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UNITED STATES BUREAU OF PRISONS
STAFF STUDY: INSTITUTIONAL DRUG
ABUSE TREATMENT PROGRAMS AND
UTILIZATION OF PRESCRIPTION
DRUGS AT FIVE INSTITUTIONS

A REPORT
OF THE
SELECT COMMITTEE ON NARCOTICS
ABUSE AND CONTROL
NINETY-SIXTH CONGRESS
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U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, D.C., August 26, 1980.

Hon. LESTER L. WOLFF,
Chairman, Select Committee on Narcotics Abuse and Control,
U.S. House of Representatives.

DEAR CHAIRMAN WOLFF: We are pleased to submit for publication the Staff Study by the Task Force on the Bureau of Prisons, entitled "Institutional Drug Abuse Treatment Programs and the Utilization of Prescription Drugs at Five Institutions." This Study involved extensive compilation and analysis of statistical and other pertinent data supplied by the Bureau of Prisons on prescribing amounts.

You will note that the Study identifies a strong reliance by selected Federal penal institutions on the major tranquilizers to the extent that there are concerns as to whether or not such high utilization levels reflect sound medical practice under adequate supervision. While the Bureau of Prisons has provided its own appraisal of our findings, their conclusions must be questioned and examined in more detail. The Study is excellent but only presents preliminary data warranting further investigation. In view of the critical issues raised, the Task Force deemed it important to publish the Study at this time.

There may be a need for an independent review of prescribing practices at each of the institutions to formulate more comprehensive guidelines for the dispensing of controlled substances (as well as some potent noncontrolled substances). Consideration should be given to placing limitations on dosage strengths, establishing a central formulary stock inventory, and implementing a centralized, on-going drug utilization model. In addition, this review should consider the creation of a medical education program for physicians assigned to the prison setting. The review could be conducted by the National Academy of Sciences, similar to that undertaken on the Veterans Administration's hospital system.

Former Committee staff counsel, Mr. Richard S. Carro, is to be commended for his work on this Study.

Respectfully submitted,

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MAY 6 1983

ACQUISITIONS

FOREWORD

The problem of drug abuse among special populations has been a dominant concern of the Select Committee on Narcotics Abuse and Control. Separate committee reports examine the particular problems of women, ethnic minorities, the elderly, the Armed Forces, and veterans.

Part I of this volume is a report on a hearing held by the Select Committee on July 25, 1978. At this hearing the committee examined the institutional drug abuse treatment programs of the U.S. Bureau of Prisons, U.S. Department of Justice.

Part II of this volume is a staff study on the utilization of prescription drugs at five institutions under the jurisdiction of the Bureau of Prisons.

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PART I

INSTITUTIONAL DRUG ABUSE TREATMENT PROGRAMS

INTRODUCTION

On July 25, 1978, the Select Committee on Narcotics Abuse and Control conducted a hearing to examine the status of the drug abuse treatment program within the Bureau of Prisons, U.S. Department of Justice. Representing the Bureau of Prisons was Mr. Norman A. Carlson, Director. Testimony was also taken from Dennis Curtis, Professor (adjunct) of Law and Director of Clinical Studies at Yale Law School, Ms. Judith Resnik, Lecturer, Yale Law School and Supervising Attorney, Yale Legal Services; Matthew L. Myers, Chief Staff Counsel, The National Prison Project of the American Civil Liberties Foundation; William Cleary, ex-inmate and past participant in the Atlanta Federal Penitentiary Drug Abuse Program; and Carlton Lewis, III, inmate and participant in the Atlanta Federal Penitentiary Drug Abuse Program.

The overall mission of the Bureau of Prisons is to provide for the care and custody of persons convicted of Federal crimes and sentenced by the courts to serve a period of time incarcerated in a Federal penal institution. The present drug abuse treatment program finds its genesis in title II of the Narcotic Addict Rehabilitation Act of 1966 (NARA) (P.L. 89-793, 18 U.S.C. § 4251 *et seq.*).

In 1968, NARA treatment units were established in three Federal correctional institutions: Danbury, Conn.; Alderson, W. Va.; and Terminal Island, Calif. These programs provided treatment to approximately 300 inmates. For several reasons, some of which were developed at the hearing, few additional NARA units were established. Although there are NARA-sentenced Federal prisoners in 13 institutions, treatment is not based on the NARA act. Furthermore, the number of Federal offenders sentenced under NARA has been steadily decreasing in recent years, as illustrated in the following table:

BUREAU OF PRISONS, U.S. DEPARTMENT OF JUSTICE, INSTITUTIONAL TREATMENT POPULATION: INMATES SENTENCED UNDER TITLE II OF THE NARCOTIC ADDICT REHABILITATION ACT OF 1966

Year ¹	NARA participants	Percent treatment population	Institutions with NARA-sentenced inmates
1976.....	396	18.6	10
1977.....	369	14.8	10
1978.....	258	9.8	13

¹ As of March.

Source: U.S. Bureau of Prisons, Department of Justice.

Commenting on this trend, Mr. Carlson stated that, "The courts simply don't use it; it turned out to be, frankly, a piece of legislation that is not very effective in terms of dealing with the problem. It precludes many offenders who need the program . . ." The strict limitations placed on eligibility for NARA treatment [See P.L. 89-793 § 201(f), 18 U.S.C. § 4251(f)] excluded many Federal inmates with drug abuse problems from receiving treatment. In 1972, the Bureau expanded treatment opportunities to inmates ineligible for NARA participation. The new Drug Abuse Program (DAP) units were structured to provide treatment opportunities to any inmate incarcerated in an institution offering such a program, irrespective of NARA eligibility criteria. By March 1978, the Bureau operated 23 drug abuse treatment units in 20 institutions. The number of inmates participating in the drug abuse treatment program is limited by the Bureau to between 100-125. The Bureau believes that participants in excess of this level would result in "diminishing returns in terms of staff inmate interactions." Many of the drug abuse treatment programs are structured residential units and the Bureau is pursuing a policy to institute this modality system-wide.

As the following table indicates, the number of Federal inmates volunteering to participate in DAP programs has been steadily increasing:

INSTITUTIONAL TREATMENT POPULATION—VOLUNTARY PARTICIPANTS

Year ¹	DAP participants	Percent treatment population	Number of institutions
1976	1,730	81.4	16
1977	2,117	85.2	18
1978	2,374	90.2	20

¹ As of March.

Source: U.S. Bureau of Prisons, Department of Justice.

The Drug Abuse Program (DAP) programs have completely replaced NARA units, and at the present time the Bureau maintains no NARA-specific treatment programs. Director Carlson testified that the Bureau of Prisons does "not have separate programs for the NARA commitments versus the DAP commitments. The reason is the use of (NARA) by the Federal courts has declined substantially in recent years."

In March, 1978, the Federal prison population numbered approximately 28,700. According to Director Carlson, of this number approximately 10,000 were "hard" drug addicts at the time of their commitment.

As an adjunct to the institutional drug abuse treatment programs, individuals who have received treatment are accorded special aftercare services following their incarceration. Although the Bureau of Prisons contracts with a variety of community agencies to provide aftercare services, offenders who receive aftercare services within the community are under the supervision of the U.S. Probation Service. In March, 1978, the number of persons receiving aftercare treatment services numbered approximately 2,300.

SUMMARY OF TESTIMONY

DEPARTMENTAL AND FEDERAL-LOCAL COORDINATION

The Bureau of Prisons, according to Director Carlson, utilized resources offered through the National Institute on Drug Abuse (NIDA), principally community aftercare agencies which have been supported by NIDA with funds and technical assistance. The Bureau also participates as a member of the NIDA Criminal Justice Advisory Board and coordinates its programs with the other agencies represented. The Bureau is a member of the Advisory Corrections Council, which includes representatives from the U.S. Probation Service, the Parole Board, the judiciary, and the U.S. Attorney's Office. No testimony or other evidence was received by the committee to indicate the extent to which Bureau cooperation with these other agencies and offices has impacted upon the prison drug abuse treatment programs. Testimony at a previous Select Committee hearing indicated that the level of cooperation between NIDA and the Bureau of Prisons has been decreasing and it was suggested that prison officials are not responsive to suggestions made by NIDA and NIDA consultants.

With respect to aftercare drug abuse treatment the Bureau has been relegated to utilizing whatever resources are available in the community. In his opening statement before the committee Director Carlson stated: "[T]he level of aftercare services vary considerably. Some are quite good, others, frankly, are marginal. In aftercare programs we have to use whatever is available in the community. We can't go out and insist on a given type of program, because we have to depend on existing community resources, hospital programs, mental health programs, and so forth."

