with an Audit Team Evaluation Form with the request that the entity evaluate the audit team's performance in conducting the audit upon completion of the exit conference.

B. The audit team shall review entity documents, conduct interviews, observe conditions, and conduct other audit tests as indicated in the Audit Program or as determined necessary by the AIC and BIA Director.

C. If at any time during an audit, the AIC identifies a significant security, health, safety or financial problem or impairment

which significantly inhibits the audit from being completed, the AIC shall:

1. meet with the entity manager for problem resolution;

2. contact the BIA Director and provide a summary of the discussion with entity manager and the proposed resolution; and

3. submit a written report to the Director of BIA within one calendar day of the meeting. The Director of BIA shall submit a report to the Deputy Director within one calendar day of receiving the report from the AIC.

D. The audit team shall develop working papers documenting findings, judgments, conclusions, and recommendations.

E. Working papers shall be maintained in safe custody and storage for time sufficient to satisfy legal and administrative requirements.

1. All audit working papers and reports, whether prepared by BIA staff or audit liaisons, are classified confidential pursuant to 64-13-25, subsection (2)(c), and are available only at the discretion of the Executive Director or Governor or upon court order.

2. Audit working papers and reports are classified as protected by the Government Records and Management Act, Utah Code Ann. Section 63-2-101 et seq.

F. If it is determined by the AIC that additional time is needed to successfully complete an audit, the AIC shall:

1. discuss the extension with the entity manager to determine whether the extension would create an undue hardship on the entity's daily operation or personnel; and

2. submit the request to the director of BIA who shall review and approve/deny the request and inform the Deputy Director, who shall make a final determination.

G. On the last day of the on-site visit, the AIC shall conduct a comprehensive review with the entity manager for clarification of preliminary findings.

ACr13/03.03 Evaluation

A. Audit team members shall review all working papers to assess internal controls and determine findings.

B. Issues of a confidential nature may be excluded from the final draft report at the discretion of the BIA director with the approval of the Deputy Director.

C. In the final draft report, BIA shall identify and justify areas needing further study.

D. A working draft report of findings and recommendations shall be completed within thirty-five calendar days of the end of the on-site verification phase.

E. Copies of the working draft report shall be provided to those authorized by the Executive Director to be scheduled for the exit conference at least seven days prior to the exit conference.

ACr13/03.04 Exit Conference and Final Draft Report

A. Exit Conference, Protocol and Purpose

1. The Executive Director/designee shall determine who is to attend the exit conference, schedule and chair an exit conference.

2. The conference shall be attended by:

a. the Executive Director/designee;

b. the Deputy Director/designee;

c. the division director;

d. the Director of Bureau of Internal Audit;

e. a representative from the Attorney General's Office;

f. the Auditor-in-Charge;

g. the entity manager; and

h. any other persons deemed appropriate or necessary by the Executive Director/ designee or division director.

3. In preparation for the exit conference, the entity manager/designee shall prepare a written entity response in the following format:

(Audit Number and Entity Audited)
Entity Response

Summary of Finding	Entity Comments	Entity Action

4. The BIA director/designee shall make an oral and written presentation of the final draft report.

5. The entity manager shall make an oral and written response to each finding and recommendation.

6. The entity manager shall:

a. accept/reject the findings;

b. accept/reject/modify the recommendations;

c. provide an explanation for acceptance/rejection;

d. indicate action to implement the recommendation or acceptable alternative;

e. indicate who shall be responsible for resolving the audit finding; and

f. provide a date by which implementation of recommendations shall be completed.

B. Audit Team Evaluation

The entity manager/designee shall complete the Audit Team Evaluation Form provided at the entrance conference and return it to the BIA Director within seven working days after the exit conference.

C. Final Draft Report

1. BIA shall submit the final draft report to the Executive Director within fourteen calendar days of the exit conference. The final draft report shall generally include:

a. scope and objectives of the audit;

b. statement that the audit was conducted in accordance with generally accepted government and internal audit standards;

c. statement as to whether information has been omitted because of confidentiality;

d. statements of positive assurance and negative assurance;

e. description of material weaknesses found in the internal control system;

f. description of noteworthy accomplishments within the entity;

g. recommendations for actions needed to improve problems noted in the audit findings;

h. entity response; and

i. issues needing further study.

2. The final draft report shall be distributed as authorized by the Executive Director/designee.

ACr13/03.05 Follow-Up and Closure on Audit Reports

A. The entity manager/designee shall provide documentation in writing of audit finding resolution to BIA on an ongoing basis as action plan activity occurs.

B. BIA shall conduct follow-up audits to determine if an audit is still in progress. Closure of an audit report shall be made upon preparation of a follow-up audit wherein all agreed-upon action plans developed at the exit conference or alternatives approved by the Executive Director are determined to have been satisfactorily resolved.

C. A follow-up audit report shall be submitted to the Executive Director and others as ordered by the Executive Director. An exit conference shall be scheduled.

D. Compliance investigations of audit findings may be scheduled and conducted by the CIB.

Section: 01 Administration and General Office
Subsection: 11 Audits
Subject: 102 Fiscal Internal Audits

I. POLICY

A. Authority

1. Ill. Rev. Stat., Ch. 15, Para. 1001 et.seq.

2. Standards for the Professional Practice of Internal Auditing, Institute of Internal Auditors.

B. Policy Statement

It is the policy of the Department to maintain a comprehensive, independent program of internal auditing to examine and evaluate its activities to assist management in maintaining an effective system of internal control and effectively and efficiently managing the Department.

II. PROCEDURE

A. Purpose

The purpose of this directive is to establish a written procedure governing the Department's fiscal internal auditing program in accordance with the Fiscal Control and Internal Auditing Act.

B. Applicability

This directive is applicable to all divisions and bureaus within the Department.

C. Internal Audits

An internal audit of this directive is not required by any facility or program.

D. Definitions

1. Internal control - the overall plan of organization and all the methods and procedures an agency uses to ensure: the reliability and integrity of information; compliance with policies, plans, procedures, laws, and regulations; the safeguarding of assets; the economical and efficient use of

ILLINOIS DEPARTMENT OF CORRECTIONS
ADMINISTRATIVE DIRECTIVE

Section: 01 Administration and General Office
Subsection: 11 Audits
Subject: 102 Fiscal Internal Audits

resources; and the accomplishment of established objectives and goals.

2. Administrative controls - the broad controls on all activities which officials use to accomplish their objectives economically, efficiently, and effectively.

3. Fiscal controls - the controls on authorizing, processing, recording, and reporting transactions. Fiscal controls are part of the administrative controls environment.

4. Internal auditing - an independent appraisal of the operations and controls within an organization to determine whether acceptable policies and procedures are followed, established standards are met, resources are used efficiently and economically, and the organization's objectives are being met.

E. Responsibilities

1. The Chief Internal Auditor shall report directly to the Director and has responsibility for directing the internal auditing program which includes:

a. Audits of major systems of internal accounting and administrative control conducted on a periodic basis so that all major systems are reviewed at least once every two years. The audits must include testing of: the obligation, expenditure, receipt, and use of public funds of the State and of funds held in trust to determine whether those activities are in accordance with applicable laws and regulations; and grants received or made by the Department to determine that the grants are monitored, administered, and accounted for in accordance with applicable laws and regulations.

b. Reviews of the design of major new electronic data processing systems and major modifications of those systems before their installation to ensure the systems provide for adequate audit trails and accountability.

c. Special audits of operations, procedures, programs, electronic data processing systems, and activities as directed by the Director.

2. The Chief Internal Auditor shall submit a two-year plan, identifying the audits scheduled for the pending fiscal year, for approval by the Director before the beginning of the fiscal year.

3. By September 30 of each year, the Chief Internal Auditor shall submit to the Director a written report detailing how the audit plan for that year was carried out, the significant findings, and the extent to which recommended changes were implemented.

4. The Chief Internal Auditor will coordinate the external compliance audit process with the Office of the Auditor General and assist the Director in the annual evaluation and certification to the Auditor General regarding the adequacy and effectiveness of the Department's systems of internal control.

5. The auditing staff has full unrestricted access to all Department activities, records, property, and personnel. The manager of an area being audited shall make all records and required information available and answer questions relevant to his area of responsibility.

6. The Chief Administrative Officer (or the appropriate manager in the service bureau) has the responsibility to devise, install, and supervise systems of internal control adequate to safeguard the assets of his organization, ensure the accuracy and reliability of account data, promote operational efficiency and effectiveness, and ensure adherence to prescribed managerial policies.

F. Audit Standards

1. The Department's internal auditing program will follow the Standards for the Professional Practice of Internal Auditing promulgated by the Institute of Internal Auditors and adopted by the State of Illinois Internal Audit Advisory Board.

2. The general standards are:

a. Internal auditors should be independent of the activities they audit.

b. Internal audits should be performed with proficiency and due professional care.

c. The scope of internal audits should encompass the examination and evaluation of the adequacy and effectiveness of the organization's system of internal control and the quality of performance in carrying out assigned responsibilities.

d. Audit work should include planning the audit, examining and evaluating information, communicating results, and following up.

e. The Chief Internal Auditor should properly manage the internal auditing department.

3. An audit manual containing approved audit programs and procedures shall be maintained by the Fiscal Audit Unit to ensure audits are performed in accordance with required audit standards.

Authorized by:

DIRECTOR

Supersedes:

01.11.102	AD	11/15/82
01.11.105	AD	07/01/88

APPENDIX D

Audit Programs/Audit Objectives

Illinois Department of Corrections (APPPTK**.GR), Excerpt
(May 6, 1991)

New Jersey DOC Audit Program for District Parole Offices, Internal Control Questionnaire, Internal Audit Unit, District Parole Office,
DOC Bureau of Audits and Accounts

Illinois Department of Corrections
Audit Actuarial Form

Federal Bureau of Prisons Operations Memorandum 162-91 (5324),
Program Review Guidelines for Psychology Services
in the Institutions (July 26, 1991)

Utah Department of Corrections, Audit 92-9 DIO
Internal Security and Key Control

ILLINOIS DEPARTMENT OF CORRECTIONS
Excerpt from Audit Program

APPPTK**.GR 05/06/91

DEPARTMENT OF CORRECTIONS

_____
Institution

Personnel/Payroll/Timekeeping

AUDIT PROGRAM

AUDIT OBJECTIVE(S):

To determine that personal services and related appropriations were expended in accordance with state law, the personnel code and regulations, and the department's administrative directives relating to personnel, payroll and timekeeping. To verify the adequacy and accuracy of payroll/timekeeping records.

AUDIT STEPS

____ 1. Review related findings and recommendations from the prior external and internal audit reports. Copy these findings and recommendations for work papers, and during audit determine implementation status of the recommendations.

____ 2. Review all business office job descriptions to determine they are up to date and duties are in accordance with job descriptions. Review internal control for all general revenue activities such as purchasing, payroll/timekeeping.

____ 3. Describe by flow chart the payroll cycle from employee sign-in/roll call to warrant distribution.

____ 4. Obtain a recent Personal Services Management Information System (PSMIS) report by function and choose a representative sample of employees from the various functions for detail testing; i.e., administration, business office, security, dietary, etc. (At least 1/3 being RC-6 security).

____ 5. Obtain a semi-monthly payroll voucher corresponding with the PSMIS report in Audit Step 4 and for the sample chosen, determine from personnel and payroll files that:

A. Performance appraisals are current
B. Gross pay is correct
C. Federal and state withholding deductions are correct
D. Voluntary payroll deductions are properly authorized (includes optional health and life).

____ 6. For the same sample, obtain a copy of the "Employee's Time Sheet" (DC 333F) for each employee selected. Verify:

A. Accuracy of benefit and earned time balances carried forward from prior year.

B. Vacation accrual and date of next higher vacation accrual is correct.

C. Holiday, vacation, sick and personal business time earned, used and balance due are correct for calendar year.

D. Holidays, accrued over one year, were properly "banked".

F. Increments of time used are in accordance with personnel code or appropriate labor contracts.

____ 7. For one month for the employee sample selected, determine:

A. "Notification of Absence" slips are properly approved, in proper increments of time and on file for all absences for the month.

B. Documentation is on file for all compensatory time/overtime earned for the month.

C. The calculation of compensatory time, straight overtime and premium overtime earned, paid/used, and balance due is accurate.

D. The calculation of roll call, shift differential and temporary assignment is correct and documented.

E. Roll Call/Sign-in Sheets or daily attendance records match time sheets.

F. Review Roll Call/Sign-in Sheets for inconsistency of sign-in times or one person signing for another. Review for supervisory approval.

____ 8. Obtain listing of employees living in state-owned housing:

A. Determine "maintenance" charges are accurate

B. Select a representative sample and determine that voluntary deduction authorizations are on file

C. For the same sample, verify deduction on recent payroll voucher or direct payment in miscellaneous receipts journal.

____ 9. Obtain listing of all current part-time employees. Determine accuracy of benefit time prorations and accuracy of prorated earnings to scheduled and worked time.

____ 10. Obtain listing of employees leaving state service during year with lump sum payments of over $1,000. Test the accuracy of lump sum calculations for at least 10 such employees. Ensure employees have not been rehired.

____ 11. Review all salary refunds. Investigate any partial salary refunds and determine why they are not a full refund.

____ 12. Write conclusions for personnel/payroll/timekeeping caption and file immediately after audit program.

NEW JERSEY DEPARTMENT OF CORRECTIONS AUDIT PROGRAM
FOR DISTRICT PAROLE OFFICES
Department of Corrections
Bureau of Audits and Accounts
Internal Audit Unit
Audit Program
District Parole Offices

1. Planning
   A. Audit Objectives
      1. The audit has been properly planned.
      2. Provide continuity between prior and present audits.
      3. Benefit from the experience of prior audit in the planning of the present audit.
      4. Determine that the current audit file has been established with reference to the prior audit file and that advantage has been taken of prior audit experience in creating the current file.
   B. Prior to the start of the audit engagement, while still at Central Office, review the file of the agency's previous audit. Give special attention to the following areas:
      1. Findings: Note these as subjects for potential continuing review.
      2. Concerns: Items of a more minor nature than the Findings, which may be worthy of notation for further review.
      3. Problems: Indications in the workpapers of areas where difficulties were experienced in conducting the audit, and which may be problem areas once again during the planned audit.
      4. Preparation: Assembling of forms and documents such as:
         Bank confirmation letter
         Disclosure declaration
         Audit program
         Internal Control Questionnaire
         Audit finding
         Conversation record
         Daily log
         Work paper outlines
      5. Aids: Suggestions previously noted for providing a smoother audit, from such things as idiosyncracies of personnel to dealing with problems of physical conditions of the work area.
   C. Prepare the entrance conference IOC and mail it to the agency.
   D. Schedule and conduct the audit entrance conference.