Prior to incarceration, Federal offenders are also exposed to local policies over which the Bureau of Prisons has no control. Generally, Federal offenders are initially placed in local detention facilities and if they are drug abusers, are detoxified according to local program standards. According to Director Carlson, "Some of the detoxification programs are quite effective and humane; others leave much to be desired." The specific technique of detoxification remains within the discretion of local physicians and psychiatrists with the Bureau of Prisons adhering to a policy of noninterference. The most prevalent local detoxification technique is methadone; other methods utilized include Thorazine, Valium and other types of tranquilization.

PROGRAM PLANNING

Criticism of Bureau of Prisons Drug Abuse Treatment Programs

Witnesses Curtis, Resnik, and Myers were uniformly critical of the drug abuse treatment services provided by the Bureau of Prisons. Mr. Curtis and Ms. Resnik testified on the basis of their contact with prisoners at the Federal Correctional Institution at Danbury, Conn., while Mr. Myers based his testimony on information received by the National Prison Project of the American Civil Liberties Union Foundation.

Common throughout the testimony of these public witnesses was the assertion that the Bureau of Prisons drug treatment program

lacked the substantive content necessary to make them effective and successful. As defined by the Narcotic Addict Rehabilitation Act of 1966, "treatment . . . includes, but is not limited to, medical, educational, social, psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services designed to protect the public and benefit the addict by eliminating his dependence on addicting drugs, or by controlling his dependence, and his susceptibility to addiction." [P.L. 89-793 § 201(c), 18 U.S.C. § 4251(c), as amended by P.L. 92-420 § 3].

Referring to the Bureau policy requiring program participants to undergo 180 hours of drug abuse treatment in order to be certified eligible for parole, Ms. Resnik testified that "[w]hat is wrong with it is 180 hours masquerading as drug treatment. That 180 hours has achieved magical proportions. Once you clock the 180 hours, you get certified as eligible for parole, because you have made progress with your drug addiction. For some people, maybe it takes 40 hours, for others it might take 250 hours. It is making, unfortunately, a numerical number something that it isn't, which is the problem." Ms. Resnik further testified that the only requirement imposed on inmates "is that [they] be physically present in the beginning when attendance is taken. People walk in and out during the groups. They eat, drink coffee, several conversations go on at one time, occasionally tapes are played, which cannot always be heard because of the inmates talking all at once." Commenting on the effectiveness of the group counseling compliment of the Danbury treatment program, Ms. Resnik stated "You can't just tack on a bunch of groups, give them a lot of pop labels, send people to them one or two or three hours a week and call that drug treatment. You have to relate to what happens during the 23 other hours." Although conceding that such groups "might be helpful in a general psychological sense," Ms. Resnik asserted that "none of it is tailored to drug addiction. It is a general kind of panoply of psychological theories, all of which are sort of scatter-gunned around and while any inmate might find it useful, diverting, and interesting," they are not drug-specific treatment.

Ms. Resnik further testified that the Danbury inmates perceive group-counseling assignments as relating more "to the need for numbers in groups." As an illustration, she testified that nine inmates whose only language is Spanish are also assigned to attend groups where the only language spoken is English. She questioned the ability of the drug treatment program to help these inmates with their addiction problems.

Mr. Curtis echoed the criticisms leveled at the drug treatment program stating that:

"There is no real drug treatment program at Danbury now. There are about 40 NARA inmates at Danbury, and for them the situation is an extremely difficult one. They have been sentenced for treatment, they have a right to treatment, and they have not been getting treatment at Danbury."

Mr. Curtis cited § 201(e) of the Narcotic Addict Rehabilitation Act of 1966, [18 U.S.C. § 4253(a)] which provides that "no offender shall be committed under this chapter if the Attorney General certifies that adequate facilities or personnel for treatment are unavailable." He went on to state that "the Bureau should either institute

a program that it thinks will work, or should refuse to accept any more NARA inmates and tell the sentencing judges of those inmates [who] have not been receiving the treatment that the act prescribes."

Mr. Myers stated the view of the National Prison Project that "for years the Bureau has failed to cope with" the severity and scope of drug abuse and characterized the treatment programs as "ill-funded, disorganized, and by-and-large a series of sporadically held group therapy sessions perceived by prisoners as nothing more than a degrading opportunity to enhance their chances for early release." Mr. Myers charged that the drug abuse treatment programs suffer from an "extraordinary lack of guidance, supervision, and quality control from the central office of the Bureau of Prisons. Program content varies widely, and few programs take advantage of the up-to-date knowledge of how to deal with drug abusers." To illustrate this point Mr. Myers testified that:

In preparation for these hearings, my office contacted the Bureau's central office to speak with the individual with overall responsibility for the Bureau's drug treatment programs. The individual to whom we were directed advised us that the central office of the Bureau of Prisons did not maintain information about the programs at the individual institutions and did not control the program's content. To confirm this incredible admission, we contacted the individual in charge of drug treatment at Lewisburg, who told us he was not supervised by the central office, and that based upon his knowledge each institution is free to administer its own drug abuse program with little or no guidance from above.

Mr. Myers asserted that the description of the Danbury drug abuse treatment program as described by witnesses Resnik and Curtis "comports completely with the descriptions [the National Prison Project has] been given of programs in other institutions. The lack of overall policy guidance has inhibited the integration of these programs into the overall prison program, as essential element of any program with any hope of success. Group counseling is meaningless if the prisoner continues to spend the vast majority of his or her time in the otherwise unchanged negative environment."

In concluding his opening statement, Mr. Myers testified that it is the opinion of the National Prison Project that "until the Bureau formulates a national policy on how they are going to deal with drug abusers, until the Bureau devotes resources at the Central Office to look into and to begin to develop the basics for what a drug abuse program must and should contain, meaningful treatment throughout the facilities will not take place."

During the preparation for this hearing the committee received identical correspondence from several inmates at the U.S. Federal Prison at Leavenworth, Kans. These inmates charged that "the so called drug abuse program here at Leavenworth Federal Prison does not exist in any other form other than occasional group counseling. There are between 300 and 400 men in this prison who need drug abuse treatment. We are told for the most part that there is no drug program and that most of us are unable to be transferred to institutions that have drug abuse treatment programs."

Responding to these allegations, the Bureau of Prisons wrote the committee:

Although [Leavenworth Federal Penitentiary] has no residential drug unit, there is a major effort at this institution to identify and assist inmates with a drug abuse problem. Currently, most of the drug abuse programs are operated by the Mental

Health Department. This department is continuously operating group and individual counseling programs which focus on drug-problem inmates, and there are generally between 150 and 200 inmates involved in these specific programs. The following data outline the number of inmates involved and the frequency of meetings of each counseling group:

Group	Inmates involved	Times per week	Hours per meeting
Transactional analysis.....	16	1	1 1/2
Rational behavior therapy marathon.....	15	1	1 1/2
Rational behavior therapy.....	15	1	1 1/2
Ananda marga meditation.....	20	1	1 1/2
Christian drug abuse counseling.....	10	1	1 1/2
Biofeedback.....	2	2	1 1/2
General drug abuse group (6).....	90	1	1 1/2
Yoga training.....	19	1	1 1/2

Although highly critical of the level of treatment provided by the Bureau of Prisons, the public witnesses believed that they could become successful if proven modalities of treatment were integrated into the programs. In her prepared statement, Ms. Resnik listed four components essential to any drug therapy program, as described by Dr. Herbert Kleber:¹

1. Addicts have to be treated separately from non-addicts, because combining addicts with the general psychiatric population results in the addicts manipulating groups so as to avoid dealing with the problems of addiction.

2. Since addicts use drugs for many different reasons, individualization within a general therapeutic format is necessary. Each addict must be screened, interviewed, and given a program designed to deal with why he or she is addicted. Periodic evaluations of progress are required.

3. Personnel trained to work with drug addicts are essential. Treatment of drug addiction is a specialized area; general mental health workers do not have the skills or expertise to handle the difficult issues posed by the drug addict. In addition the addict members of the treatment community must themselves participate in providing therapy, and they too must be trained.

4. A drug program must provide a structured environment. Therapy occurs when addicts test the limitations imposed and are confronted by staff and peers.

According to Ms. Resnik, these four elements are designed to implement an effective treatment modality. With respect to the Danbury Federal prison, she stated in her prepared testimony that:

The program at F.C.I. Danbury does not contain any of the basic elements described by Dr. Kleber, nor does it meet the expectations of Congress or the judiciary as to what treatment NARA is supposed to provide. There is no concept of how addicts behave and what treatment structures are required for treatment. Inmates are not evaluated before assignment to groups. Group sessions have no relation to the rest of the inmates' routine at Danbury. Neither the staff nor the other addicts are trained to implement any therapeutic approach. In theory, NARA inmates are a special group, selected after a Federal district judge has determined that an individual would be likely to be rehabilitated. In practice, at F.C.I. Danbury, NARA inmates do not receive help in ending their drug addiction.

In contrast, Director Carlson testified "I first of all don't know what a definition would be of an intensive drug program. I would have that defined for me."

Director Carlson testified that of the approximately 2,000 female prisoners within the Federal system, 1,000 are narcotic addicts. Fifty

¹ Professor of Clinical Psychiatry, Yale Medical School and Director of the Substance Abuse Treatment Union of the Connecticut Mental Center, New Haven, Conn.

percent of all women prisoners are narcotics addicts while 33 percent of male prisoners are addicts. In response to questioning as to whether the Bureau of Prisons provides different types of treatment for women prisoners with drug problems, Director Carlson indicated that the Bureau did not. He noted, however, that the Bureau is "in much better shape in providing resources for female offenders than for their male counterparts" because more resources have been devoted to the two all-female institutions.

The Atlanta Experience

In direct contrast to the criticism leveled specifically at the Danbury facility and at the Bureau of Prisons drug treatment program generally, witnesses Cleary and Lewis praised the drug program at the U.S. Penitentiary at Atlanta, Ga. Mr. Cleary was one of the 10 original participants in the Atlanta program and Mr. Lewis testified as a present participant in that program.

According to Mr. Cleary "[I]n order to have a meaningful drug program, you need one ingredient only, you need the individual who is going to be in that program willing to change." With regard to substantive program content Mr. Cleary testified that in addition to the more traditional therapy modalities:

there has to be other things involved, education for one, social education. . . . most addicts in prison don't have social skills that most other citizens have. Some of them have no idea how to walk into a restaurant and sit down and order a meal. . . . These things have to be taught. And it is not going to be taught overnight, or in 180 hours. Or even in 180 days.

Mr. Cleary described the Atlanta program during his tenure as an intensive 24-hour-a-day therapeutic community. Commenting that few addicts look at the consequences of the acts, Mr. Cleary stated "there was confrontation, there was overexaggeration of things. They blew things out of proportion to make you look at the consequences of a little act." He stressed as extremely positive the fact that inmates and staff alike were involved in the decisionmaking process of the program.

According to Mr. Cleary, nine of the original ten participants in the Atlanta program successfully completed the program and "are now productive, tax paying citizens, when just a few years ago they, including myself, were liabilities costing the U.S. taxpayer about \$13,000 per year."

Mr. Lewis described the Atlanta drug abuse treatment program as it presently exists. He testified that it is a "program that focuses on acquiring skills—social skills, educational skills." The program, he said, "has expanded since Mr. Cleary participated, to include treatment modalities which help us get a clear understanding of ourselves and also the problems that we find ourselves in." According to Mr. Lewis, the prime objective of the Atlanta program is to "stimulate the physical, emotional, and intellectual growth of the [participant] so that upon release [the inmate] will be mature, responsible, and an effective person in the community." Program participants, in conjunction with the program staff, "develop an understanding of what your goals are" and then design an individualized program to facilitate achieving these goals. "The structure is based on building within the individual. . . .

We start out gradually, whether it is an educational deficit or communications deficit or just an inability to express yourself." To facilitate this growth process, the Atlanta program utilizes a variety of treatment modalities, including psychodrama, assertiveness training, interpersonal communications, values clarification and self esteem. Commenting on how the drug abuse treatment program has helped him Mr. Lewis stated that "I have learned how to solve problems more effectively and make plans for the future by thinking about the long-range consequences of my actions." He noted that the program relies heavily on skilled professionals in the community to supplement the daily activities of the permanent program staff. To illustrate how the program utilizes other community resources Mr. Lewis cited how "bankers come in from the outside community and give [the inmates] information about establishing credit, setting up savings accounts and obtaining loans. All of this is designed to prepare us to meet problems realistically and plan for them."

Mr. Lewis also testified that program participants are encouraged to participate in the development of the drug abuse program and that inmates are integrated into the program management to "increase their responsibility and involvement in the program."

Both Mr. Cleary and Mr. Lewis agreed that program availability was essential and that an individual who was serious about overcoming his or her drug abuse problem would benefit from its existence.

Bureau of Prisons Drug Abuse Task Force

In January, 1978, Bureau of Prisons Director Norman Carlson directed the Bureau's Drug Abuse Task Force to undertake a thorough and comprehensive review of the Bureau's drug abuse program with particular emphasis on its effectiveness, standards, staffing and funding. The Drug Abuse Task Force met from January 31 through February 1, 1978, and delivered its report² to the Director on March 15, 1978.

According to the Task Force Report:

[O]ne of the areas which has caused frequent difficulties in Drug Abuse unit programming has been the determination of exactly what the program should consist of. There are wide variations through the Bureau of Prisons regarding these programs. At the present time each manager has the option of developing his particular program. . .

To remedy this situation the Task Force recommended that every drug abuse unit have three phases of program involvement: First, an introductory and opting out phase consisting of an intensive orientation program, participant evaluation, a drug education class, exposure to the different program modalities, a minimum of one group counseling meeting weekly, and specified work assignments; Second, an intensive program phase based on a contractual agreement "spelling out the things which the inmate and staff have agreed upon as being effective approaches to the inmates' problems of dependency on . . . drugs" and consisting of an identifiable unit program modality (with alternatives for inmates who cannot accept or participate in that modality), group and individual counseling, classes or groups in personal development, group or individual psychotherapy, a narcotics surveillance program, and social skills development program; and

² This report is contained in Appendix A.

third, a pre-release phase consisting of the dissemination of aftercare information to the inmate, and encouraging the community aftercare contractor to meet with inmates.

The Task Force also recommended that inmates be made aware of the requirements for completion of the drug abuse treatment program. The Task Force recommended the establishment of "a definite standard before an inmate can be considered as having completed a program" and that such a standard minimally include:

"An orientation period of at least 40 hours, a minimum of 100 hours in counseling and/or psychotherapy, a demonstrated knowledge of drug information, a demonstrated pattern of good work habits, good institutional adjustment, a demonstrated pattern of clean urine analysis, completion of at least 40 hours in a pre-release program, preparation for aftercare in the community, work assignments . . . , recreation and/or leisure program within unit, communication type meetings, community involvement if appropriate to the institution" and an "inmate progress assessment."

The Task Force recommended that all institutions establish drug abuse treatment units, and that institutions not having an adequate financial base [be funded] through existing funds, and that new drug abuse treatment units be implemented and financed only upon certification that the unit meets the basic standards which are set forth for drug abuse units.

EVALUATION

In his prepared statement, Director Carlson testified that "the effectiveness of drug abuse programs is admittedly difficult to measure. Evaluation requires the tracking of individuals for a substantial period of time following release in order to determine whether or not they remain free of re-addiction and lead a crime-free life. On balance, we are pleased with research results to date. They indicate that re-addiction and re-commitment rates are considerably lower than generally assumed."

Ms. Resnik testified that outside evaluation teams should systematically go "to every one of the institutions, throughout the system, because there is no sort of general supervision from the central staff and we can't get the information generalized. It really requires people who know a lot about the therapy, to go out and look unit by unit for a week on different site visits."

The report of the Drug Abuse Task Force stated that "there should be an ongoing evaluation program within [each] unit which will evaluate program and inmate participation. Local program evaluation should give the institutional executive staff adequate information to assess whether the program is really accomplishing what it should." The report specifically recommended that a system of data collection be established which would indicate the number of inmates and months of post release success as reflected by unit assignments; the institutional adjustment of inmates by units; and a comparison of units within institutions, institutions within regions and regional priorities.