2. Evaluation of Internal Control
   A. Audit objectives
      1. Evaluate the extent to which the agency's assignment of duties among its personnel creates a working environment that may be relied upon to preclude errors and irregularities.

      2. Ascertain that no single employee is in control of sufficient areas of responsibility which would likely lead to a lack of checks and balances in the work area and commissions of undetected undesirable acts.
      3. Determine that the plan of organization, procedures and work assignments provides adequate assurance as to the safeguarding of assets and efficient operation of the agency.
      4. Design audit activities which will adequately review those areas where internal control weaknesses have been identified.
   B. Obtain responses to the Internal Control Questionnaire from the agency's personnel.
   C. Prepare flow charts of work patterns, and narrative descriptions, as deemed necessary to delineate the status of internal control.
   D. Review the agency's written procedures relating to areas to be audited.
   E. Highlight weaknesses revealed in the internal control structure by means of steps A. through D. above; note these as areas for special review during the audit.

REFERENCES:
Treasury Circular Letter 85-31 Internal Controls

3. Cash
   A. Audit objectives
      1. Separate depository accounts are maintained for each fund for which required.
      2. Cash balances reflect a proper cutoff of receipts and disbursements and are stated at the correct amount.
      3. Cash balances are presented properly, including, if applicable, by fund, and any restrictions on cash balances are adequately disclosed.
   B. Audit Procedures
      1. Cash in Bank - Financial Aid
         a. Have the Supervisor complete the Disclosure Declaration form for all bank accounts that were open during any part of the audit period. For depository accounts opened or closed during the period, trace to appropriate authorization.
         b. Confirm balances as of the end of the audit period by direct correspondence with the bank for all bank accounts that were open during any part of the audit period.
         c. Obtain list of authorized check signers.
         d. Obtain copies of agency's bank reconciliations, bank statements, and canceled checks at the end of the audit period and for any other months to be tested.

1. Verify the accuracy of the bank reconciliations: verify book balances to checkbook and financial records. Prepare a Composition of Funds.
2. Verify balances reported in bank confirmations to agency's bank reconciliations.
3. Trace deposits in transit to subsequent bank statements.
4. Investigate any remaining significant reconciling items.
5. For periods audited, make copies of bank statements, agency's bank reconciliations, checkbook balance page, and any Requests for Replenishment of Funds covering receipts in transit.
6. Age outstanding checks: those over one year old should be voided.

e. Determine that balances on deposit at the banks have not exceeded insured levels.

f. Identify which individual funds are required by law or other contractual agreement to maintain separate bank accounts. Ascertain that separate bank accounts are maintained and note any withdrawal or other restrictions which may exist.

g. Prepare schedule of checks issued. Examine checks and supporting documentation. Test check signatures, endorsements, and for absence of alterations.

h. Prepare schedule of checks issued verified to files. Cross-reference payee's name and number to a Parole Office file.

REFERENCES:

Accounting Bulletin 91-04 Signature Record Cards
Accounting Bulletin 85-10 Banking Services
Treasury Circular 85-10 Banking Services
B.P. Administrative Manual Sec. 814 Financial Aid Program

4. Revenue Program

A. Audit objectives

1. Adequate internal controls over cash exist.
2. Data are recorded and maintained as required.
3. Cash received is fully accounted for in the records.
4. Substantial efforts are made on an ongoing basis to collect balances owed.
5. Deposits are made on a timely basis.
6. Accounts receivable balances are accurate and are in agreement with the control account.

B. Audit procedures

1. Journal pages-all pages: foot and cross-foot, verify control figures and carryforwards, using deposit slips verify deposits (incl. amounts of cash and checks and also dates).
2. Schedule of Transactions (ledger cards) - Test sample of payment entries, per ledger cards, to journal (to provide assurance re: deposit).
3. Schedule of Transactions (payments) - Test sample of payment entries per journal as having been entered on the ledger cards.
4. Schedule of Transactions (charges) - Test accuracy of entries for charges. Verify sample of journal entries to documents in files and to ledger cards.
5. Schedule of Transactions (transfers) - Test accuracy of entries for transfers. Verify sample of journal entries to documents in files and to ledger cards. Verify that other DPOs are actually making the correct offsetting entries.
6. Schedule of Transactions (adjustments) - Test accuracy of entries for adjustments. Verify sample of journal entries to documents in file and ledger cards.
7. Schedule of Deposits - Test timeliness of bank deposits. List all deposits or sample. Spread across worksheet to proper category for days taken. Make copies of problem deposit slips. Verify actual deposits into Treasury account.
8. Schedule of Casecount Additions - Verify sample from casecount list to ledger cards to determine whether cards were opened for new cases.
9. Schedule of Accounts Receivable - Prepare listing from ledger cards for last month of audit period. Compare to control account. Investigate and adjust differences.
10. Schedule of Revenue Received - Test for sample period to determine whether total payments reflected per ledger cards equal total deposits reflected per journal.
11. Schedule of Payments - For sample period compare Deposits column with Payments column per the journal to verify actual deposit of payments received.

REFERENCES:

B. P. Administrative Manual Para. 805 Revenue Program

5. Fixed Assets

A. Audit objectives
1. Appropriate records are maintained for each asset.
2. Fixed assets are identified and periodically inventoried to verify that they are on hand..
3. Restrictions on the use or disposition of fixed assets have been complied with.

B. Audit procedures
1. For a sample taken from the agency's fixed asset records:
   a. Locate the assets within the agency.
   b. Determine that assets are properly identified (tagged).
   c. Determine that assets purchased at an acquisition cost of $300 or more have been properly entered in the Fixed Asset Register.
2. Determine that inventory cards are being prepared for newly acquired fixed assets.
3. Determine that required forms are being completed for transferred, sold, or scrapped fixed assets, and that they are being properly deleted from the schedule.
4. Determine the the Fixed Asset Register is complete and up-to-date.

REFERENCES:
Treasury Circular Letter 83-8 Uniform Perpetual Fixed Asset Inventory System

6. Inmate Wages (Pilot Program)

A. Audit objectives
1. Separate depository account is being maintained.
2. Disbursements for inmate wages are being made in accordance with draft of procedures.
3. Documentation for the inmate wages program is being provided by the DPO as required.

B. Audit procedures
1. Cash in Bank - Inmate Wages
   (Complete steps a. through h. as outlined under 3.B.1.. Cash in Bank - Financial Aid, in the Audit Program)
   a. Complete Disclosure Declaration.
   b. Confirm balance with bank.
   c. Obtain list of authorized check signers.

   d. Obtain copies as noted.
      1. Verify bank reconciliations, etc.
      2. Verify balance reported by bank.
      3. Trace deposits in transit.
      4. Investigate remaining reconciling items.
      5. Make copies as noted.
      6. Age outstanding checks.
   e. Check insured levels.
   f. Identify needs for separate bank accounts.
   g. Prepare schedule of checks issued. Perform tests as noted. Verify payments to notification lists. Test for compliance with deduction of maximum of one-third of wages due for Revenue Collection. Test for deposit entry for revenue collected in the journal.
   h. For a sample of checks perform tests noted.

REFERENCES:
Bureau of Parole Office Memorandum (Second Draft) - 12/20/88
Accounting Bulletin 91-04 Signature Record Cards
Accounting Bulletin 85-10 Banking Services
Treasury Circular Letter 85-10 Banking Services

7. Personnel

A. Audit objectives
1. Records of compensatory time are maintained as required.
2. Compensatory time balances do not exceed guidelines.

B. Audit procedures
1. Review personnel records to determine whether compensatory time balances reflected are in accordance with departmental guidelines.

REFERENCES:
Human Resources Bulletin 86-11

8. Other

A. Audit objectives
1. Verify the adherence to existing guidelines and the accuracy of record keeping for selected areas of administrative or accounting activity.

INTERNAL CONTROL QUESTIONNAIRE
INTERNAL AUDIT UNIT
DISTRICT PAROLE OFFICE
DOC BUREAU OF AUDITS & ACCOUNTS

TABLE OF CONTENTS

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Institution _____ Audit Period _____

	Y	N	NA	COMMENTS
1. Does the Department of Treasury authorize all bank accounts?				

2. Who are the current check signers?

List Accounts	Authorized Signers

3. Is the bank immediately notified of all changes of authorized check signers?				

Cash Receipts

4. Is incoming mail opened and receipts listed in duplicate by personnel having no access to cash receipts or accounts receivable records?				
5. Is the listing of mail receipts subsequently compared to currency cash sheets, cash receipts records and authenticated copies of deposit slips by an employee having no access to cash?				
6. Are business checks and money orders restrictively endorsed "for deposit only" by the individual who opens the mail when received?				
7. Are bank deposits taken to the bank by an employee having no access to cash receipts or to the keeping of the cash records?				
8. Does an employee who is independent of the cash receiving, recording and bank deposit functions verify the accuracy of the stamped bank deposit slip to the journal?				
9. Are prenumbered cash receipts issued for all payments received?				
10. Do adequate physical controls exist over the supply of unused prenumbered cash receipt forms?				
11. Is a log kept of the prenumbered receipt forms received and used?				
12. Are cash receipts entered in books of original entry by persons independent of the mail opening and receipt listing function?				

	Y	N	NA	COMMENTS
13. Are all receipts (business checks, money orders and currency) deposited intact a minimum of twice weekly, on non-consecutive days, and prior to 3 P.M. on the last working day of each month?				
14. Do adequate physical controls exist over cash receipts from the time received until deposited in the bank?				
. Are personnel collecting currency closely supervised and separate from accounting functions?				
6. Are unidentified receipts and similar items received and investigated by persons independent of preparation of deposits and posting of accounts receivable detail?				
17. Is the receipt collection function segregated from subsidiary ledger functions?				
18. For Financial Aid and Inmate Wage bank accounts, is there an adequate review of the supporting documents before the Request for Replenishment of Funds form is submitted to Central Office?				
a. Are the reimbursement checks made payable to the DPO?				
Cash Disbursements				
19. Are all disbursements, except petty cash disbursements, made by check?				
20. Check stocks --				
a. Are checks prenumbered and used in sequence?				
b. Are controls over blank check stocks adequate?				
c. Is there a specified custodian for blank check stocks?				

	Y	N	NA	COMMENTS
21. Check preparation --				
a. Are checks prepared by specified employees who are independent of voucher/invoice approval?				
b. Is there a clearly defined approval process?				
c. Are all check numbers accounted for?				
d. Are voided/spoiled checks properly mutilated (signature portion removed) and retained?				
e. Are checks made payable to specified payees and never to cash or bearer?				
f. Is a check protector used?				
g. Does all support documentation accompany checks presented for signature and are the documents reviewed for completeness and accuracy prior to signing of the check?				
h. Are all supporting documents properly canceled at time of signature to prevent duplicate payment?				
i. Do only persons authorized to prepare checks have access to blank checks?				
22. Check signing --				
a. Are check signers authorized?				
b. Are checks required to be counter-signed?				
c. Have dollar limits been established for one-signature checks?				
d. Are authorized check signers independent of:				
(1) Voucher preparation and approval for payment?				
(2) Check preparation, cash receiving and imprest funds?				

	Y	N	NA	COMMENTS
e. Are disbursements that require special approval of Superintendent or Board of Trustees properly documented?				
f. Is signing blank checks prohibited?				
g. If check signing machines are used, are facsimile signature plates adequately safeguarded, used in the presence of the custodian, and controlled by using numbering devices?				
Reconciliation				
23. Are bank accounts reconciled within a timely specified period after the end of each month?				
24. Are reconciliations made by someone other than persons who participate in the receipt or disbursement of cash?				
25. Does a responsible individual receive the bank statements (with canceled checks, debit and credit advices, etc.) unopened from the banks?				
26. Do the reconciliation procedures for all bank accounts include the following, with respect to deposits:				
a. Comparison of dates and amounts of daily deposits as shown on the bank statements with the cash receipts journal?				
b. Investigation of bank transfers to determine that both sides of the transactions have been properly recorded on the books?				
c. Investigation of items rejected by the bank investigated by a person independent of those responsible for receipt or recording of cash?				

	Y	N	NA	COMMENTS
27. Do the reconciliation procedures for all bank accounts include the following with respect to disbursements:				
a. Comparison of canceled checks with the checkbook as to number, date, payee and amount?				
b. Account for the sequence of check numbers?				
c. Examination of canceled checks for authorized signatures?				
d. Examination of canceled checks for irregular endorsements?				
e. Examination of canceled checks for alterations?				
f. Review of voided checks?				
28. Are completed bank reconciliations reviewed by a responsible official?				
a. Is the review documented by initialing and dating the reconciliation?				
29. Are checks outstanding for over 90 days:				
a. Periodically investigated?				
b. Payment stopped and an entry made restoring such items to cash?				

Y N NA COMMENTS

Indicate the types of potential misstatements, if any, identified, and any modifications of the audit program for strengths or weaknesses identified.

Type of Potential Misstatement	Modification of Audit Program

Prepared or Updated by:

19		19		19		19		19	
Name	Date	Name	Date	Name	Date	Name	Date	Name	Date

RECEIVABLES

Institution _____ Audit Period _____

	Y	N	NA	COMMENTS
1. Are the amounts of all receivables recorded when the initiating documents are received?				
2. Are receivables reconciled to the control account monthly?				
3. Are court orders reviewed to determine amounts to be collected by the District Parole Office?				
4. Are receivable cards prepared based upon court orders which reflect the amounts to be collected from parolees?				
5. When payments are received from parolees are they posted to the Accounts Receivable cards?				
6. Are postings to the Accounts Receivable cards made by an employee who does not handle or record receipt of payments?				
7. Are entries to the receivable ledger cards made exclusively through the one-write system and not as original entries on the cards?				
8. Are all entries to the receivable ledger cards based upon adequate supporting documentation which is placed in the parolees' files?				
9. Are Accounts Receivable cards kept in a secure locations with access available to authorized employees only?				

	Y	N	NA	COMMENTS
10. Are receipts given to parolees to acknowledge payment by them of Accounts Receivable balances?				
a. If so, do such receipts reflect the remaining balance due from parolees?				
b. If so, are such receipts pre-numbered sequentially?				
11. Are Accounts Receivable balances written off or otherwise removed from the balance due?				
12. If accounts are removed, are approvals received to take such action?				
13. Are receivables aged each month?				
a. Is the aged listing reviewed by a responsible person?				
b. Are delinquent receivables followed up for collection?				
14. Are loans to employees and Board of Trustees members prohibited?				