PROGRAM STAFF

The residential drug abuse treatment units are typically composed of a staff of six: a unit manager who has overall responsibility for the program, a psychologist, several case workers and two correctional

counselors. According to Director Carlson, the permanent staff of the drug abuse treatment unit is supplemented by "members of the education staff and consultants" from the local community. While he did not indicate that the drug program itself was suffering from a lack in the number of staff available he candidly stated that the Bureau as a whole has "insufficient staff." While the number of inmates participating in the drug abuse treatment program has been steadily increasing, the number of institutional staff assigned to the drug program has remained relatively constant since 1971. The following table illustrates the steadily increasing ratio of drug program participants to unit staff:

BUREAU OF PRISONS DRUG ABUSE TREATMENT PROGRAM: PROGRAM PARTICIPANTS AND BOP INSTITUTIONAL STAFF

Fiscal year	Program participants	Staff	Ratio of participants to staff
1971	381	129	3.0
1972	852	129	6.6
1973	1,238	129	9.2
1974	1,714	141	12.2
1975	2,114	144	14.7
1976	2,313	144	16.1
1977	2,828	127	22.3

Notes: (1) Position allocations exclusive of overhead or indirect positions. (2) For fiscal year 1974 the supplemental request for positions to activate the transfer of Lexington, Ky., was not fully utilized for operation of the program. (3) Position decrease in fiscal year 1977 reflects the change in position accounting procedures for functional unit management system. (4) Staff does not include non-Bureau personnel providing treatment services pursuant to contract.

Source: Bureau of Prisons, U.S. Department of Justice.

In comparison with the present 22.3 inmate to staff ratio within the drug treatment program, the ratio of inmates to correctional officers is approximately 6.2 and the ratio of inmates to all Bureau employees is approximately 3.1.

The Bureau of Prisons also utilizes the services of 61 physicians from the U.S. Public Health Service who are assigned throughout the Bureau's 38 institutions. Sixteen (26.2 percent) of these physicians are assigned to the Springfield, Mo. Federal Prison, although that institution does not contain a drug abuse treatment program. In response to questioning as to how these physicians are integrated into the drug abuse treatment program, Dr. Harry Weller of the U.S. Public Health Service and Deputy Medical Director of the Bureau of Prisons testified that:

"[s]ince the drug abuse programs are in various institutions, and since the physicians are not really assigned to the drug abuse programs per se, they are really providing medical care in general through the medical facility at each particular institution, so none of them are really specifically for the drug abuse programs."

Seventeen of the 61 physicians assigned to the Bureau are psychiatrists and according to Dr. Weller "most of them would have special training in [drug abuse treatment.]" Seven (41.2 percent) of the psychiatrists are assigned to the Springfield facility. Dr. Weller also testified that the Bureau has contracts with approximately 500 community physicians who supplement the medical staff of the Bureau of Prisons.

Director Carlson testified that he did not consider the training afforded the Bureau drug program staff to be adequate. He added that "[t]here is no specific training program per se that I know of in the country for people who work in drug abuse programs, either in the communities or in the institutions . . . I think, however, our personnel do read what is in the literature, they do avail themselves of what is available in the community in terms of knowledge as far as dealing with the problem of narcotic addiction. In all of our basic training programs we try to sensitize all the staff [to] problems narcotics addiction can present."

Ms. Resnik testified about the lack of trained staff at the Danbury Federal Correctional Institution, stating that "the staffing of the NARA unit was the same as the staffing of every other unit. There was no psychologist or any trained personnel available." She noted that group counseling sessions "continue to be run by people who have no specific drug training and by social workers." She testified as to her conversations with Dr. Herbert Kleber who informed her that "the fact that someone has a psychiatry or psychology master of social work label does not tell you that someone is able to do drug treatment. There needs to be someone who has been through a specialized training program in which you learn about the problems of addiction and learn about the minimal requirements and then learn about the different kinds of programs that are across the country." She also stressed the need for inmate participants to receive training generate "interactions between addicts."

Mr. Myers testified that the National Prison Project is also concerned "about the lack of adequately trained staff." He noted that at the new Lewisburg drug treatment program there is no indication that the two drug counselors "have received any training" and that the drug program staff in general "has received no additional training." Mr. Myers testified that a prisoner at the Leavenworth facility "didn't bother to go to the group therapy sessions available to him" because they were "being run by the mess steward."

Contrasting the testimony of Ms. Resnik and Mr. Curtis was that of Mr. Cleary who stated "you don't need super-duper trained staff, who are experts in anything . . . It doesn't make any difference if the guy has a mess steward or a 16-year correctional officer as a counselor." He related that the one staff member within the Atlanta drug abuse treatment program who had the most impact on him was a correctional officer "who didn't even know what drugs looked like until he was assigned to that program."

Mr. Lewis stressed the importance of integrating specialized consultants into the treatment program noting that the individual participant's problems are often "multiple and each one of these consultants has a way of focusing in on them."

The report of the Bureau of Prisons Drug Abuse Task Force devoted not less than seven of its twenty-six recommendations to the area of staff resources. The report noted that "staffing patterns of drug abuse units vary throughout the Bureau of Prisons . . . and is usually dependent upon the degree of staffing conversion that was or can be made in the local institution." In recent months, the report stated, "staffing patterns have required a much larger ratio of inmates to staff because of our overcrowded institutions. There should be a higher

level of staffing in specialized program units which is needed to provide intensive unit programs." Specifically, the report recommended that a drug treatment program consisting of 100 or less inmates be staffed by six persons (1 unit manager, 1 case manager, 2 correctional counselors, 1 clerk/typist and 1 psychologist) and be supplemented by a part-time educational representative with correctional officers (guards) on all shifts. Presently UMT staff at some institutions must double as correctional officers. The report recommended that additional staff be assigned to drug abuse treatment units at the rate of 1 case worker per 75 inmates and 1 correctional counselor per 40 inmates. For a drug unit of 100, the recommended inmate to staff ratio would be 16.6; for a unit of 180 the recommended ratio would be 20. This contrasts to the present inmate to staff ratio of 22.3. The report recommended that drug abuse treatment programs be made available in the 18 institutions which do not now have them, concluding that drug abuse treatment programs "should be made available to all offenders in the Bureau or Prisons" and that "present funding is adequate" for their support.

The extension drug abuse treatment programs to the 10,000 Federal prisoners estimated to have drug abuse problems would require a program staff of 500, or an increase of 373 staff positions over the current level of 127, based on individual treatment units of 180 participants supported by a staff of 9. Similarly, in order to provide 100 participant capacity treatment programs to the 18 institutions which currently do not have them, minimum additional staff of 108 would be required, based on a per unit staffing of 6.

The report recognized the inability of Bureau staff personnel to provide certain kinds of treatment and services to program participants and recommended that community consultants "be used in conjunction with" unit staff members. The report cautioned, however, against the excessive utilization of community consultants noting that "consultants have too often been used to supplement programs that should be provided by unit staff, and in some cases have taken over the responsibility of programs in drug abuse units [and] staff have often reverted back to a basic general operational type of posture in the units relinquishing the program responsibilities to the consultants."

The report also recommended that drug abuse treatment program staff receive special training "over and above that which is presently provided by the Bureau for all of its employees." It specifically recommended that the drug program be provided for each staff member in the unit. The report further noted that "it is expected that all staff who work in a drug abuse unit will complete a course in drug education." The Task Force urged that community consultants be utilized for training staff in various counseling techniques and modalities when institutional or Bureau resources are not available.

RESEARCH

The amount of funds devoted by the Bureau of Prisons for research in the area of narcotics treatment and related fields has been understandably small in view of the overall care-and-custody mission of the Bureau. Between fiscal years 1969 and 1976 total research obligations of the Bureau's drug abuse program amounted to \$184,000, or

less than one percent of drug abuse treatment program funding for that period.

The report of the Drug Abuse Task Force recommended that all research projects be approved prior to funding by the appropriate Bureau central office personnel and that research "should be useful to management at all levels and written in nontechnical terms." The Task Force report made no recommendation with regard to consultation with the National Institute on Drug Abuse prior to the initiation of research projects so that a duplication of efforts and funding could be avoided. The report also stated that "at the present time \$100,000 is taken out of the drug abuse funds for research purposes. The Task Force questions the use of these moneys."

FUNDING

The following table illustrates funding levels of both institutional and after-care drug abuse treatment programs within the Bureau of Prisons:

Fiscal year	Institutional program		After-care program	
	Expenditures (millions)	Expenditure per participant ¹	Expenditures (millions)	Expenditure per participant
1970	\$0.719	\$2,577	\$0.390	\$2,010
1971	.935	2,454	.555	1,961
1972	1.260	1,467	.669	1,694
1973	1.653	1,335	1.597	1,012
1974 ²	2.033	1,186	3.114	1,186
1975	2.620	1,239	3.376	1,280
1976	2.770	1,198	2.531	1,112
1977	2.940	1,040	2.805	1,262

¹ Includes both NARA and DAP participants.

² Beginning in fiscal year 1974 the accounting system relating to drug and other programs was changed; figures represent best available estimates.