Indicate the types of potential misstatements, if any, identified, and any modifications of the audit program for strengths and weaknesses identified.

Type of Potential Misstatement	Modification of Audit Program

Prepared or Updated by:

19		19		19		19		19	
Name	Date	Name	Date	Name	Date	Name	Date	Name	Date

PERSONNEL

Institution_____ Audit Period_____

	Y	N	NA	COMMENTS
1. Does Payroll perform the function of ensuring that comp time does not exceed the allowable limits?				
a. If limits are exceeded, is appropriate action taken?				
2. Are comp time balances reviewed on a periodic basis?				

Indicate the types of potential misstatements, if any, identified, and any modifications of the audit program for strengths or weaknesses identified.

Type of Potential Misstatement	Modification of Audit Program

Prepared or Updated by:

19		19		19		19		19	
Name	Date	Name	Date	Name	Date	Name	Date	Name	Date

FIXED ASSETS

Institution_____ Audit Period_____

COMMENTS

	Y	N	NA	
1. Are Purchase Bureau guidelines followed for all fixed asset:				
a. Additions?				
b. Dispositions?				
2. Are detailed fixed asset records maintained that include description, date purchased or received by donation, cost or fair value at donation, donor or funding source restrictions on use or disposition, etc.?				
3. At least annually, is a physical inventory of fixed assets taken that is compared with subsidiary records?				
a. Are discrepancies immediately followed up and explained?				
4. Is the accounting department informed of any material changes in the status of items of fixed assets (such as moves, sales, scrapping, obsolescence, etc.)?				
5. Are fixed assets properly identified by numbered metal tags or other means of identification?				
6. Are fully depreciated assets maintained in the accounting records to help provide control?				
7. Are items adequately safeguarded from loss due to fire, theft or misplacement?				
a. Is an alarm system in operation?				

Indicate the types of potential misstatements, if any, identified, and any modifications of the audit program for strengths or weaknesses identified.

Type of Potential Misstatement	Modification of Audit Program

Prepared or Updated by:

19		19		19		19		19	
Name	Date	Name	Date	Name	Date	Name	Date	Name	Date

DEBT AND OTHER LIABILITIES

Institution _____ Audit Period _____

COMMENTS

	Y	N	NA	
1. Are lease documents in the custody of a responsible official and updated for any changes?				

Indicate the types of potential misstatements, if any, identified, and any modifications of the audit program for strengths or weaknesses identified.

Type of Potential Misstatement	Modification of Audit Program

Prepared or Updated by:

19		19		19		19		19	
Name	Date	Name	Date	Name	Date	Name	Date	Name	Date

PROCEDURES MANUALS

Institution_____ Audit Period_____

COMMENTS

	Y	N	NA	
1. Are Procedures Manuals maintained for each department:				
a. Superintendent's Office?				
b. Business Office?				
c. Classification?				
d. Payroll/Personnel?				
e. Other?				

Indicate the types of potential misstatements, if any, identified, and any modifications of the audit program for strengths or weaknesses identified.

Type of Potential Misstatement	Modification of Audit Program

Prepared or Updated by:

19		19		19		19		19	
Name	Date	Name	Date	Name	Date	Name	Date	Name	Date

Illinois Department of Corrections

AUDIT ACTUARIAL FORM

SYSTEM PROBLEM?	YES 0	NO 0	MAJOR +5	MINOR +2	
ISOLATED INCIDENT?	YES 0	NO 0	MAJOR +3	MINOR 0	
FOUND DURING INTERNAL AUDIT?	YES 0	NO +3			
RESOLVED AT FACILITY AFTER INTERNAL AUDIT?	YES -3	NO +2			
RECURRED (AFTER RESOLUTION)?	YES +3	NO -1			
				TOTAL	

WRITTEN AUDIT REPORT WOULD INCLUDE ITEMS CODED +3 OR MORE TOTAL.
(Other items would show up as minor issues in memo form).

DC 1117
IL 426 6387

11/8/85

U.S. Department of Justice
Federal Bureau of Prisons

Operations Memorandum

Number 162-91 (5324)
Date July 26, 1991
Subject Program Review Guidelines for Psychology Services in the Institutions

Cancellation Date July 31, 1992

1. PURPOSE: To re-issue Program Review Guidelines for the Psychology Services Program in the institutions.

2. DIRECTIVES AFFECTED: Operations Memorandum 160-90 (5324) is hereby superseded.

3. BACKGROUND: The Program Review Guidelines for the Psychology Program have been re-issued as a product of the annual assessment conducted by Psychology Administrators and reviewed by the Program Review Division. Effective FY'91, the Program Review Division assumed responsibility for all institution, regional and Central Office Program Reviews.

4. ACTION:

   A. The Program Review Branch will use these guidelines for official reviews.

   B. The Chief Psychologist will use these guidelines for operational reviews.

Patrick R. Kane
Assistant Director
Correctional Programs Division

PROGRAM REVIEW GUIDELINES FOR PSYCHOLOGY SERVICES

GENERAL INSTRUCTIONS

The program review objectives set forth in these guidelines were developed by means of a management assessment conducted in May of 1991, and are consistent with the procedures and responsibilities outlined in the management control and audit manual. Reviewers conducting evaluations of institution based Psychology Services shall adhere to these objectives unless unique situational circumstances justify deviating from this format and these circumstances are adequately documented.

A. Program Review Frequency. Each institution's Psychology Service Program must be reviewed at least once every two years.

B. Program Review Personnel and Duration. The size of each review team and the length of the review process will be established individually by the review objectives and size of the psychology program. However, each review team will consist of at least two members, typically the Regional Psychology Administrator and a Chief Psychologist from another institution. Each review, except for camp and MCC operations, should involve at least five review days.

C. Scope of Program Review. The reviewers will be expected to visit all areas of the institution with emphasis on areas having the greatest impact on psychology programming. In addition, an adequate sampling of documents pertaining to the delivery of psychology services will be reviewed and interviews will be conducted with the staff and inmates most affected by psychology programs.

D. Sampling methods. The reviewer will conduct a sufficient review of physical and documentary material and will interview adequate numbers of staff to meet standards of evidence as required by the Management Control and Audit Manual.

E. Program Review Checklists. Reviewers are encouraged to develop and utilize worksheets, checklists, and interview sheets to facilitate review objectives and review steps contained within this policy and should be retained at the completion of the review for purposes of documentation of review findings.

F. Previous Program Review Compliance. Reviewers should review all past reviews and operational reviews and evaluate the adequacy of corrected deficiencies to insure continued compliance with previous review response.

1.0 PROGRAM COMPONENT: ADMINISTRATION AND MANAGEMENT

To maintain high quality psychology programs, it is important that all psychologists receive the proper administrative and professional supervision from qualified supervisors. Inadequacies in these areas contributed to poor recruitment, morale, retention, and raise potential for litigation.

1.1 OBJECTIVE: PROFESSIONAL STANDARDS

Assess the adequacy of psychology work space with regard to functional integrity, privacy, space requirements, record and test security, and professional milieu. Insure that all psychologists receive annual continuing education, administrative and professional supervision, and adhere to all ethical standards.

BACKGROUND:

Throughout the Bureau there are problems related to the adequacy and professional nature of available office and program space. In addition, psychologists have frequently been unable to obtain yearly continuing education.

POLICY/REGULATION:

PS 1400.2 Contacts With Other Agencies and Organizations
PS 5310.8 Psychology Services Manual
PS 5500.3 Correctional Services Manual
OM 104-91(3932) Continuing Professional Education

PROGRAM REVIEW STEPS:

1.1.1 Assess accessibility of office space to inmates.

1.1.2 Determine if each staff member has an office available and that it is private regarding sound and visual integrity.

1.1.3 Examine storage areas for size, accessibility, and appropriateness.

1.1.4 Determine the serviceability and adequacy of equipment.

1.1.5 Determine the adequacy of group rooms for

size, privacy, ventilation, and competition for utilization.

1.1.6 Determine if psychology department is centralized to facilitate security and ease of departmental communication.

1.1.7 Determine if all psychology staff receive annual continuing professional education.

1.1.8 Determine if written input from the Regional Psychologist, regarding professional functioning, is incorporated into the Chief Psychologist's yearly performance evaluation.

1.1.9 Insure that a significant incident log is maintained on the Chief Psychologist.

1.1.10 Determine if all psychologists adhere to ethical conduct as outlined in the APA published Standards.

1.1.11 Determine if psychology staff make regular contacts with other organizations, universities, etc.

1.2 OBJECTIVE: BUDGETING

Assess the degree of control and review that the Chief Psychologist exercises over Cost Centers 316 and 317, contract services, and insure that resources are used effectively.

BACKGROUND:

Management assessment indicates that the management of financial resources is highly important in meeting the overall objectives of effective psychology programming. Past management assessments have shown that inadequate management skills and procedures often create inefficient delivery of services and poor utilization or waste of resources.

POLICY/REGULATION:

PS 5310.8 Psychology Manual
PS 2100.1 Budget Manual

PROGRAM REVIEW STEPS:

1.2.1 Insure that Chief Psychologist is manager of Cost Centers 316 and 317.

1.2.2 Check property control procedures and

inventory lists for accountability of equipment.

1.3 OBJECTIVE: HUMAN RESOURCE MANAGEMENT

Review staffing levels, continuing education, training, performance evaluations, staff utilization/supervision to determine the overall adequacy of management practices in the department.

BACKGROUND:

Past management assessments have shown that inadequate management, supervision, and staff development can result in insufficient use of human resources, poor staff morale, and reduced productivity. These problems have had an adverse effect on recruitment and retention efforts.

POLICY/REGULATION:

PS 5310.8 Psychology Services Manual
PS 3906.7 Training Standards
PS 3000.1 Civilian Personnel Manual
Executive Staff's Psychology Staffing Guidelines

PROGRAM REVIEW STEPS:

1.3.1 Review all psychology staff position descriptions to determine if they are current, in proper format, and have been reviewed annually.

1.3.2 Interview the Warden and Associate Warden of Programs to evaluate the Chief Psychologist's management skills regarding departmental operations.

1.3.3 Interview all psychology staff to determine their opinion on:

a. position description accuracy;
b. appropriateness of assignments;
c. quantity of work assigned;
d. ability to complete work assigned and possible solutions for any problems;
e. adequacy of the evaluation process;
f. staff development and training program;
g. future career aspirations.

1.3.4 Determine if inter- and intra-departmental communications are adequate.

1.3.5 Determine if the Chief Psychologist is sufficiently aware of staff work loads, work quality, extra departmental assignments, etc.

1.3.6 Determine if an annual leave schedule, professional training schedule, and work schedule are developed, maintained, and followed.

1.3.7 Interview training officer and review training records to determine if all staff receive annual refresher training, specialty training, and continuing professional training.

1.3.8 Determine if psychologists possess adequate educational/licensure requirements to perform assigned duties (i.e. study case evaluations, WITNESS evaluations, competency evaluations).

1.3.9 Determine if sufficient on-site clerical support is provided to psychology staff (i.e. 12 hours of assistance per psychologist per week).

1.4 OBJECTIVE: PROFESSIONAL PROGRAM MANAGEMENT

Review record keeping, documentation, and management of on-going inmate programs to ascertain their quantity and quality. Also, review the development, adequacy, and administration of specialized psychology programs to determine if they meet the unique needs of the agency.

BACKGROUND:

It is the Bureau's policy to maintain sufficient documentation of every activity that the psychology department performs. Previous management assessments have indicated that poor program management and documentation have lead to insufficient program development, inadequate documentation of on-going care, poor continuity of treatment, and an inability to identify future program and resource needs. Failure to provide this management oversight can lead to inadequate treatment, litigation, and possibly loss of life.

POLICY/REGULATION:

PS 5310.8 Psychology Services Manual
PS 3792.2 Employee Assistance Program
PS 5324.1 Suicide Prevention Program
DOJ Order 1792.2 Employee Assistance Program

PROGRAM REVIEW STEPS:

Psychological Data System (PDS)

1.4.1 Determine if the Chief Psychologist completes all monthly Psychological Data System (PDS) reports and submits them in a timely fashion.

1.4.2 Assess whether PDS is being used to document all inmate contacts with Psychology Services:

a. Is PDS down-loaded to central data base and, transmitted on schedule;
b. are records up-to-date, and (where appropriate), closed out;
c. are group program participation records maintained;
d. are monthly statistical records accurately maintained;
e. are all records electronically backed-up weekly.

Employee Assistance Program

1.4.3 Determine if sufficient record keeping procedures are in place to comply with Employee Assistance Program reporting requirements, as specified in DOJ Order 1792.1.

1.4.4 Determine if timely and accurate reports of past and present EAP activities are available.

Files

1.4.5 Examine the special psychology files to determine if they contain:

a. test materials utilized;
b. documentation of all contacts;
c. completed treatment records.

Intake Screening

1.4.6 Review 20 or 5% of Intake Screening Summaries to insure their proper filing or their storage in PDS.

1.4.7 Review the Summaries identified in 1.4.6 for completeness, relevance, and recommendations.

1.4.8 Review the screening summaries selected in step 1.4.6 to determine if initial identified treatment needs have been followed.

1.4.9 Review 20 or 5% of the screening summaries to determine if the psychologist sees each inmate individually within 14 days of arrival.

Treatment Plans

1.4.10 Review 20 or 5% treatment plans of those inmates involved in on-going treatment to assess the adequacy of treatment strategies with professionally accepted practices.

Special Housing Unit

1.4.11 Evaluate the adequacy of the record keeping system used by the Psychology Department to identify inmates needing a 30-day Special Housing Unit (SHU) review.

1.4.12 Review 20 inmates eligible for 30-day reviews for the presence of written summary.

Psychological Evaluations

1.4.13 Examine two psychological evaluations (S&O, Witness, Parole, etc.) to determine the adequacy of examination procedures, the thoroughness of referral question responses, and the timeliness of report submissions.

1:4:14 Review 20 inmates eligible for 30 Day Reviews, for the presence of a written summary.

Suicide Prevention Program

1.4.15 Review relevant documentation (Risk Assessment, Post Suicide Watch Report, etc.) on two inmates placed on suicide watch to insure the adequacy of their care.

1.4.16 Review Suicide Prevention Program records to determine if inmate companions are trained and paid for services.

1.4.17 Review yearly Suicide Prevention Program report for timeliness and accuracy.

1.4.18 In the event of a suicide, review the evalua-

tion and reconstruction of events for accuracy and completeness.

Sufficiency of Existing Programs

1.4.19 Review all inmate programs to determine if the quantity and the quality of existing activities is sufficient to meet inmate needs.

1.4.20 Determine if successful completion of psychology programs is documented in PDS.

1.4.21 Interview a sample of inmates for their views on treatment programs.

2.0 PROGRAM COMPONENT: INMATE SERVICES

Early identification of psychological problem cases has been shown to enhance the orderly running of the institution by immediately involving these inmates in needed psychological treatment.

2.1 OBJECTIVE: ASSESSMENT

Determine if every inmate arriving at the institution is involved in the Admission and Orientation (A & O) Program, is seen by a psychologist, is informed of available psychology services, receives an orientation to the Drug Abuse Program, and has treatment program needs identified. Evaluate the needs of all inmates subsequently referred to the Psychology Department.

BACKGROUND:

Previous management assessments have determined that a percentage of all committed inmates suffer from serious emotional disturbance, mental retardation, drug/alcohol addiction, or other severe adjustment difficulties.

POLICY/REGULATION:

PS 5310.8 Psychology Services Manual
PS 5270.7 Discipline and Special Housing Units.
PS 5214.3 Procedures for Housing HIV Positive Inmates Who Pose a Threat to Others
PS 5566.3 Use of Force and Applications of Restraints on Inmates
OM 143-90 (6100) HIV Counseling
Comprehensive Crime Control Act of 1984, Section 3521(c).

PROGRAM REVIEW STEPS:

2.1.1 Interview Hospital Administrative Officer to determine responsiveness of Psychology Department when a Physician Assistant identifies an inmate with a mental health history.

2.1.2 Review SHU sign-in logs to determine if psychologists visit the unit at least once weekly.

2.1.3 Interview appropriate correctional staff to determine frequency, regularity, and usefulness of psychology visits to segregation.

2.1.4 Interview the Disciplinary Hearing Officer (if there is one available in the institution), or the Chief Correctional Supervisor's secretary to determine Psychology Services' responsiveness to requests for psychological evaluations.

2.1.5 Interview Chief Psychologist to determine awareness of policy guidelines concerning Witness Program Evaluations, extent of participation in evaluations and appropriateness of evaluations.

2.1.6 Determine if Psychology Department is involved in assessing HIV positive inmates who pose a threat to others prior to their removal from special population. Determine if psychologists provide regular reviews while these inmates are in Special Housing.

2.1.7 Determine if psychologists are involved in confrontation avoidance procedures and if an institution supplement is written and followed concerning use of force.

2.1.8 Determine if psychologists provide counseling and evaluate all HIV positive inmates for ongoing educational and counseling needs.

2.2 OBJECTIVE: PROGRAM IMPLEMENTATION

Evaluate the scope and quality of psychological programming available to the inmate population.

Determine whether that programming is meeting specified inmates needs.

BACKGROUND:

Previous management assessments have determined that a percentage of all committed inmates suffer from serious emotional disturbance, mental retardation, drug/alcohol addiction, or other severe adjustment difficulties. Prompt and appropriate therapeutic intervention significantly reduces the risk of management problems, emotional deterioration, and life threatening situations.

POLICY/REGULATION:

PS 5324.1 Suicide Prevention Program
PS 5310.8 Psychology Services Manual
APA Standard for Providers of Psychological Services
State Licensing Standards
APA Ethical Standards for Psychologists
PS 5070.3 Study and Observation Cases
Comprehensive Crime Control Act of 1984

PROGRAM REVIEW STEPS:

General Psychology Programs

2.2.1 Observe psychology staff delivering non-confidential psychological services to assess adequacy of treatment.

2.2.2 Interview administrative staff for their impressions of responsiveness to treatment of inmates.

Suicide Prevention Program

2.2.3 Determine if institution supplement on Suicide Prevention Program has been written.

2.2.4 Determine if the supplement designates the Chief Psychologist as the Program Coordinator.

2.2.5 Evaluate the adequacy of the suicide watch room.

2.2.6 Assess the adequacy of information transmission, i.e. if an inmate with suicidal potential is transferred to another

institution, that the appropriate communication between the two departments is established in a timely fashion.

2.2.7 Interview training officer and review training records to insure yearly suicide prevention training for all institution staff has occurred.

2.2.8 Review program records to determine if inmate companions are trained and paid for services.

2.2.9 Interview hospital staff to assess the performance of inmate companions during suicide watch procedures.

2.2.10 Examine suicide logs maintained by inmate companions or staff observers for completeness and accuracy.

3.0 PROGRAM COMPONENT: STAFF SERVICES

Employee counseling programs are designed to remedy employee problems and restore adequate performance. Furthermore, it is important to enhance employee performance through effective, on-going training programs.

3.1 OBJECTIVE: DELIVERY OF PSYCHOLOGICAL SERVICES TO STAFF

Review all psychological services provided to staff to determine if adequate assessment and therapeutic intervention is provided to all employees during times of crises, to evaluate psychology's contribution to selection and training of new employees, and to assess the impact of psychology related training activities.

BACKGROUND:

Substandard performance can have serious consequences for the employee and the mission of the organization. Therefore, it is important that the best candidates be selected for employment and that employee personal problems affecting performance be corrected at an early stage.

POLICY/REGULATION:

PS 5310.8 Psychology Services Manual
PS 3792.2 Employee Assistance Program
FPM Chapter 792 Alcohol and Drug Abuse Programs
DOJ Order 1792.2 Employee Assistance Program

PS 3000.1 Personnel Manual
PS 3906.11 Training Standards

PROGRAM REVIEW STEPS:

3.1.1 Determine if there is a current institution supplement written for EAP.

3.1.2 Determine if the Chief Psychologist is designated as the EAP coordinator.

3.1.3 Determine if available community mental health resources have been identified for staff use and that adequate referral procedures have been developed to insure the prompt referral of staff in need of mental health services.

3.1.4 Determine if an EAP contract with a local service provider has been written. Review the credentials, services offered, cost, and procedures for reporting data for annual report.

3.1.5 Determine if supervisors and staff have received training about EAP.

3.1.6 Determine if program coordinator has adequately publicized EAP.

Pre-employment Interview

3.1.7 Interview Human Resource Manager and Associate Wardens to assess the attendance, contribution, and adequacy of the department's participation in pre-employment interviews.

3.1.8 Review, where possible, 10 or 20% of all completed evaluation forms to assess the quality of psychological input to pre-employment interviews.

Staff Training

3.1.9 Review all specialized training offered by course title and content (supervisory, stress management, EAP) and insure adequate time was allotted.

3.1.10 Review course evaluations to assess quality of instruction.

3.1.11 Review lesson plans for adequacy and completeness.

3.1.12 Randomly interview 10 staff members to determine their opinion regarding the adequacy of training provided.

3.1.13 Review records to determine if the psychology department is involved in training new employees and contributes to annual refresher training.

4.0 PROGRAM COMPONENT: PROGRAM EVALUATION/RESEARCH

4.1 OBJECTIVE: DATA COLLECTION AND ANALYSIS

Review all psychology program evaluation activities in the institution to assess the effectiveness of programs. Also review all research activities for compliance with policy.

BACKGROUND:

The BOP is engaged in, and encourages the use of program evaluation to assess the effectiveness of programs offered to the inmate population. In addition, a variety of research projects to further the knowledge base of correctional practitioners is also advocated. In institutions without research staff, the Chief Psychologist is responsible for coordination of the Research Program.

POLICY/REGULATION:

PS 5310.8 Psychology Services Manual
PS 1070.2 Research

PROGRAM REVIEW STEPS:

4.1.1 Review institution supplement to determine if research policy has been written and approved by the Warden.

4.1.2 Determine if Research Committee meets and reviews research proposals at required intervals.

4.1.3 Determine if all on-going research is coordinated through the Research Committee.

5.0 PROGRAM COMPONENT: FORENSIC STUDY SITE PROGRAM

5.1 OBJECTIVE: FEDERAL COURT EVALUATIONS

Review the adequacy and appropriateness of Psychological Evaluations prepared for the Federal Courts.

BACKGROUND:

The Comprehensive Crime Control Act of 1984 requires licensed psychologists to conduct evaluations responding to specific criteria, question formats, and time schedules.

POLICY/REGULATIONS:

PS 5310.8 Psychology Services Manual
18 USC 4247 Psychological Examination

PROGRAM REVIEW STEPS:

Review 5 evaluations, randomly selected to insure that:

5.1.1 Reports are completed by licensed psychologists;

5.1.2 Proper criteria is utilized in determining competence and responsibility;

5.1.3 Time frames specified by law were followed and any time extensions were appropriately filed and justified;

5.1.4 They were prepared in the format outlined in 18 USC 4247;

5.1.5 Reports reflect that the inmate was informed of the lack of confidentiality in the forensic setting, and was allowed an opportunity to give informed consent;

5.1.6 The report responded to the questions posed by the court order.

5.1.7 Interview appropriate administrators to

determine whether feedback was received from courts concerning Psychological Evaluations submitted to the courts.

5.1.8 Interview Chief Psychologist to determine if any problems have arisen regarding reports submitted to Federal Courts or other formally requested reports.

6.0 PROGRAM COMPONENT: AMERICAN PSYCHOLOGICAL ASSOCIATION INTERNSHIP PROGRAM

The Bureau's Internship Training Program serves as an excellent training opportunity for psychology graduate students and has been an excellent recruitment vehicle for the Bureau in its efforts to hire qualified, doctoral level, clinical psychologists.

6.1 OBJECTIVE: APA-APPROVED PROGRAMS

Evaluate the internship program in institutions where such internship exists.

BACKGROUND:

In recent years, state laws regarding licensure as a psychologist have changed and now indicate that only psychology graduate students who attend internship training programs accredited by the American Psychological Association will be considered eligible for licensure consideration. As a result of these changes in state law, most psychology graduate training centers now insist that their students attend only those internship training centers with APA approval. To keep abreast of these changes and to continue to maintain our ability to hire the most qualified psychologists available, the Bureau has modified its standards for internship training to bring them into compliance with standards established by the APA. Noncompliance with these APA standards can result in a significant drop in qualified candidates for employment with the Bureau.

POLICY/REGULATION:

PS 5310.8 Psychology Services Manual
American Psychological Association Accreditation Handbook (1986 Edition)

PROGRAM REVIEW STEPS:

6.1.1 Review psychology staffing level to insure that a minimum of four, full-time, doctoral

level psychologists are involved in the internship training program.

6.1.2 Determine if one psychologist is designated as the Director of Psychology Training (DOPT).

6.1.3 Review the position description of the DOPT and verify through interview that the DOPT devotes 50% of his/her time to the supervision and regulation of intern activities.

6.1.4 Review available documentation to insure that DOPT is currently licensed (preferably in the state where the internship training site is located).

6.1.5 Review available documentation to insure that all other psychologists involved in supervising internship activities are either licensed or license eligible and actively pursuing licensure.

6.1.6 Review personnel records to insure that there are four intern positions allotted and filled at internship training center. (If there are fewer than four interns, review documentation to determine whether reasonable efforts were made to fill existing positions).

6.1.7 Assess intern access to clerical/secretarial services to insure that clerical services are provided to interns and are equivalent in nature to those received by full-time psychology staff.

6.1.8 Examine intern work area to insure that each intern has an office and that intern offices are adequately equipped to meet basic security needs (locking file cabinet) and to provide adequate sight and sound confidentiality for conducting interviews and treatment sessions.

6.1.9 Assess the availability of equipment/resources (i.e. computer equipment, a wide range of psycho-diagnostic instruments, professional books and journals, etc.) for intern use to insure that they are adequate to meet training goals.

6.1.10 Review intern supervision logs to determine

if interns are receiving adequate supervision as prescribed by APA Accreditation Standards.

6.1.11 Review training experiences (i.e., in-service training, seminars, workshops, etc.) attended by interns to insure that they meet intern training needs and provide interns with a broad exposure to current issues/trends in both clinical and correctional psychology.

6.1.12 Interview interns to insure that supervisory staff are responsive to their input regarding the formulation and scheduling of their training experiences.

6.1.13 Determine if internship training funds allotted through the Central Office are used appropriately to enhance the quality of the Internship Training Program.

6.1.14 Assess the quality of outplacement sites used by the Internship Training Program through interviews to insure that these sites offer high quality services/supervision compatible with APA Standards and Guidelines

7.0 PROGRAM COMPONENT: INSTITUTIONAL DRUG PROGRAMS

To maintain high quality drug programs, it is important to provide a continuum of professional drug education and counseling services to the substance abusing inmate population. Failing to provide these services contributes to the cycle of offender drug use and misconduct that leads to repeated incarcerations. The substance abusing offender can create additional burdens in safety and security management within the institution, and is a prominent safety concern to the community-at-large.

7.1 OBJECTIVE: DRUG EDUCATION PROGRAM

Review the record keeping, documentation, and management of on-going Drug Education Programs to determine that these Drug Education Programs maintain the quality of services and quantity of inmates consistent with the guidelines and criteria established for the Bureau's Drug Education Programs.

BACKGROUND: It is the Bureau's policy to maintain sufficient documentation of each requisite activity that the Drug Education Unit performs. If the level of Drug Education development and application is

insufficient, it is likely to result in an increase in the Bureau's substance abusing population, creating additional obstacles in institutional and community security and safety.

POLICY/REGULATION:

OM 132-90 Drug Abuse Program, Inmate

PROGRAM REVIEW STEPS:

7.1.1. Assess the appropriateness of the Drug Abuse Program staff as compared with the Position Descriptions for Drug Abuse Treatment Specialist and Drug Abuse Program Psychologist.

7.1.2. Determine if a monthly Drug Abuse Program Statistical Report is completed and sent to the Regional Psychology Administrator by the seventh of the following month.

7.1.3. Determine if the Chief Psychologist is responsible for managing the F317 cost center, or has delegated this responsibility to the Drug Abuse Program Coordinator.

7.1.4. Determine if all new admissions to the institution have been screened by a Drug Abuse Treatment Specialist using the Substance Abuse Signs Checklist (SASC).

7.1.5. Determine if there is a Drug Abuse Treatment Specialist employed under the supervision of the Psychology Department who is responsible for the implementation of the Drug Education Program.

7.1.6. Assess if the Drug Education participants complete the standardized course during their first six months of incarceration, as required.

7.1.7. Assess if those inmates participating in the Drug Education Program match the established eligibility criteria through a review of the SASC's.

7.1.8. Determine if a post-test has been

administered to all Drug Education Program participants upon completion of the Drug Education Program.

7.1.9. Determine if those inmates required to participate in, and complete the Drug Education Program, but fail to do so, are restricted to the lowest pay grade and are deemed ineligible for community activities.