Source: Bureau of Prisons, U.S. Department of Justice.

The report of the Drug Abuse Task Force expressed concern over the allocation of funds intended for use within the Bureau's institutional drug abuse treatment programs, stating that "at the present time there is a wide disparity in the use of drug abuse funds, and in some cases are used for other programs." The report recommended that drug abuse units be directly provided with funds for operational and consultant needs and that "operational money is not to be spent on major equipment, basic institutional needs, or services provided elsewhere in the institution. Consultant money will be spent only for services which cannot be provided by staff of the institution." The task force report also questioned the diversion of \$100,000 from treatment program funds for research purposes. In response to questioning regarding the diversion of drug program funds for other purposes Director Carlson noted that the amount in question was very small and that "the funds were used to buy video tape equipment used in the drug abuse treatment program. We felt the appropriated funds could be used for that purpose. There was nothing illegal, it was merely the drug managers used it to purchase equipment or do other things not directly related to inmate treatment." The Director indicated that the task force recommendation in this regard would be fully implemented.

Mr. Curtis testified that the Danbury facility received \$253,000 for drug abuse treatment in 1977; and of that amount \$30,000 was spent:

to get counseling through the University of Connecticut. That leaves about \$220,000, as best I can tell, for staff salaries. Now the staff that runs the NARA unit at Danbury consists of a unit manager, counselors, caseworkers, correctional officers, and that is the staff. I think that what the Bureau of Prisons is spending its money on for drug treatment is simply the staff to run the drug unit [which] is the same kind of staff they get to run the other units.

As noted earlier in this report, the Drug Abuse Task Force recommended that drug abuse treatment programs be instituted in each of the 18 Bureau facilities which currently have no drug program. Although noting that funds are "not earmarked for drug abuse programs *per se*," Director Carlson testified that "it is our full intent to use those funds, as far as we can, to implement drug abuse programs in virtually all the institutions."

DRUG ABUSE WITHIN FEDERAL PRISONS

Trafficking

In his prepared statement Director Carlson noted that "controlling the traffic in illicit items among an offender population is a difficult task. Nearly a third of this population have histories of drug abuse." In response to questioning the Director cited contact visiting, more social settings, furloughs, and work-release programs as institutional practices and policies which "exacerbate the problem of smuggling narcotics into the institutions." He also testified that on occasion prison officers and staff have been involved in the introduction of narcotics into the institutions. The Bureau of Prisons immediately refers such cases to the Federal Bureau of Investigation and the U.S. Attorney's Office for prosecution. Mr. Carlson testified that "three or four cases in the past year" had been prosecuted and that these former Bureau personnel are "serving time" as a result of their trafficking activities.

To detect and deter illicit narcotics use in its facilities the Bureau subjects each inmate to a thorough search following a visitation. Furthermore, inmates participating in community work or study release programs are subjected to regular urine testing, as are inmates who have a history of drug abuse or who are suspected of abuse. In addition to testing inmates regarded as potential high-risk drug abusers, the Bureau has instituted a random urinalysis program in which 5 percent of the inmates in each institution are selected for testing. A computer generates the random list of inmates to be tested and the urine samples are sent to a laboratory under contract with the Bureau for the actual testing. These tests are administered without warning and Director Carlson stated that "the circumstances under which these tests are administered are carefully controlled so as to insure the integrity of the tests." Director Carlson testified that 3.7 percent of the inmates given urinalysis tests had positive results and are accordingly disciplined for unauthorized drug use. In his prepared statement, the Director said that "we have been pleased with the results of the surveillance programs." Urinalysis is also routinely administered to inmates released to aftercare facilities following their incarceration.

Ms. Resnik testified that a recently published study conducted by the Law Enforcement Assistance Administration suggested serious problems with forensic laboratories conducting urinalysis testing, and that the "testing is often inaccurate." She noted that some urinalyses are conducted by non-specific tests and in such cases "you can take vitamin pills and get back amphetamine-positive" results. Since inmates with positive urinalysis tests are subject to loss of accumulated good-time and administrative segregation, Ms. Resnik urged that careful attention be paid to the administration of urinalysis tests. Prisoners in the Federal Penitentiary at Leavenworth, Kansas, wrote the committee that

First, if an inmate refuses to take the Urine test, he is placed in the HOLE and will lose what ever (sic) among of goodtime that the staff wishes to take from him. If, he takes the Urine Test and it comes up Dirty he is again subject to being placed in the HOLE and a loss of goodtime. There have been many times when a man has lost as much as 300 to 400 days of earned good time. [Emphasis in original.]

A possible index of the level of drug abuse within the Federal prisons is the incidence of Type B Viral Hepatitis (acute serum hepatitis). At the time of admission to a Federal prison, all inmates are subjected to a thorough medical examination. According to information provided by the BOP, during the first half of fiscal year 1978, 26 inmates were discovered to have type B hepatitis subsequent to their admission. Projecting this number of cases to 52 for fiscal year 1978, the incidence of type B hepatitis is 17.3 cases per 10,000 inmates. According to the Center for Disease Control, U.S. Public Health Service of the Department of Health, Education and Welfare, the incidence of type B hepatitis among U.S. males aged 20-50 is 1.6 cases per 10,000 population, and the incidence among all persons in the United States is 0.7 cases per 10,000 population. Furthermore, during the first half of fiscal year 1978, 22 cases of type C hepatitis (undefined hepatitis) were discovered subsequent to admission in the inmate population. If these 22 cases of type C hepatitis contain the same ratio of type B hepatitis cases as type B bears to type A (acute infectious hepatitis) among the prison population, the number of inmate type B hepatitis cases for fiscal year 1978 can be projected to 81, or an incidence of 27.1 cases per 10,000 population.

*Prison Medical Drug Prescription*³

In his prepared statement, Mr. Myers raised the issue of questionable Bureau of Prisons medical drug prescription practices and made reference to the 1975 investigation conducted by the Comptroller General of the United States. This report suggested that prisoners at the medical center for Federal prisoners at Springfield, Mo., were receiving excessive doses of phenothiazines. Mr. Myers prepared statement noted that the National Prison Project sent a copy of this report to the Medical Committee for Human Rights for review. The responding physician wrote:

. . . The GAO survey shows that the dosages reported were frequently in excess of the safe maximum, particularly where the drug was given for long periods (six months or more). The survey further reveals that these major tranquilizers are

³ This topic was the subject of further investigation by the Select Committee. The results and analysis of this investigation are discussed in Part II of this report, *infra*.

being used to a significant extent on persons not diagnosed as psychotic. I consider this a questionable practice and one might very well question whether the drug (or drugs) are being used for a therapeutic purpose or as an instrument of administrative physical control.

Mr. Myers' prepared statement contains two additional illustrations of what he termed "an official kind of abuse involving the forced administration of psychotropic prescription medication." The first concerns an inmate sentenced by a Federal court with the recommendation that he be incarcerated in an institution providing drug abuse treatment. The inmate was assigned to the Leavenworth Federal Penitentiary where he requested a transfer because of the absence of an intensive drug treatment program. The inmate was reassigned to the Addiction Research Center at Lexington, Ky. according to Mr. Myers' prepared statement:

While at the Addiction Research Center [the inmate] participated in experiments with barbiturate amphetamines, methadone and a host of other drugs identified only by code name. After seven months at the center [he] was approached by doctors who asked him if he was interested in participating in a "chronic morphine study." [He] agreed to participate and was addicted to a particular tolerance level on which he was maintained for nearly six months. After six months of morphine addiction, [he] was hurriedly detoxified by the doctors in time for his parole board hearing, although he was given no real drug addiction treatment. [He] was granted parole and released four months later. However, he was soon returned to Leavenworth when it was discovered that he had returned to the use of drugs. While serving the remaining ten months of his sentence, [he] made repeated requests to Leavenworth officials for a transfer to the Federal Correctional Institution at Fort Worth, Tex., to participate in their drug abuse therapy programs . . . His requests for transfer were denied.

Mr. Myers prepared statement also quoted from an article appearing in January, 1977, concerning a prisoner at the Marion, Ill., facility.

. . . When the guards brought [the inmate] to my interviewing cubicle . . . it was immediately obvious that [he] was heavily under the influence of drugs. He kept looking wildly around the room . . . His responses to my questions were almost totally incoherent. He spoke rapidly and slurred his words. He often forgot what he was saying. [He] was distressed at his condition and promised that he would 'write everything down' for me.

Through my fifteen minute talk with [him], I asked him six or seven times whether he consented to taking drugs. Each time he told me that he was pressured, and often forced, into taking thiorazine . . .