7.2 OBJECTIVE: DRUG ABUSE COUNSELING SERVICES (CENTRALIZED, NON-RESIDENTIAL)

Review the record keeping, documentation, and management of on-going Drug Abuse Counseling Services (Centralized, Non-Residential), to determine that these Drug Counseling Services maintain the quality of services and quantity of inmates consistent with the criteria and guidelines established for Centralized, Non-Residential Drug Abuse Counseling Services.

BACKGROUND: It is the Bureau's policy to maintain sufficient documentation of each requisite activity that the Centralized, Non-Residential Drug Abuse Counseling Program provides. If the level of Non-Residential drug treatment is either unavailable or insufficient, it is likely to result in an increase in the Bureau's substance abusing population, creating additional obstacles in institutional and community safety and security.

PROGRAM REVIEW STEPS:

7.2.1. Determine if Centralized Counseling Services are provided by a Psychologist or Drug Abuse Treatment Specialist and are available to all inmates at any time during their incarceration.

7.2.2. Assess if individualized treatment plans are developed and documented and entered on PDS for all inmates receiving Centralized Counseling Services.

7.3 OBJECTIVE: COMPREHENSIVE DRUG ABUSE TREATMENT PROGRAMS

Review the record keeping, documentation and the management of on-going Comprehensive Drug Abuse Treatment Programs to determine that these Comprehensive Programs maintain the quality of

services and quantity of inmates consistent with the criteria and guidelines established for Comprehensive Drug Abuse Treatment Programs.

BACKGROUND: It is the Bureau's policy to maintain sufficient documentation of each requisite activity that the Comprehensive Drug Treatment Program provides. If the level of comprehensive treatment were to fall below the established standards, anticipated results could include an increase in the Bureau's overall population and additional security and safety risks, both within the institution, and within the community-at-large.

PROGRAM REVIEW STEPS:

7.3.1. Using the organizational chart, determine if there are Drug Abuse Treatment Specialists employed under a Psychologist designated as the Drug Abuse Program Coordinator, who is responsible for the implementation and operation of the Comprehensive Drug Abuse Treatment Program and who maintain the established treatment staff to inmate ratio of 1:24.

7.3.2. Determine if the participants in the Comprehensive Program meet the following established criteria for program entry and acceptance:

a. At least 15 months remaining on sentence
b. Moderate to severe drug abuse history (DSM III R Diagnosis)
c. No medical, psychological or psychiatric problems prohibiting full participation
d. Voluntary program participation
e. Signed informed consent
f. Completion of Drug Education Program (or completed as an initial phase of program they have entered.)

7.3.3. Determine if the Comprehensive Drug Abuse Treatment Unit is separated from the general population, (e.g., housing,

program staff, program space.)

7.3.4. Assess the PDS documentation of treatment staff contact with the inmate to determine if:

a. a comprehensive assessment has been completed
b. individualized treatment plans are maintained
c. there is contact with each inmate of 3 - 4 hours a day, five days a week
d. individual and group therapy is conducted
e. unit team reviews are conducted (every 90 days)
f. treatment reviews are conducted (every 30 days)

7.3.5. Determine if urinalysis surveillance is conducted and further determine if the frequency of urinalysis surveillance is sustained at an increased level of frequency in comparison to the urinalysis surveillance among the general population.

7.3.6. Through review of program modules, determine the treatment model(s) used in the Comprehensive Drug Abuse Treatment Program. Modules are to address:

a. Criminal Thinking Confrontation
b. Cognitive Skill Building
c. Relapse Prevention
d. Wellness Development
e. Rational Emotive Therapy/Behavioral Emotive Therapy (RET/BET).
f. Self-Help
g. Support Groups

7.4 OBJECTIVE: PILOT DRUG ABUSE TREATMENT PROGRAMS

Review the record keeping, documentation and the management of on-going Pilot Drug Abuse Treatment Programs to determine that these Pilot Programs maintain the quality of services and quantity of inmates consistent with the guidelines and criteria established for the Pilot Drug Abuse Treatment Programs.

BACKGROUND: It is the Bureau's policy to maintain sufficient documentation of each requisite activity that the Pilot Drug Abuse Treatment Program provides. If the level of the Pilot's treatment were to fall below the established standards, anticipated results could include an increase in the Bureau's overall population and additional security and safety risks, both within the institution and within the community-at-large.

PROGRAM REVIEW STEPS:

7.4.1. Using the organizational chart, determine if there are Drug Abuse Treatment Specialists employed under a Psychologist designated as the Drug Abuse Program Coordinator, who are responsible for the implementation and operation of the Pilot Drug Abuse Treatment Program and who maintain the established treatment staff to inmate ratio of 1:12.

7.4.2. Determine if the participants in the Pilot Program meet the following established criteria for program entry and acceptance:

a. At least 18 months remaining on sentence
b. Moderate to severe drug history (DSM III R Diagnosis)
c. No medical, psychological or psychiatric problems prohibiting the inmate from participation
d. Voluntary participation
e. Signed informed consent
f. Completion of Drug Education program

7.4.3. Determine if the Pilot Drug Abuse Program is separated from general population, (e.g., housing, program staff, program space.)

7.4.4. Assess the PDS documentation of treatment staff contact with the inmate to determine if:

a. a comprehensive assessment has been completed
b. individualized treatment plans are maintained
c. there is contact with each inmate

of a least four hours a day, five days a week
d. individual and group therapy is conducted
e. unit team reviews are conducted (every 90 days)
f. treatment reviews are conducted (every 30 days)

7.4.5. Determine if urinalysis surveillance is conducted and further determine if the frequency of urinalysis surveillance is sustained at an increased level of frequency in comparison to the urinalysis surveillance among the general population.

7.4.6. Through review of program modules, determine the treatment model(s) used in the Pilot Drug Abuse Program. Modules are to address:

a. Criminal Thinking Confrontation
b. Cognitive Skill Building
c. Relapse Prevention
d. Wellness Development
e. Rational Emotive Therapy/Behavioral Emotive Therapy (RET/BET)
f. Self Help
g. Support Groups

7.5 OBJECTIVE: TRANSITIONAL SERVICES

Review the record keeping, documentation and the management of Transitional Services to determine the quality of Transitional Care Services and the quantity of inmates receiving these services to insure it is consistent with the established criteria and guidelines for Transitional Services.

BACKGROUND: It is the Bureau's policy to maintain sufficient documentation on each of the requisite activities that Transitional Services provides. If the level of Transitional Services falls below the established standards, the community is at greater risk as re-offending is likely to occur.

PROGRAM REVIEW STEPS:

7.5.1. Assess the extent to which a formalized referral mechanism is established that

places the inmate who has completed the Comprehensive or Pilot Residential Treatment Program Successfully, into Community Corrections Centers. Further determine if a specific Drug Abuse Treatment staff member has been designated as responsible for this transitional service provision.

7.5.2. Determine if an individualized treatment plan has been developed and documented and communicated to the Community Corrections personnel, for each individual inmate to receive a course of intensive out-patient treatment for a minimum of 90 days.

7.5.3. Determine if there are formalized linkages established between the Community Corrections Center and U.S. Probation to ensure the successful transfer of the offender between agencies and to insure a continuity in the treatment regimen.

Utah Department of Corrections

AUDIT 92-9 DIO INTERNAL SECURITY AND KEY CONTROL

AREA I: KEY CONTROL

OBJECTIVE A: POLICY AND PROCEDURE
OBJECTIVE B: RECORDING AND STORAGE
OBJECTIVE C: INVENTORY
OBJECTIVE D: ISSUE OF KEYS
OBJECTIVE E: LOST OR MISPLACED KEYS AND/OR KEY RINGS
OBJECTIVE F: HANDLING OF KEYS
OBJECTIVE G: EMERGENCY KEYS
OBJECTIVE H: RESTRICTED KEYS
OBJECTIVE I: PERSONAL KEYS
OBJECTIVE J: KEY OR LOCK MAINTENANCE
OBJECTIVE K: UNAUTHORIZED DUPLICATION OF KEYS

AREA II: INMATE COUNTS

OBJECTIVE A: POLICY AND PROCEDURE
OBJECTIVE B: COUNT PROCESS
OBJECTIVE C: RECONCILIATION OF PHYSICAL COUNT WITH ALPHA ROSTER

AREA III: CONTROL ROOM SECURITY

OBJECTIVE A: POLICY AND PROCEDURE
OBJECTIVE B: ACCESS
OBJECTIVE C: EQUIPMENT ISSUE
OBJECTIVE D: WEAPONS, AMMUNITION AND MUNITIONS
OBJECTIVE E: BATTERY OPERATED RADIO
OBJECTIVE F: EMERGENCY PROCEDURES
OBJECTIVE G: RECORD-KEEPING
OBJECTIVE H: COMMUNICATIONS EQUIPMENT
OBJECTIVE I: CONTROL CENTER STAFFING
OBJECTIVE J: STAFF CONCERNS

AUDITOR ASSIGNMENTS:
NORTHPOINT - DAN REISNER
SOUTHPOINT - LYNNE CARTWRIGHT
SOUTHPOINT - GRANT MADSEN
CUCF - CLARK BOREN
IC/USCF - CLARK BOREN
IC/USCF - DAN REISNER
IC/USCF - GRANT MADSEN

AUDIT 92-9 DIO INTERNAL SECURITY AND KEY CONTROL

AREA I: KEY CONTROL
OBJECTIVE A: POLICY AND PROCEDURE

1. The following policies and procedures should be reviewed by the auditors consistent with their assignments or for their information if there is no formalized policy and procedure for their assigned area:
   - -Northpoint DIOSO 88-024, Key Control and Emergency Access to Control, Electronic and Maintenance Rooms
   - -Southpoint Draft FF 10, Keys and Locking Systems - DIO, Southpoint (check with Sharon Fronk to ascertain if this is a special order)
   - -Support Svs DIOSO 91-02-SS, Key Control
   - -Medical TMF 06/07.02, Security Responsibilities
   - -FY 85 Locksmith
   - -FY 87 Locksmith Specialist
   - -CUCF DIGSO 92-006-CUCF, Keys and Locking Systems - CUCF Control Procedures
   - -IC/USCF None provided

   -Utah State Prison Key Control System - authored by Robert Glass - for your information

2. Determine the current status of each policy and procedure as per auditor assignments(Auditors assigned to Southpoint should review Draft FF 10, TMF 06/07.02 as well as DIOSO 91-02-SS). Check with Sharon Fronk at DIO and Pam Elliott in Administrative Services if necessary. If policies and procedures are not current as either special orders or a DIO manual chapter, determine why and recommend action to bring them current.

3. Do policies and procedures address all operational areas? Recommend including areas in policy and procedure which may have been overlooked or not included for some other reason but in the auditor's opinion should be included. My personal opinion is that the most complete policy and procedure is the one authored by Robert Glass.

4. Determine if DIO staff members are complying with applicable policy and procedure and post orders even if they are not current. Auditors should specifically ask staff members they interview if "Key Control" policy and procedure exists and if they have read it. Auditors at Southpoint should verify compliance with draft FF 10, TMF 06/07.02 (follow-up of applicable audit issues from Audit 91-8) and DIOSO 91-02-SS which applies to the DIO Maintenance unit.

5. Are post orders of staff members with key control responsibilities consistent with key control policy and procedure?

6. Are key control policies and procedures consistent Division-wide? For the most part, I think the policies and procedures should be consistent throughout DIO.

7. Are all staff members trained in key handling procedures at least annually?

8. If you think there are other issues regarding key control policy and procedure which should be addressed, please let me know.

AREA I: KEY CONTROL

OBJECTIVE B: RECORDING AND STORAGE

1. Are unused keys stored in either a control center or in the Institutional lock shop?

2. Are keys rings tagged and identified by color code, unit designation, key ring number and include the total number of keys on the ring?

3. Is the key control document which is maintained by the institutional locksmith for each auditor's assigned area accurate and up-to-date? I believe this information is supposed to be on the Best Key computer program. I provided each auditor with a copy of the format utilized by this program. I believe the Locksmith will also have much of this information in hard copy form. The information should be updated when any changes are made to a lock, locking device, when a key change is made or when a change is made in keys assigned to staff members or posts. The key control document should include the following information:
   - -the location of all locks by facility (floor plan)
   - -manufacturer
   - -type
   - -series
   - -keys assigned to which rings
   - -rings available to which staff members or posts

4. How many copies of this information are available? It seems appropriate that a current copy of the information should be maintained offsite. Is this the case?

5. Is access to this information in both computer media form as well as hard copy form restricted to those who have a legitimate need to know?

AREA I: KEY CONTROL

OBJECTIVE B: RECORDING AND STORAGE

6. Auditors assigned to Draper facilities should interview both the locksmith (Glen Peterson) as well as the locksmith specialist (Mark Pemberton) to determine the accuracy and completeness of the key control document for their assigned areas. Auditors assigned to CUCF and IC/USCF should interview the locksmiths and other staff as deemed appropriate.

OBJECTIVE C: INVENTORY

1. Are operational and emergency keyboards/key boxes provided in the facility control centers sufficient to accomodate all keys and key rings routinely used?

2. Do all keys hang on soldered closed key rings? If not, ascertain why.

3. Do contol center supervisors account for all key rings/keys at the beginning of each shift?

4. Is a record of this accounting recorded in the control center log book?

5. Are all established key rings inventoried at least once during an eight hour shift?

6. Are all keys inventoried at least every three months and a record kept of the inventory in a secure place?

7. Are the inventories conducted by persons not concerned with direct accountability of those keys?

8. Are the physical inventory counts reconciled with the key control document maintained by the locksmith?

9. Each auditor should conduct a physical inventory as follows:
   - Northpoint - Women's Correctional Facility
   - Lockshop (Draper site)
   - Southpoint - Infirmary Unit, Dental Unit and Pharmacy
   - please follow-up on the issue of the 30 copies of the medical exam rooms key provided to the medical unit when according the locksmith they use no more than eight keys at any given point in time

AUDIT 92-9, DIO INTERNAL SECURITY AND KEY CONTROL

AREA I: KEY CONTROL

OBJECTIVE C: INVENTORY

9. SOUTHPOINT - Oquirrh I
CUCF - as determined by auditor
IC/USCF - as determined by auditors
Each auditor should meet with the locksmith after conducting the assigned physical count to see if it reconciles with the key control document maintained in the lockshop.

10. Is a duplicate set of all facility keys maintained by the lockshop for use in duplicating replacement keys?

11. Do all institutional keys remain on property or do staff members take keys home after duty?

OBJECTIVE D: ISSUE OF KEYS

1. Verify that no operational keys have been or are being issued to inmates. Auditors should determine whether inmates working in maintenance, recreation, culinary or as custodians have access or are issued operational keys. Document any instances where inmates have possession of or access to keys. Is the possession or access authorized?

2. Some of the key control policies require the use of a chit by staff members in order to draw keys from operational key boards. Is the chit system operational?

3. Each auditor should select a sample of staff members to verify that the access they have to keys has been approved by someone authorized and designated to do so. Is a record kept of which staff members or posts are authorized access to which keys?

4. Under what circumstances are non-staff members issued or have access to institutional keys? If there are instances when they are allowed access, has this access been appropriately authorized?

OBJECTIVE E: LOST OR MISPLACED KEYS AND/OR KEY RINGS

1. Are verbal reports made by staff within 30 minutes of when the loss or misplacement occurred?

2. Is a written report completed for each incident involving lost or missing keys?

3. For each incident reported, were the locks changed?

OBJECTIVE E: LOST OR MISPLACED KEYS AND/OR KEY RINGS

4. Are all changes in locks or keys initially ordered by the Warden/designee?

OBJECTIVE F: HANDLING OF KEYS

1. Auditors should observe staff member practice in carrying and using keys with attention given the following:

   a. are keys securely fastened by chain to the belt and carried in the pants pocket or in a leather pocket attached to the belt?
   b. is a check count conducted when keys are exchanged from one authorized person to another?
   c. is reference to key numbers or any identifying information avoided by staff members in the presence of inmates?
   d. are keys exchanged hand-to-hand and not tossed or thrown?
   e. do staff avoid the use of force to operate locks?
   f. are lock repairs only completed by the locksmith or other authorized personnel?
   g. are inmates allowed to handle security keys under any circumstances?

2. Are traps or chutes available in the floor of each control room for the disposal of keys if a takeover is imminent?

OBJECTIVE G: EMERGENCY KEYS

1. Are emergency keys readily accessible to authorized staff in the event of an emergency?

2. Are emergency keys used by staff members only in the event of emergencies?

3. Is use of emergency keys always documented on an IR-1 form?

4. Are emergency key rings properly tagged and identified by color code, unit designation, key ring number and the total number of keys on the ring?

5. Are lists of emergency keys maintained at key control locations and in the lockshop?

6. Are emergency keys accounted for at the beginning of each shift and is a record of this accounting maintained?

7. Are emergency keys tested on a monthly basis?

AREA I: KEY CONTROL

OBJECTIVE H: RESTRICTED KEYS

1. Are key rings given a color code corresponding to the sensitivity or degree of control required over the area to which they allow access?

2. Is staff member access to restricted keys limited to only those members who have a legitimate need in the course of their normal duties?

3. Is an accurate and current record maintained of staff members or posts which have access to which restricted keys?

OBJECTIVE I: PERSONAL KEYS

1. Are personal keys of staff and non-staff alike taken into secure parts of the facility?

2. Are lockers or key boxes provided to staff and non-staff alike for securing their personal keys prior to entering a secure area of any facility?

OBJECTIVE J: KEY OR LOCK MAINTENANCE

1. Are keys only removed from or added to key rings by the locksmith as authorized by the warden/designee? What system is in place to ensure that maintenance, repair and installation of all locking devices is completed in an appropriate and timely manner? Auditors should sample maintenance work orders pertaining to the lockshop to ascertain if repairs and maintenance are being completed properly and timely.

2. Ascertain from the locksmith how he plans to dispose of broken, damaged or obsolete keys. Should policy be more definitive in this area?

3. The locksmith's post order FY 85/02.03 H says one of his duties is to:

   establish a written preventative maintenance plan which ensures that all high security locks are checked semi-annually to establish proper serviceability.

   Find out if a p. m. plan exists and determine the extent of the locksmith's compliance with it. Obtain related documentation.

AREA I: KEY CONTROL

OBJECTIVE K: UNAUTHORIZED DUPLICATION OF KEYS

1. Does all unauthorized possession, alteration, marking, duplication, manufacture, or impression-making of keys by either staff members, inmates or others result in disciplinary action and/or prosecution? Auditors should check with the IDHO and the ALJ to determine if inmates or staff have been disciplined for this infraction? Auditors should check with Internal Security management or the Director of Investigations to determine if any outsiders have been prosecuted.

AREA II: INMATE COUNTS

OBJECTIVE A: POLICY AND PROCEDURE

1. FE 03 HEAD COUNT AND RECONCILIATION, is the only DIO policy and procedure related to inmate counts I could find. Talk to Sharon Fronk to verify that this is the only DIO policy pertaining to Inmate counts. Ascertain if the policy is under revision. The review date is 8-1-91. If the policy is being revised, interview the person responsible for the revision to find out what changes have been or will be made. Does it address all important operational areas?

OBJECTIVE B: COUNT PROCESS

1. Auditors should observe a sample of on-property counts at each housing facility to which they are assigned on each shift which will be used in determining staff compliance with policy and procedure. Obtain related documentation.

   a. are inmate counts completed according to schedule?
   b. is inmate flesh always observed by the counting officer?
   c. ascertain compliance with FE 03/04.03 D which says:

      > to maintain accurate inmate housing unit count totals, no inmate will change housing assignments until the facility classification secretary and the Central Control have been notified and a move order initiated.

   Does this practice only apply to the YACF or does it apply to the other facilities as well?

2. Auditors should also observe on-property out count of inmates at their assigned facilities (if applicable) who are at work, school, treatment, etc. to ensure compliance with policy and procedure. Obtain related documentation.

3. Auditors should sample off-property out count inmates at their assigned facilities who are on home visits, work release, school release or special leave to ensure they have an authorized clearance including date and time of departure and date and time of return in compliance with policy. Obtain related documentation.

AREA II: INMATE COUNTS

OBJECTIVE B: COUNT PROCESS

4. Auditors assigned to Southpoint should check the count sheets at Control I to determine if the officer at UMC as well as Community Correctional Centers are calling in their inmate head counts at the required times. Obtain related documentation.

5. Auditors assigned to Southpoint should check with the Out Count Coordinator to obtain a current count of inmates housed in other state/federal facilities. This number should then be verified with Control I to ensure its accuracy.

OBJECTIVE C: RECONCILIATION OF PHYSICAL COUNTS WITH ALPHA ROSTER

1. The auditor assigned to CUCF will interview management and staff as well as obtain documentation of reconciliations of physical counts with the Alpha Roster.

AREA III: CONTROL ROOM SECURITY

OBJECTIVE A: POLICY AND PROCEDURE

1. The only policies and procedures I found which pertain directly to Control Rooms are FF 25 South Point Control Centers and DIOSO 92-001-CUCF Controlled Security Points. I am interested in determining what policy and procedure is in place. Check with the control room officers as well as Sharon Fronk and Pam Elliott if necessary.

2. Does existing policy and procedure address all operational areas? For example the storage, use and inventory of control room weapons and munitions?

3. Are the control room staff members complying with existing policy and procedure?

4. Ask control room staff members what policies and procedures are in place to guide control room operations. Ask contol room staff members if they have read applicable policy and procedure.

AREA III: CONTROL ROOM SECURITY

OBJECTIVE B: ACCESS

1. Does policy and procedure govern who is allowed access to control rooms and under what circumstances? Policy should say that inmates are never allowed access to control rooms at any time for any reason. If policy and procedure does not address who is allowed access, recommend that it be included. Ask control room officers who is allowed access.

2. Auditors should determine whether documentation is maintained regarding persons who are allowed access to control rooms and the reason(s) for their access.

OBJECTIVE C: EQUIPMENT ISSUE

1. Auditors should ask control room staff what equipment is issued from the control room to other internal security staff members such as radios and keys.

2. Is a log kept which details what equipment is issued to whom, when it was issued and when it was returned. Additionally, is the equipment accounted for by control room staff at the beginning of each shift. Is a periodic inventory conducted by someone who does not have custody of the assets?

OBJECTIVE D: WEAPONS, AMMUNITION AND MUTIONS

1. Ask control room officers if they have read and are familiar with applicable policy and procedure: TMA 04/25 FIREARMS, FFr09 USE OF LETHAL FORCE, and FG 25 NON-LETHAL FORCE/FORCED ENTRIES.

2. Additionally, ask officers if and when they have been trained in the use of both firearms and any non-leathal weapons available in the control room. They should also have received training in the use of SCBAs.

3. Are control room officers in compliance with the requirements of TMA 04/25, FFr09, and FG 25? Obtain any available documentation.

OBJECTIVE E: BATTERY OPERATED RADIO

1. There should be at least one operational battery-operated radio in each control room. Verify with control room officers if this is the case. I am not aware of any specific policy which requires the availability of a battery-operated radio in each control room. This recommendation was included in an internal security manual I received from NIC.

OBJECTIVE F: EMERGENCY PROCEDURES

1. Ascertain whether a copy of emergency procedures is maintained and readily accessible in each control room. These would probably include: FGr01 CONTINGENCY PLANS, FGr02 DISATERS, FGr03 EVACUATION PROCEDURES, FGr04 MEDICAL EMERGENCIES, FGr07 EMERGENCY: WEATHER RELATED, FGr 13 BOMB THREAT/INCENDIARY DEVICES, FGr15 HAZARDOUS MATERIALS/ CHEMICAL SPILLS, FGr17 EARTHQUAKE, AND FGr18 ESCAPES/WALKAWAYS. Ask control room staff if they have read these policies, received applicable training, and could respond effectively and efficiently in an emergency.

OBJECTIVE G: RECORD-KEEPING

1. Auditors should determine if complete and accurate documentation is maintained in control rooms such as: pass-down logs, equipment issue logs and inmate count sheets. There may be other logs and documentation that are maintained as well.

OBJECTIVE H: COMMUNICATIONS EQUIPMENT

1. Identify the various types of communications equipment which are available in each control room such as: intercoms, radios, telephones, computer terminals and printers, closed circuit television, video cameras, telephone monitoring and recording equipment, fire alarm systems, and perimeter alarm systems. Ascertain if staff have been trained in the use of this equipment. Determine if staff are utilizing the equipment as intended by management.

2. Is the equipment operational and in good repair? Are maintenance and repairs completed in a timely manner?

OBJECTIVE I: CONTROL CENTER STAFFING

1. Are posts within the control center staffed by RFMS and RDOs? Are copies of applicable position post orders maintained in the control room and are they accurate? Have staff members filling control room posts read the applicable post orders recently? Do they have a sound working knowledge of all aspects of the post? Are staff fulfilling position duties and responsiblities in compliance with applicable post orders?

OBJECTIVE J: STAFF CONCERNS

1. Ask control room staff what security-related concerns they have pertaining the control room(s) in which they work. Auditors should make a record of all concerns raised by staff.

APPENDIX E

Working Papers

Federal Bureau of Prisons, Reviewer Worksheet
Program Review and Strategic Management Course

"REVIEWER WORKSHEET - ORGANIZING EVIDENCE INTO FINDINGS"

REVIEWER WORKSHEET - ORGANIZING EVIDENCE INTO FINDINGS

REVIEW SIZE: *FCI SEATTLE* DATE: *10/3/87*

PROGRAM COMPONENT: *N/A - Audit objective developed based on indicator information*

REVIEW OBJECTIVE RELATED TO FINDINGS: *Review procedures and activities for existing construction projects to determine if they are adequate to prevent escape.*

EVIDENCE	CRITERIA
Of 30 contract employees, only 18 have verifiable NCIC clearances. One employee has a serious criminal history. Processing of contract employees in and out of the institution is disorganized. ID procedures and tool control is questionable. Staff are not present when class "A" tools are used. Construction workers were observed moving without escorts. Construction materials stored at the construction sites reduce visual surveillance by outside patrols. Mat'ls. at the UNICOR warehouse facilitate fence access.	*Contract employees should be searched to insure it is unlikely they will engage in illegal activity. Contract employees must be positively identified. Tool control accountability procedure must be accurate. P.S. ... Local procedures require staff supervision. P.S. ... Requires staff escorts within the secure perimeter. Adequate visual surveillance for perimeter patrols must be maintained at all times.*

OVERALL CONDITION FOUND (ONLY ONE):
Contract construction security procedures are inadequate.

EFFECT(S) (CURRENT AND POTENTIAL): *Integrity of construction workers questionable. Loss of construction worker productivity. Access to perimeter fence possible without detection.*

IS EFFECT SIGNIFICANT AND WHY: *Possible introduction of contraband, loss of tools, and inmate escape.*

PROBABLE CAUSE(S) OF CONDITION: *Staff ignored P.S. requirement for NCIC checks. No Bureau policy that provides standards and guidelines for construction security. Poor professional judgement.*

POSSIBLE SOLUTION(S) TO CORRECT/IMPROVE CONDITION: *Conduct required NCIC checks. Process workers through rear gate only. Erect construction fences. Store construction worker tools in mechanical services class "A" tool room after each days work. Reduce amount of construction materials and store inside construction fences. Captain should be member of INPC for security planning.*

REVIEWER WORKSHEET - ORGANIZING EVIDENCE INTO FINDINGS

REVIEW SIZE: *FCI Seattle* DATE: *10/3/87*

PROGRAM COMPONENT: *Operation Security*

REVIEW OBJECTIVE RELATED TO FINDINGS: *Examine procedures and controls applied for accountability of inmates to determine if controls are effective and enforced.*

EVIDENCE	CRITERIA
Detail kits for UNICOR cable, FS, and plumbing shop. 15% out of date, 5% w/out photo, 10% with cards missing. Observed counts in Alpha and Bravo units on 10/3. Both counts interrupted by inmate movement. Total inst. census on 10/1. Observed staff conducting a body count. Pass system--passes not required to and from main recreation yard. On 9/30 observed two inmates from plumbing shop working in FS w/out passes. Passbook accountability control center--six books issued Alpha unit since July with no accountability.	*PS--detail officers must have a current photo for all inmates. Officers observing count must control inmate movement to obtain good count. PS 5500.1, Chap. 9 requires staff to insure inmates under their supervision are authorized in area. If pass system is to be effective, all movement must require a pass. PS--requires that passbooks issued must be properly accounted for prior to issuance of new books.*

OVERALL CONDITION FOUND (ONLY ONE):
Inmate accountability procedures are unreliable.