Several weeks after I left Marion, I wrote to [him] and asked him a few follow-up questions. This is an excerpt from his reply to me: 'In your note you mentioned you talked to me during your visit here. However, sir, I don't recall being called out to see you, as I was eagerly anticipating . . . In response to your query: Yes, the officials here forced and continue to force me to ingest drugs, 100 to 200 milligrams of thiorazine in four daily dosages, plus cogentin per dosage which supposedly is to offset the side effects of thiorazine—an obvious admission of the hazards of thiorazine.'

In response to questioning concerning the use of sedatives and other drugs for institutional control purposes, Mr. Carlson testified that "our psychiatrists and doctors do sedate inmates that they feel are a danger to themselves and other inmates. I don't think we do over-sedate inmates in our institutions." The Director also testified that "all medication is prescribed by a medical doctor. Any other staff are not permitted to prescribe any type of medication. The actual dispensing is done by physician's assistants [and] paramedics." A random survey conducted by the Bureau of Prisons just prior to the hearing

⁴ Miller, Tom, "Behind Bars," The Progressive, January 1977.

indicated that about "4 percent of the total inmate population is receiving any type of tranquilization." Director Carlson stated that "I think we have reasonably good controls on the dispensing of these prescriptions" although conceding in his prepared statement that "some institutions use more drugs than others." He also noted in his prepared statement that the experience with the Bureau's medical staff "indicates that they are more likely to underprescribe than over-prescribe for those individuals with a drug abuse history."

FINDINGS

1. The Bureau of Prisons operate 23 drug abuse treatment programs in 20 of its 38 institutions.
2. Approximately 10,000 of a total 28,700 Federal prisoners were 'hard' drug addicts at the time of their commitment.
3. The number of Federal prisoners volunteering for drug abuse treatment has been steadily increasing. In 1976, 1,730 prisoners volunteered for treatment; by 1978 the number had increased by 37 percent, to 2,374 volunteers and accounted for 90.2 percent of all prisoners receiving drug abuse treatment.
4. The number of Federal prisoners sentenced to receive drug abuse treatment under Title II of the Narcotic Addict Rehabilitation Act of 1966 (NARA) has been steadily decreasing. In 1976, 396 Federal prisoners in 10 institutions were NARA participants; by 1978 the number had decreased by 35 percent, to 258 in 13 institutions.
5. There are no NARA-specific treatment facilities within the Bureau of Prisons. All drug abuse treatment is provided through voluntary Drug Abuse Programs (DAPs). However, participation in the DAPs by NARA sentenced prisoners is mandatory.
6. Approximately 50 percent of the 2,000 female prisoners within Federal penal institutions are narcotics addicts, while 33 percent of male prisoners are narcotics addicts.
7. Drug abuse treatment units are typically composed of a staff of six: a unit manager, psychologist, caseworkers and correctional counselors.
8. The staff of the drug abuse treatment units is supplemented by consultants and specialists from the community.
9. The ratio of drug abuse treatment program participants to Bureau of Prisons drug program staff has been steadily increasing. In 1971 there was one staff member for every 3 participants; by 1974 there was one staff member for every 12.2 participants; and by 1977 there was one staff member for every 22.3 participants.
10. The quality of the drug abuse treatment programs varies widely among Federal penal institutions.
11. There is a lack of supervision of drug abuse treatment programs by the Central Office of the Bureau of Prisons.
12. The Bureau of Prisons maintains no centralized training program for staff assigned to drug abuse treatment programs.
13. Since 1970, the amount of institutional drug abuse program expenditures per program participant has been steadily decreasing. In 1970, the Bureau expended \$2,577 per institutional participant; by 1974 the amount was \$1,186; and by 1977 the amount was \$1,040.
14. The Bureau of Prisons and the U.S. Probation Service cooperate

to provide aftercare drug abuse treatment services to inmates upon their release. Approximately 2,300 ex-inmates receive aftercare.

15. Since 1970, the amount of aftercare drug abuse treatment program expenditures per participant has decreased. In 1970 the Bureau expended \$2,010 per aftercare participant; by 1974 the amount was \$1,186; and by 1977 the amount was \$1,262.

16. Bureau of Prisons policies of contact visitation, furloughs, and work-release programs have increased opportunities for illicit drug trafficking within Federal penal institutions.

17. The Bureau of Prisons subjects inmates participating in community work or study programs to regular urinalysis testing; the Bureau also conducts a program of random urinalysis in which 5 percent of the prison population is selected for testing each month. Approximately 3.7 percent of those inmates tested yield positive test results.

18. The incidence of type B viral hepatitis (acute serum hepatitis) within the Bureau of Prisons is significantly greater than the incidence in both the total United States population and U.S. males aged 20-50.

19. The Bureau of Prisons utilizes resources offered through the National Institute on Drug Abuse (NIDA), principally community aftercare agencies which have been supported with NIDA funds and technical assistance. The Bureau is a member of the Advisory Corrections Council.

20. The Bureau of Prisons does not consult with NIDA prior to the initiation of drug-related research projects.

CONCLUSIONS

1. Approximately 75 percent of Federal prisoners with drug abuse problems are not receiving treatment within the Bureau of Prisons. Although many prisoners decline treatment opportunities and others are deemed ineligible for treatment by virtue of the long length of their sentences, many prisoners with drug abuse problems are incarcerated in Federal institutions which do not offer a drug abuse treatment program.

2. Title II of the Narcotic Addict Rehabilitation Act of 1966 (NARA) is not an effective mechanism for providing drug abuse treatment to Federal offenders identified as narcotic addicts.

3. The number of prisoners volunteering for participation in Bureau of Prisons drug abuse treatment programs is increasing at a higher rate than the assignment of Bureau institutional staff to these programs.

4. The lack of Central Office control over drug abuse treatment programs leads to widely different quality levels of treatment. Since the Bureau of Prisons has no standardized training program for institutional staff, the ability of treatment program staff to affect inmate drug use is dependent on individual staff qualifications. The recommendations of the Drug Abuse Task Force for staff training are insufficient.

5. The extension of drug abuse treatment programs to the 10,000 Federal prisoners estimated to have drug abuse problems would require a program staff of 500, or an increase of 373 staff positions over the current level of 127, based on individual treatment units of 180

participants supported by a staff of nine. Similarly, in order to establish 100 participant-capacity treatment programs in the 18 institutions which currently do not have DAP units, minimum additional staff of 108 would be required, based on a per unit staffing of six. The committee questions the adequacy of present Bureau resources to implement this recommendation.

6. Although Bureau of Prisons policies encouraging contact visiting, furloughs, and work- and study-release programs have increased opportunities for illicit drug trafficking within Federal penal institutions, the committee concludes as a principle that these policies should be maintained while efforts to control illicit drug trafficking continue.

7. Efforts of the Bureau of Prisons to monitor trafficking in illicit drugs within Federal penal institutions by both targeted and random urinalysis testing are sufficient to monitor the level of drug trafficking.

8. The extremely high incidence of type B viral hepatitis (acute serum hepatitis) among the Federal prison population suggests the high availability of heroin within Federal prisons.

RECOMMENDATIONS

1. Drug abuse treatment programs should be made available to Federal prisoners in all institutions. Alternatively, prisoners incarcerated in an institution not offering a drug abuse treatment program should be permitted to transfer to an institution offering such a program.

2. The Bureau of Prisons should make drug abuse treatment available to all inmates regardless of their length of sentence.

3. The Bureau of Prisons should revise its policies to provide standardization of substantive program content among drug abuse treatment units. Unit managers, however, should retain the discretion to vary program content as may be appropriate.

4. The Bureau of Prisons should standardize the level of training required of drug abuse program staff. In addition, program staff should be required to participate in supplementary training programs on a regular basis. The committee recommends that the Bureau seek assistance from NIDA in this regard.

5. The Congress and the Bureau of Prisons should allocate more financial resources for drug abuse treatment programs.

6. The Congress should repeal Title II of the Narcotic Addicts Rehabilitation Act of 1966. The committee recommends, however, that drug abuse treatment funding provided to the Bureau of Prisons not decrease as a result of such a repeal.

7. The Bureau of Prisons should consult with NIDA prior to initiating drug-related research.

PART II

UTILIZATION OF PRESCRIPTION DRUGS AT FIVE INSTITUTIONS

INTRODUCTION

During the Select Committee hearing on July 25, 1978, certain questions were raised by committee members and witnesses concerning the policies and practice of the Bureau of Prisons with respect to the prescription dispensing of controlled substances¹ and certain other drugs to persons incarcerated in institutions under the jurisdiction of the Bureau.