EFFECT(S) (CURRENT AND POTENTIAL): *Inmates have an opportunity for unsupervised movement and activity.*

IS EFFECT SIGNIFICANT AND WHY: *Unauthorized inmate activity could lead to disturbances, assaults, and escapes.*

PROBABLE CAUSE(S) OF CONDITION: *Staff attitude is somewhat apathetic. This indicates a lack of emphasis on inmate accountability by supervisory staff.*

POSSIBLE SOLUTION(S) TO CORRECT/IMPROVE CONDITION: *All supervisory staff from the warden down must stress and emphasize the need for good inmate accountability. Update detail kits. Train staff in detail census procedures. Update institution supplement on inmate accountability for monthly total census.*

U.S. Department of Justice

Federal Bureau of Prisons

WORKING PAPERS

Washington, D.C. 20534

Institution STL/CORR SVC's

Subject INMATE ACCOUNTABILITY

File# MWR Page 3 of 10

Date 10/1/87 Signature Mike Fife

9:30 AM	REVIEWED DETAIL KITS FOR UNICOR CABLE, FOOD SERVICE, AND THE PLUMBING SHOP. FOR THE DETAILS COMBINED, OVER 200 INDIVIDUAL CARDS WERE COUNTED AND EXAMINED. 15% OF THE CARDS WERE OUT OF DATE. THAT IS, THE PICTURES NO LONGER WERE A TRUE REFLECTION OF THE INMATE. 5% OF THE CARDS HAD NO PICTURES AT ALL. 10% OF THE CARDS WERE MISSING; MOST OF WHICH WERE UNICOR CABLE.
11:00 AM	INTERVIEWED MR. GEORGE FELLOWSHIP, UNICOR CABLE FOREMAN. ALTHOUGH HE WAS AWARE OF THE CREW KIT DISCREPANCIES, HE HAS YET TO TAKE ANY ACTION TO REMEDY THE SITUATION. HE DID INDICATE THAT THERE IS AN INSTITUTION PROCEDURE FOR UPDATE OF CREW KITS (NEW PICTURES, ETC.)
1:30 PM	A TOTAL INSTITUTION CENSUS WAS CONDUCTED AND I OBSERVED THE ACTIVITY IN THE MAIN RECREATION YARD. THE OFFICER CONDUCTING THE CENSUS COUNTED ALL INMATES PRESENT BUT DID NOT VERIFY THAT THEY WERE WHERE THEY

APPENDIX F

Reporting Program Review Results

Program Review, Correctional Services, Federal Correctional Institution, Seattle, Washington
September, 1993
[Attachment D4 to Bureau of Prisons Program Statement 1210.12]

PROGRAM REVIEW

CORRECTIONAL SERVICES

FEDERAL CORRECTIONAL INSTITUTION

SEATTLE, WASHINGTON

Prepared by:

Bob Hunt
Correctional Services Reviewer-in-Charge
Program Review Division
Washington, D.C.

September 1993

TABLE OF CONTENTS

PROGRAM REVIEW DATA SHEET

Review Authority and Scope:

1. Program Review Authority.....Assistant Director, PRD
2. Review Site.....FCI Seattle, Washington
3. Gender of the Population.....Male
4. Program/Function Reviewed.....Correctional Services
5. Overall Rating.....Acceptable
6. Reviewer-in-Charge (R.I.C.).....Bob Hunt
7. R.I.C.'s Duty Station.....Central Office
8. Number of Examiners Total.....Seven
9. Scope of Review.....Routine

Background:

10. Date of Last Review.....June 24-28, 1991
11. Date of Last Operational Review.....May 1992

Tracking Information:

12. Starting Date of Review.....September 20, 1993
13. Ending Date of Review .....September 24, 1993
14. Date of Report.....October 20, 1993
15. Date Mailed to CEO.....October 29, 1993
16. Date CEO Response Due.....November 26, 1993
17. Date of Next Review .....Fiscal Year 1995

Findings:

18. Number of Significant Findings.....Two
19. Number of Repeat Deficiencies.....One

Executive Staff:

20. Warden.....Rodney Ramer *
21. Associate Warden (O).....Mary Wilson **
    EOD - July 1993

* Al Jones was the warden prior to Mr. Ramer's arrival in June 1993.

** Mike Smith was the prior Associate Warden (O).
or
** Mike Smith, AW (P), and Mary Wilson, AW (O), switched responsibilities in July 1993.

(Indicate EOD if under six months)

REVIEWER ASSURANCE STATEMENT

As Reviewer-in-Charge, I certify that the review was conducted in accordance with generally accepted government auditing standards. Findings of noncompliance with policy or inadequate controls identified in the report are supported by evidence that is sufficient and reliable. The evidence is contained in the program review working papers filed in the Central Office.

I further certify that, within the scope of the program review, I have reasonable assurance that, except as noted in this report and in the list of advised items, the Correctional Services operation at FCI Seattle is operated in compliance with applicable law and policy; and that property and resources are efficiently utilized and adequately safeguarded. An adequate system of internal controls is in place to promote continued compliance and ensure resources are protected against waste, fraud, abuse, and mismanagement.

_____ _____
Bob Hunt, Examiner Date

Members of the Review Team:

Maria Hernandez, Examiner, Central Office, PRD
Scott Johnson, Examiner, Central Office ,PRD
Pete Kennedy, Examiner, Central Office, PRD
Robert Robinson, Chief Correctional Supervisor, USP Kansas City
Dominick Finney, Bureau Security Specialist, SCRO
Dirk Jones, Chief Correctional Supervisor, FCI McNeil

BACKGROUND INFORMATION

The Federal Correctional Institution (FCI) Seattle, Washington, is a medium security facility housing adult male offenders. It is located north of Seattle in Edmonds, Washington.

The Correctional Services Department has an authorized complement of 143 which includes 11 lieutenants. Their average length of service at Seattle is 15 months, with the most senior lieutenant having 60 months at the facility. Their average number years experience with the Bureau is nine, with the most senior lieutenant having fifteen years. There are four GS-9 lieutenants, two of which have completed the new Lieutenants Self-Study course. Six lieutenants have attended the Advanced Lieutenants Training course, and four lieutenants have attended the SIS Training course.

Captain Tom Davis has been in this position since May 1991. He began his career in September 1975 as a Correctional Officer at USMCFP Springfield. He transferred to FCI Ray Brook and later promoted to lieutenant at USP Leavenworth and FCI Butner, respectively. Mary Wilson, Associate Warden of Operations, has responsibility for the Correctional Services operation and has been in this position since July 1993.

The following statistical information was obtained from the Key Indicators/Strategic Support System using data input from the period of January 1993 through June 1993.

As stated previously, the Correctional Services Department has an authorized complement of 143 positions. The inmate to staff ratio for Correctional Services is slightly below the national average. Nationally, Correctional Services staff encompass an average of 43.6 percent of all staff in medium security facilities. Seattle's Correctional Services staff comprise 42 percent.

The Correctional Services monthly reports for escapes, assaults, and homicides for the past year revealed 20 assaults, (6 on an inmate with a weapon, 12 on an inmate without a weapon, and 2 on staff without a weapon), no escapes, no suicides, and no homicides. All reports indicated Seattle's statistics are comparable to the national average for significant misconduct incidents reported in the past year at medium security facilities.

Analysis of the inmate urine surveillance program indicated the percentage of test rates is below the national average for medium security institutions. The number of positive and unauthorized test results are also slightly below the national average.

GENERAL COMMENTS

The Correctional Services operation is functioning in an acceptable manner. Although several deficiencies and two significant findings were noted, the Correctional Services Department has adequate internal controls to effectively respond to areas of concern and accomplish their overall mission. Additionally, the operation is performing their vital functions in an acceptable manner. Staff appeared to work well with others. They were viewed as cheerful, energetic employees, who were open, honest, and responsive to the review team members. Communication within the department appeared to be good up-and-down the chain of command, as well as with other departments.

Tool control had improved significantly since the last program review. Further, tool control deficiencies identified during the UNICOR Program Review had been resolved. Locking devices identified as a repeat deficiency during the June 1991 Program Review had also been replaced with appropriate locks.

During the entire week, the examiners observed only one occasion where a staff member challenged an inmate to determine if he was in an authorized area. Ms. Patricia Nelson, Physical Therapist, should be commended for her efforts to ensure proper inmate accountability was maintained in the institution hospital.

Correctional Services' system of perpetual reviews is not achieving their intended results. The reviews appear to be incomplete, with little or no follow-up. Many of the perpetual review results indicated no deficiencies were found in a specific area, when in fact, deficiencies were readily apparent and discovered by the review team.

SIGNIFICANT FINDINGS

Finding # 1: Inmate Accountability

Condition and Effect:

Inmate accountability procedures for conducting the total institution census, use of detail kits, conducting counts, and inmate movement via the pass system are unreliable. This creates

the potential for unauthorized inmate activity that could lead to disturbances, assaults, and escape.

Evidence:

-- Inmate detail kits for the UNICOR cable factory, Food Service Department and Facilities plumbing shop were examined. (P.S. 5511.3, para. 9)

a) Approximately 15 percent of the detail cards did not have photographs that reflected an accurate image of the inmate.

b) Approximately 5 percent of the detail cards did not have inmate photographs.

c) Approximately 10 percent of the required detail cards were not in the kits.

-- On September 21, 1993, the 4:00 p.m. count was observed in units Alpha and Bravo. Both counts were disrupted by inmate movement and recounts were required. In both cases, probationary officers observed the count to monitor inmate movement. The officer in Alpha Unit was inattentive (negligent), and the officer in Bravo Unit was distracted because of his lack of experience and guidance. (P.S 5500.3, CH 7, Sect. 701)

-- Observation of the total institution census conducted on September 22, 1993, indicated staff were not checking to insure inmates were in authorized areas; they are conducting only a body count instead. (P.S.5500.3, CH 7, Sect. 705 & P.S. 5511.3, para. 5)

-- Although the institution has an inmate pass system, inmates are not required to have a pass when moving to and from the main recreation yard. Recreation staff have no means to determine if an inmate is authorized to be in the area. On September 22, 1993, two inmates from the plumbing shop working in Food Service did not have passes. Follow-up on expended passbooks was inconsistent. Six passbooks had been issued to Alpha Unit since July with no evidence of accountability for expended passbooks. (P.S. 5511.3, para. 8)

Cause:

-- Staff were not checking the detail kit assigned to

their area of responsibility to insure that the photograph and information were accurate.

-- Probationary officers were not trained to properly monitor formal counts in the units.

-- Staff throughout the institution were not trained in the correct procedure to conduct an institution census.

-- The inmate pass system is not properly monitored by staff throughout the institution.

Recommendations:

-- Institution executive staff should reinforce and stress the need for accurate and consistent inmate accountability procedures.

-- All detail kits should be updated immediately. Staff requiring guidance should receive individualized training from the lieutenants in the proper methods of conducting a detail census. Lieutenants conducting weekly detail census checks must insure that detail kits are accurate and take appropriate follow-up action.

-- The institution inmate accountability supplement should be revised to state specific steps required for the monthly total census. Lieutenants should observe staff conducting accountability checks to insure proper procedures are followed.

-- All staff should receive training in proper inmate accountability procedures.

Finding # 2: Key Identification and Accountability

Condition and Effect:

Key identification and accountability procedures are inadequate to prevent loss of keys and use of compromised keys. This condition creates a potential for inmate access to controlled areas that could facilitate disruptive behavior or escape.

Evidence:

-- Four compromised keys are currently in use at FCI Seattle. Details have been provided to the captain in

a separate report. (P.S. 5500.3, CH 3, Sect. 307)

-- The cross-reference system had a 25 percent error rate. A cross-reference system is required to facilitate locating specific keys and locks within the institution at any hour, day or night. (P.S. 5500.3, CH 7, Sect. 307)

-- The garage keys were stored in a wooden box retained in the garage office during the day. The garage office is not considered a secure area since numerous windows make access easy for inmates. (P.S. 5500.3, CH 7, Sect. 308)

-- The key cabinet in the control center did not conform to Bureau specifications. The keyboard is in alphabetical sections with the key numbers below the alphabetical section. Policy requires vertical rows be lettered and horizontal rows be numbered. (P.S. 5500.3, CH 7, Sect. 308)

**** See Attachment A for additional evidence supporting Significant Finding # 2.**

Cause:

-- Based on interviews with the captain, day watch lieutenants, and the security officer, it is apparent the security officer has devoted, at best, only 50 percent of his time to lockshop duties. This is due to the increased population (additional unit) and an abnormally high Correctional Officer turnover during the past year.

Recommendations:

-- The security officer should be relieved of all other duties so he can dedicate 100 percent of his time to lockshop duties.

-- A day watch lieutenant should be given specific supervisory responsibility to insure appropriate priorities are established, e.g., removal and replacement of compromised keys and locks, as well as a proper record system to take corrective action when keys are compromised.

REPEAT DEFICIENCIES

There was one repeat deficiency from the review conducted in June 1991.

-- There has been no improvement in the SIS office to prevent unauthorized entry. Plans were developed but apparently never implemented.

COMMENDATION

Terri Brothers, Special Housing Unit (SHU) Supervisor, is to be commended for her innovative renovation ideas and procedural changes which significantly increased the security and control of the segregation unit. Most notable was her suggestion that the SHU office be relocated to the former inmate law library. This increased the officer's ability to visually monitor administrative detention, disciplinary segregation, and the unit recreation yard.

Because of this procedure, serious inmate incidents (destruction of government property, flooding cells, etc.) have decreased by over 50 percent; and administrative detention inmates are allowed one hour of recreation seven days per week. (It should be noted that ten of the eighteen deficiencies reported in the 1991 review were based on conditions in segregation. No deficiencies in segregation were noted during this review.)

APPENDIX G

Auditor Evaluation

Utah Bureau of Internal Audit
AUDITOR-IN-CHARGE EVALUATION

Illinois DOC Auditor Appraisal

UTAH DEPARTMENT OF CORRECTIONS, BUREAU OF INTERNAL AUDIT

OFFICE OF THE DEPUTY DIRECTOR
BUREAU OF INTERNAL AUDIT

AUDITOR-IN-CHARGE EVALUATION

AUDITOR-IN-CHARGE: ____________________ DATE: __________

AUDIT: ______________________________

BUREAU DIRECTOR/DESIGNEE: Evaluate the auditor-in-charge in each category according to the criteria listed below:

OUTSTANDING	(O)
SATISFACTORY	(S)
UNSATISFACTORY	(U)
NOT APPLICABLE	(N/A)

267

"Outstanding" as well as "Unsatisfactory" performance on any audit should be supported by written comments in the appropriate category listed on this form.