Committee staff subsequently discussed the availability of data with Bureau personnel at which time it was determined that the information would be provided with respect to five institutions to be selected by committee staff. The institutions selected for analysis were the U.S. Penitentiary at Leavenworth and Federal Correction Institutions at Alderson, Terminal Island, El Reno and Lexington. These institutions represent geographical diversity as well as an almost complete spectrum of security classifications.

The raw data supplied by the Bureau of Prisons (Appendix B) covered the three year period July 1, 1975 through June 30, 1978. These data indicated the quantity of every controlled substance, by dosage strengths, in inventory on July 1, 1975; additions to inventory between that date and June 30, 1978; the quantity of each drug dosage dispensed to both outpatients and inpatients between such dates; the quantity of each drug dosage destroyed or otherwise disposed of between such dates; and the quantity of each drug in inventory on June 30, 1978. Identical data for three noncontrolled substances was subsequently provided to the committee by the Bureau of Prisons.

In analyzing the raw data supplied by the Bureau of Prisons, committee staff classified the substances into two groups: those drugs which exhibit "personnel control" properties and those which do not exhibit such properties. Drugs primarily utilized for psychic relief were placed in the control-drug classification while those drugs primarily utilized for physical relief were placed in the noncontrol classification.

To analyze the data with respect to the control-drugs committee staff constructed a table for each of the five institutions to show the average number of dosages of each drug dispensed to inpatient and

¹ Controlled substances are those scheduled in the Controlled Substances Act (P.L. 91-513, Title II, Part B, § 202, 84 Stat. 1247, 21 U.S.C. 812).

outpatient inmates during the three year period.² These tables, based upon actual dosage levels dispensed at the institutions, proved inadequate for the purposes of comparing drug utilization at the five institutions because different institutions would rely on different dosage strengths of the same drug. To illustrate, FCI Alderson dispensed chlordiazepoxide (Librium) only in 10-mg dosages; FCI Terminal Island dispensed 5 mg, 10 mg, and 25 mg dosages; USP Leavenworth and FCI Lexington dispensed 10 mg and 25 mg dosages; and FCI El Reno dispensed 5 mg and 25 mg dosages. To facilitate analysis of the data committee staff, relying on such sources as the *Physicians' Desk Reference* (32d Ed., 1978) and the *National Prescription Audit* (1974, 1975), selected a standard dosage unit representing a typically prescribed dosage strength for each drug. Actual dispensed dosages of each drug were converted to standard dosage units for purposes of institutional comparison. In the case of chlordiazepoxide the standard dosage unit selected was 10 mg. Accordingly, a dosage of 5 mg is equivalent to 0.50 standard dosage units while a dosage of 25 mg is equivalent to 2.50 standard dosage units. By expressing dosages in terms of the standard dosage unit the committee staff was able to more closely standardize the comparison of prescribing practices at the five institutions.

To further facilitate the analysis of the control-drug data supplied by the Bureau of Prisons, committee staff distinguished between control drugs which are used for different purposes. The control drugs were subdivided into five classes: (1) minor tranquilizers, (2) major tranquilizers, (3) hypnotics, (4) antidepressants, and (5) sedatives.

Utilization of noncontrol drugs in the five institutions analyzed is presented in a manner similar to that used for the control-drugs. This analysis, however, is limited to actual dosage strengths dispensed. Because a patient's description of pain and a physician's perception of that pain are of a subjective nature, committee staff made no attempt to convert the noncontrol drugs into standard dosage units for the purposes of comparison.

In the tables that follow average dosage levels dispensed per inmate per year by the institutions were calculated by dividing the total dosages dispensed at an institution by the average number of inmates incarcerated at the institution during the period and then dividing by three. This methodology assumes that all inmates received drugs on an equal basis, and was utilized because it was impractical to attempt to reconstruct the number of inmates who actually received prescription drugs during the three year period. Accordingly, if prescription drugs were dispensed to less than all inmates at an institution, the average number of dosages dispensed per actual inmate-patient per year would proportionally increase. For example, if only half the inmate population at the institution received all drugs dispensed at that institution the actual average level of dosages dispensed per inmate per year would be twice that shown in the tables.

Following the analysis of the data initially supplied by the Bureau of Prisons, committee staff requested identical data for the drug

² The tabulation of the usage level of control-drugs at FCI Alderson does not include amobarbital which was dispensed once during the three year period. The tabulations also exclude the use of sodium pentothal (FCI Terminal Island, USP Leavenworth) and pentothal (FCI El Reno). Pentothal, although within the control-group classification, is generally used for its anesthetic qualities. This is apparently supported by the fact that the three institutions reporting the use of this drug dispensed all dosages to inpatients.

fluphenazine (Prolixin). Analysis of this data is found in Appendix C to this study.

CONTROL DRUGS

As previously indicated, the control drugs dispensed by the five institutions have been divided into five classifications: (1) minor tranquilizers, (2) major tranquilizers, (3) hypnotics, (4) antidepressants, and (4) sedatives. The utilization of control drugs by the five institutions varied greatly when expressed in both actual dosages and standard dosage units dispensed per inmate per year. As shown in Table 1, the average number of actual dosages dispensed per inmate per year varied from a low of 3.97 dosages (FCI El Reno) to a high of 63.93 dosages (USP Leavenworth). The remaining three institutions dispensed control drugs as follows: 16.19 dosages (FCI Alderson), 29.57 (FCI Terminal Island), and 41.62 (FCI Lexington). In each of the five institutions actual dosages of control drugs were dispensed more frequently to outpatients than to inpatients.³ The smallest percentage of control drugs dispensed to outpatients occurred at FCI Alderson (63.4 percent), while outpatients received the highest percentage distribution at FCI El Reno (84.3 percent). The remaining institutions dispensed actual dosages of control drugs to outpatients as follows: 71.5 percent (USP Leavenworth), 83.4 percent (FCI Terminal Island), and 83.5 percent (FCI Lexington).

In terms of standard dosage units dispensed per inmate per year (table 2) the average number of dosages ranged from a low of 6.40 (FCI El Reno) to a high of 127.49 (USP Leavenworth). The remaining three institutions dispensed standard dosage units of control drugs as follows: 25.87 dosages (FCI Alderson), 52.14 (FCI Terminal Island), and 55.06 (FCI Lexington). In each of the five institutions standard dosage units of control drugs were dispensed more frequently to outpatients than to inpatients. The smallest percentage of control drugs dispensed to outpatients occurred at FCI Alderson (57.2 percent), while outpatients received the highest percentage distribution at FCI Lexington (83.5 percent). The remaining three institutions dispensed standard dosage units of control drugs to outpatients as follows: 73.2 percent (USP Leavenworth), 75.9 percent (FCI Terminal Island), and 82.6 percent (FCI El Reno).

TABLE 1.—BUREAU OF PRISONS: DISTRIBUTION OF ACTUAL DOSAGES OF ALL "CONTROL" AT 5 INSTITUTIONS
JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	9,976	36.6	17,279	63.4	27,255	100	16.19
FCI Terminal Island.....	14,818	16.6	74,197	83.4	89,015	100	29.57
USP Leavenworth.....	111,729	28.5	280,650	71.5	392,379	100	63.93
FCI El Reno.....	2,136	15.7	11,507	84.3	13,642	100	3.97
FCI Lexington.....	19,967	16.5	101,185	83.5	121,152	100	41.62

³ Inpatients are treated in the institution's medical facility; outpatients remain in the general institutional population during treatment.

TABLE 2.—BUREAU OF PRISONS: DISTRIBUTION OF STANDARD DOSAGE UNITS OF ALL "CONTROL" DRUGS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average standard dosage units dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	18,635	42.8	24,907	57.2	43,542	100	25.87
FCI Terminal Island.....	37,725	24.1	119,127	75.9	156,852	100	52.14
USP Leavenworth.....	209,932	26.8	572,750	73.2	782,682	100	127.49
FCI El Reno.....	3,841	17.4	18,237	82.6	22,078	100	6.40
FCI Lexington.....	26,522	16.5	133,939	83.5	160,461	100	55.06

MINOR TRANQUILIZERS

Class Description

Minor tranquilizers (including benzodiazepines) are antianxiety agents primarily used to control moderate to severe daytime anxiety and tension in patients with neuroses and mild depressive states. The use of these drugs may also be indicated in normal individuals during situations producing unusual environmental stress; however, accepted medical practice indicates that restraint should be exercised in prescribing antianxiety agents to alleviate the stress associated with everyday living.