I. NOTIFICATION AND PRE-AUDIT SURVEY:

A. Maintains a copy of the Audit Schedule Status Report received from the Bureau Director/Designee. ____

B. Provides notification to entity by due date. ____

C. Provides entity a memo requesting Pre-Survey material. ____

D. Conducts a walk through of the audit site. ____

E. Consolidates all Pre-Survey material, commentaries and summaries. ____

F. Carefully reviews all pertinent Departmental Policies and Procedures/ Post Orders. ____

OVERALL RATING IN NOTIFICATION AND PRE-AUDIT SURVEY ____

Comments: ______________________________

____

____

II. AUDIT PROGRAM:

A. Documents auditor hours available for audit. ____

B. Clearly articulates in writing major "Areas" to be audited. ____

C. Writes a "Narrative" pertaining to each "Area" which includes pertinent Pre-Survey material. ____

D. Writes specific audit objectives within each "Area" which may include "Criteria, Condition, Cause, and Effect." ____

E. Indicates auditors assigned to each objective and estimates the auditor hours needed to complete work. ____

F. Submits the Audit Program to the Bureau Director/Designee four (4) calendar days prior to the On-Site Verification Phase. ____

G. Briefs all auditors no later than the first day of the on site. ____

OVERALL RATING AUDIT PROGRAM PHASE ____

Comments: ______________________________

____

____

Auditor-In Charge	Bureau Director
Date: __________	Date: __________

* *

III. ENTRANCE CONFERENCE AND ON-SITE VERIFICATION:

A. Conducts Entrance Conference on date scheduled. ____

B. Provides auditee an outline of the Audit Program. ____

C. Provides auditee an Audit Team Evaluation form. ____

D. Supervises all auditors in developing a systematic approach to conducting audit tests, evaluating information and reporting results. ____

E. Monitors auditors and audit liaisons in maintaining audit schedule. ____

F. Meets regularly with auditors to review working papers and provides clarification. ____

G. Reviews working papers to ascertain if sufficient supporting evidence is developed commensurate with the time expended. ____

H. Evaluates auditors work to determine if major operational irregularities are identified. ____

I. Ensures that work paper summaries are adequate. ____

J. Reviews draft Findings to determine if they contain all five (5) elements. ____

K. Ensures that Findings have sufficient documentation. ____

L. Determines that all working papers are finalized on a systematic basis and completed no later than five (5) working days after the on site. ____

M. Encourages economic and efficient development of working papers through the use of dictaphones when appropriate. ____

N. Ensures that major issues related to Findings are clarified with the auditee. ____

O. Conducts a termination conference at end of the On-Site Verification Phase. ____

P. Provides Bureau Director/Designee, Auditor/Audit Liaison Evaluation forms by due date. ____

OVERALL RATING FOR ENTRANCE CONFERENCE AND ON-SITE VERIFICATION ____

Comments: _____

_____

_____

IV. WORKING PAPER CONTENT, ORGANIZATION AND SAFEKEEPING:

A. Ensures that all working paper files are well organized and include a work paper summary, evidence of audit tests conducted and a closing entry. ____

B. Organizes working papers consistent with the Audit Program. ____

C. Oversees safekeeping of working papers. ____

OVERALL RATING PERTAINING TO WORKING PAPER CONTENT, ORGANIZATION AND SAFEKEEPING ____

Comments: _____

_____

_____

_____ _____

Auditor-In Charge Bureau Director

Date: _____ Date: _____

* *

V. REPORTING RESULTS:

A. Carefully reviews all working papers to extract pertinent information for development of Findings. ____

B. To maintain efficient work flow, the majority of the report shall be dictated for transcription by Support Staff. ____

C. Develops Draft Report Introduction, Scope, Methodology and Definitions. ____

D. Develops Findings ensuring that there is adequate documentation in the working papers to support all five (5) audit Finding elements. ____

E. Develops Areas for Further Study as appropriate. ____

F. Develops Appendices as needed. ____

G. Few major structural changes are required in the report. ____

H. Similar Findings are grouped and related to one another. ____

I. Major steps and logical development of an idea are present. ____

J. All five (5) attributes of a Finding are adequately presented. ____

K. Cross-referenced Draft Report in working papers. ____

L. Draft Report is provided to the Bureau Director/Designee by the due date. ____

M. Attends Exit Conference with working papers. ____

N. Satisfactorily answers all relevant auditee questions pertaining to the report and working papers. ____

O. Provides factual response to questions during the Exit Conference that substantiate the report. ____

P. Ensures that audio recording of the Exit Conference is made. ____

Q. Ensures that the Final Report, including Entity Response, is completed by due date. ____

OVERALL RATING FOR REPORTING RESULTS ____

Comments: _____

_____

_____

_____ _____

Auditor-In Charge Bureau Director

Date: _____ Date: _____

* *

Comments/Recommendations (outstanding achievements and/or deficiencies):

_____

_____

_____

_____

_____

_____

_____

Bureau Director/Designee

LFH/BMAS
10/6/89

ILLINOIS DOC, AUDITOR APPRAISAL FORM

AUDITOR'S ASSIGNMENT APPRAISAL						
Name:	Level: I II III Other					
Assignment:	Hours:					
TECHNICAL PERFORMANCE	E	S	A	M	NA	REF.
Accounting knowledge and application						
Auditing knowledge and application						
Evaluation of internal controls						
Ability to learn						
Understanding of business environment						
Knowledge of policies and procedures						
Development of findings and recommendations						
Report writing						
WORKING PAPER DOCUMENTATION						
Logical organization						
Conciseness, elimination of nonessentials						
Sound conclusions and clear explanations						
Cross-references and indices						
Care, completeness, and self-review						
ADMINISTRATION						
Effective planning						
Supervisors advised of problems/progress						
Ability to review/evaluate/solve problems						
Effective clearance of review comments						
Control and completion of assignment						
SUPERVISORY SKILLS (IN-CHARGE)						
Effective supervision of staff						
Working paper review						

E = Excellent, S = Superior, A = Average, M = Marginal, NA = Not Acceptable

Comments:

Prepared by:	Date:
Discussed with auditor:	Date:
Reviewed by:	Date:

APPENDIX H

Information Systems

Federal Bureau of Prisons, Institution Fact Sheet,
KI/SSS Generated

Date of request: 01/27/92 Date of data: December 91

Institution: BOP--All Institutions. . . Region:
C.E.O.: J. Michael Quinlan , Director
Phone #: 202/307-3250 (Commercial) / 367-3250 (FTS)
FAX #:

Institution Security Level: N/A
Mean inmate security level: 2.6 Median inmate security level: 3.0

TOTAL Number of Inmates: 66472
Inmates in Population (excluding holdovers and in-transits): 61081
Inmates in Holdover Status: 2845
Inmates In-Transit: 2546
Rated Capacity: 43009 55% Over Capacity

(The Population Count excludes any WITSEC inmates.
Therefore, the percent capacity may be underreported.)

Note: The following frequencies relate to the TOTAL NUMBER OF INMATES IN POPULATION (INCLUDING HOLDOVERS AND IN-TRANSITS).

White:	42868	64.5%	Hispanic:	17196	25.9%
Black:	21843	32.9%	Non-Hispanic:	49276	74.1%
Other:	1762	2.7%			

Mean age of inmates : 37.1 years
Mean sentence length: 428.3 months
Median age of inmates: 35.9 years
Median sentence length: 78.0 months

Males :	61453	92.5%	U.S. citizens :	48697	73.3%
Females:	5019	7.6%	Non-U.S. citizens:	15854	23.9%
			Colombia: 3224	4.8%	Cuba: 2805 4.2%
			Mexico: 4048	6.1%	
Designated :	54587	82.1%	Unknown :	1921	2.9%
U.S. Citizen:	43195	79.1%			
Non-U.S. Cit:	10584	19.4%	Pre-Trial :	4713	7.1%
Unknown Citz:	808	1.5%	U.S. Citizens :	1796	38.1%
			Non-U.S. Citizens:	2293	48.7%
I.N.S.:	1775	2.7%	Unknown Citizens.:	624	13.2%
Admit:	2546	3.8%	Holdovers:	2845	4.3%

Age 18-25 :	8415	12.7%	SL1's :	153	0.2%	Minimum: 15814	23.8%
Age 26-30 :	11739	17.7%	SL2's :	60	0.1%	Low : 17509	26.3%
Age 31-35 :	13294	20.0%	SL3's :	126	0.2%	Medium : 18007	27.1%
Age 36-40 :	11845	17.8%	SL4's :	106	0.2%	High : 8801	13.2%
Age 41-45 :	9140	13.8%	SL5's :	20	0.0%		
Age 46-50 :	5484	8.3%	SL6's :	0	0.0%		
Age 51-55 :	3197	4.8%	Unclass:	5883	8.9%		
Age 56-60 :	1828	2.8%					
Age 61-65 :	951	1.4%	Community custody:	4726	7.1%		
Age 66+ :	578	0.9%	Out custody :	13235	19.9%		
			In custody :	46856	70.5%		
In Aryan Brothrhood:	40	0.1%	Maximum custody :	1456	2.2%		
In Mexican Mafia :	27	0.0%	Unclassified cust:	0	0.0%		
In Texas Syndicate :	40	0.1%					
In La Nuestra Faml.:	7	0.0%	Furlough Eligible:	4048	6.1%		
In Black Guerrillas:	7	0.0%					
CIM Case :	22069	33.2%	Soph. Criminal Act :	2180	3.3%		
Separation Case :	19855	29.9%	Threat Govt Official:	199	0.3%		

Note: The following frequencies relate to SENTENCED AND DESIGNATED INMATES (INCLUDING HOLDOVERS AND IN-TRANSITS).

Sentenced under the SRA: 35370 (63.0%)
Detainers: 18478 (32.9%)

Inmates A-DES > 30 days w/o sentence comp:
492 (0.9% of 54587 A-DES inmates)

--Sentencing Information--			--Instant Offense Categories--		
No. with Data :	56116	100.0%	No. with Data :	54082	100.0%
Snt. 0-11 mo:	1396	2.5%	Drug-Liquor Offense:	31308	57.9%
Snt. 12-35 mo:	7817	13.9%	Robbery Offenses :	6335	11.7%
Snt. 36-59 mo:	7392	13.2%	Property Offenses :	3510	6.5%
Snt. 60-119 mo:	16917	30.1%	Extort.,Bribe,Fraud:	3443	6.4%
Snt.120-179 mo:	9373	16.7%	Violent Offenses :	2067	3.8%
Snt.180-239 mo:	4759	8.5%	D.C. Offenses :	1130	2.1%
Snt. 240-life:	7206	12.8%	Arms, Explos., Arsn:	3696	6.8%
(Life Sentence:	1256	2.2%)	White Collar Offns.:	711	1.3%
			Immigration Offense:	512	0.9%
Expected Length Incarc. (BP14)			Court, Corrections :	499	0.9%
No. with Data :	48285	100.0%	Sex Offenses :	399	0.7%
0-12 Months :	9618	19.9%	National Security :	73	0.1%
13-59 Months :	22195	46.0%	Miscellaneous Offn.:	399	0.7%
60-83 Months :	4959	10.3%			
84+ Months :	11513	23.8%	--Projected Time Left to Serve--		
			4 Months or less :	17369	26.1%
--% Sentence Served (BP15)--			5-8 Months :	5045	7.6%
No. with Data :	48285	100.0%	9-12 Months :	4101	6.2%
Served 0-25% :	20088	41.6%	13-24 Months :	9452	14.2%
Served 26-75% :	22793	47.2%	25-60 Months :	14511	21.8%
Served 76-90% :	3995	8.3%	61-120 Months :	9020	13.6%
Served 91+% :	1409	2.9%	121+ Months :	6966	10.5%
--Judgment & Commitment-- Obligations			--Demonstrated Responsibility(BP-15)--		
No. with Data :	54913	100.0%	No. with Data :	48285	100.0%
With 1 oblig. :	40887	74.5%	Poor :	6607	13.7%
With 2 oblig. :	8921	16.2%	Average :	21344	44.2%
With 3+ oblig.:	5105	9.3%	Good :	20334	42.1%
History of Violence (BP-14)			Type & No. of Discipl. Reports(BP-15)		
No. with Data :	60870	100.0%	No. with Data :	48284	100.0%
None :	41931	68.9%	1 100 in 10 Years :	4779	9.9%
Minor, 10+ Yrs:	1270	2.1%	1+ 200 in 2 Years :	864	1.8%
Minor,5-10 Yrs:	1343	2.2%	1 200 in 2 Years :	3403	7.0%
Minor, < 5 Yrs:	2965	4.9%	1+ 300 in 1 Year :	1409	2.9%
Serious,15+Yrs:	3078	5.1%	1 300 in 1 Year :	3064	6.3%
Serio.,10-15Yr:	3237	5.3%	1+ 400 in 1 Year :	93	0.2%
Serio.,5-10 Yr:	3935	6.5%	1 400 in 1 Year :	286	0.6%
Serio.,< 5 Yrs:	3111	5.1%	None :	34386	71.2%
--Medical Status Data--			--Mental/Psych. Status(BP-15)--		
No. with Data :	54314	100.0%	No. with Data :	48285	100.0%
Reg. Duty Stat:	40049	73.7%	Unfavorable :	804	1.7%
Medical Condit:	5630	10.4%	Favorable :	47481	98.3%
Hypertensives :	3310	6.1%			
Psych. Condit.:	2074	3.1%			
Cardiac Condit:	1569	2.9%			
Diabetics :	1682	3.1%			

Fine Print

The user should note the following:
Because of the time and sequence requirements for completion of sentence computations, BP-14, and BP-15 forms, the entries showing "No. with Data" will NOT always equal one another nor the number of inmates in population. Nevertheless, the frequencies reported are as accurate as mainframe resources will permit.

USER FEEDBACK FORM

Please complete and mail this self-addressed, postage-paid form to assist the National Institute of Corrections in assessing the value and utility of its publications.

1. What is your general reaction to this document?

   ____Excellent ____Good ____Average ____Poor ____Useless

2. To what extent do you see the document as being useful in terms of:

	Very Useful	Of Some Use	Not Useful
Providing new or important information			
Developing or implementing new programs			
Modifying existing programs			
Administering ongoing programs			
Providing appropriate liaisons			

3. Do you feel that more should be done in this subject area? If so, please specify what types of assistance are needed.

4. In what ways could the document be improved?

5. How did this document come to your attention?

6. How are you planning to use the information contained in the document?

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   ____Probation
   ____Parole
   ____Community corrections
   ____Court
   ____Juvenile justice
   ____Police
   ____Legislative body
   ____Professional organization
   ____College/university
   ____Citizen group
   ____Other government agency
   ____Other (please specify)_____

   ____Federal ____State ____County ____Local ____Regional

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   _____

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Program Review and Internal Audit

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