Component Drugs

The minor tranquilizers utilized by the five institutions include diazepam (Valium), chlordiazepoxide (Librium), meprobamate, and clorazepate (Tranxene).⁴ Each of the five institutions dispensed both diazepam and chlordiazepoxide. FCI Alderson dispensed no other minor tranquilizer; FCI Terminal Island and FCI Lexington dispensed meprobamate in addition to diazepam and chlordiazepoxide; USP Leavenworth dispenses clorazepate in addition to these two drugs; and FCI El Reno dispensed all four drugs in the minor tranquilizers class.

Actual Dosage Levels

The drugs comprising the minor tranquilizer classification were dispensed by the five institutions in various strengths as indicated in table 3.

TABLE 3.—BUREAU OF PRISONS: ACTUAL DOSAGE LEVELS OF MINOR TRANQUILIZERS DISPENSED AT 5 INSTITUTIONS, JULY 1, 1975 THROUGH JUNE 30, 1978

Institution	Diazepam (Valium)				Chlordiazepoxide (Librium)			Meprobamate, 400 mg	Clorazepate (Tranxene)	
	2 mg	5 mg	10 mg	15 mg	5 mg	10 mg	25 mg		7.5 mg	22.5 mg
FCI Alderson.....	X	○	X			○				
FCI Terminal Island.....	X			X	○	X	○			
USP Leavenworth.....		X	○						X	
FCI El Reno.....		X	○		X		○	○		
FCI Lexington.....	X	○	X			○	X	○		

Note: A dosage strength which is circled (○) indicates the most frequently prescribed dosage strength at a particular institution.

⁴ Although flurazepan (Dalmane) is a minor tranquilizer, it is most often used to promote sleep and for purposes of this study has been classified as a hypnotic drug.

Standard Dosage Units

The standard dosage units selected for the minor tranquilizers class represent the most frequently prescribed dosage strength in the United States during 1974 and 1975. The standard dosage units for the component drugs of this class are diazepam (5 mg), chlordiazepoxide (10 mg), meprobamate (400 mg), and clorazepate (7.5 mg).

Utilization

1. Quantities Dispensed.—As indicated in Table 4 the utilization of these drugs as a class varied significantly between the five institutions in terms of actual dosages dispensed. The average number of actual dosages dispensed per inmate per year by the five institutions varied from a low of 1.95 dosages (FCI El Reno) to a high of 27.42 dosages (USP Leavenworth), a variation of approximately 1400 percent. The remaining three institutions dispensed these drugs as follows: 22.72 dosages (FCI Lexington), 11.00 (FCI Terminal Island), and 7.80 (FCI Alderson).

TABLE 4.—BUREAU OF PRISONS: DISTRIBUTION OF ACTUAL DOSAGES OF MINOR TRANQUILIZERS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	5,373	40.9	7,758	59.1	13,131	100	7.80
FCI Terminal Island.....	923	2.8	32,226	97.2	33,149	100	11.00
USP Leavenworth.....	30,454	18.1	137,900	81.9	168,354	100	27.42
FCI El Reno.....	479	7.2	6,193	92.8	6,672	100	1.95
FCI Lexington.....	13,092	19.8	53,006	80.2	66,098	100	22.72

In terms of standard dosage units dispensed per inmate per year (Table 5), the average number of dosages ranged from a low of 2.87 dosages (FCI El Reno) to a high of 47.89 dosages (USP Leavenworth), a variation of over 1600 percent. The remaining three institutions dispensed standard dosage units of these drugs as follows: 30.59 (FCI Lexington), 17.28 (FCI Terminal Island), and 9.99 (FCI Alderson).

TABLE 5.—BUREAU OF PRISONS: DISTRIBUTION OF STANDARD DOSAGE UNITS OF MINOR TRANQUILIZERS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average standard dosages dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	7,503	44.6	9,309	55.3	16,812	100	9.99
FCI Terminal Island.....	1,359	2.6	50,622	97.4	51,981	100	17.28
USP Leavenworth.....	52,222	17.8	241,750	82.2	293,972	100	47.89
FCI El Reno.....	629	6.4	9,264	93.6	9,893	100	2.87
FCI Lexington.....	17,349	19.5	71,819	80.5	89,168	100	30.59

The conversion of actual dosages to standard dosage units resulted in significant increases in the utilization of these drugs by the five institutions (table 6). FCI Alderson showed the lowest percentage in-

crease in dosages (28.1 percent), indicating that its utilization of minor tranquilizers more closely approximated the standard dosage units than the other four institutions. The greatest percentage increase resulting from the conversion to standard dosage units occurred at USP Leavenworth (74.7 percent), indicating that institution's utilization of these drugs deviated greatly from the standard dosage unit.

TABLE 6.—BUREAU OF PRISONS: PERCENT CHANGE IN DOSAGES OF MINOR TRANQUILIZERS DISPENSED PER INMATE PER YEAR BY CONVERSION FROM ACTUAL DOSAGES TO STANDARD DOSAGE UNITS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Average dosages dispensed per inmate per year		Percent change
	Actual	Standard	
FCI Alderson.....	7.80	9.99	+28.1
FCI Terminal Island.....	11.00	17.28	+57.1
USP Leavenworth.....	27.42	47.89	+74.7
FCI El Reno.....	1.95	2.87	+47.2
FCI Lexington.....	22.72	30.59	+34.9

2. *Institutional Utilization.*—As indicated in Table 7, of the five control-drug classifications the use of minor tranquilizers as a class was the most frequently prescribed in terms of actual dosages dispensed. When the utilization of this class is expressed in terms of standard dosage units (table 8), however, utilization frequency becomes second to the major tranquilizers, except in the case of FCI Lexington. In terms of standard dosage units dispensed the minor tranquilizers accounted for over 33 percent of the control drugs dispensed at FCI Alderson, FCI Terminal Island and USP Leavenworth, over 44 percent of those dispensed at FCI El Reno; and over 55 percent of those dispensed at FCI Lexington.

TABLE 7.—BUREAU OF PRISONS: PERCENT DISTRIBUTION BY CLASS OF ACTUAL DOSAGES OF ALL "CONTROL" DRUGS DISPENSED AT INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Minor tranquilizers	Major tranquilizers	Anti-depressants	Hypnotics	Sedatives
FCI Alderson.....	48.2	32.4	0.9	0.	18.5
FCI Terminal Island.....	37.2	34.5	.4	2.7	25.2
USP Leavenworth.....	42.9	39.9	3.8	6.1	7.3
FCI El Reno.....	49.1	36.3	1.3	1.5	11.8
FCI Lexington.....	54.6	17.1	4.1	.7	23.5

TABLE 8.—BUREAU OF PRISONS: PERCENT DISTRIBUTION BY CLASS OF STANDARD DOSAGE UNITS OF ALL "CONTROL" DRUGS DISPENSED AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Minor tranquilizers	Major tranquilizers	Anti-depressants	Hypnotics	Sedatives
FCI Alderson.....	38.6	49.2	0.6	0	11.6
FCI Terminal Island.....	33.1	56.0	.2	1.5	9.2
USP Leavenworth.....	38.0	54.3	1.9	3.1	3.9
FCI El Reno.....	44.8	45.6	.8	.9	7.8
FCI Lexington.....	55.6	25.7	3.1	.5	15.1

3. *Inpatient-Outpatient Distribution.*—The percentage distribution of minor tranquilizers between inpatients and outpatients varied

significantly between the five institutions when expressed in both actual and standard unit dosages. In terms of actual dosages dispensed FCI Terminal Island dispensed the most to outpatients (97.2 percent) while FCI Alderson dispensed the fewest to outpatients (59.1 percent). The remaining three institutions dispensed these drugs to outpatients as follows: FCI Lexington (80.2 percent), USP Leavenworth (81.9 percent), and FCI El Reno (92.8 percent) (see table 4). When the distribution of this class of drugs is expressed in terms of standard dosage units the percentage dispensed to outpatients decreased slightly to FCI Alderson while it increased marginally at the remaining institutions (see table 5).

It is noted that FCI El Reno dispensed clorazepate (Tranxene) solely to outpatients while USP Leavenworth dispensed all dosages of this drug to inpatients.

MAJOR TRANQUILIZERS

Class Description

The majority of major tranquilizers are antipsychotic agents which decrease agitation, hostility, combativeness, and hyperactivity. This class of drugs also ameliorates delusions, hallucinations, disordered thought and perception, emotional and social withdrawal, paranoid symptoms, and personal neglect. All major tranquilizers produce varying degrees of sedation but are qualitatively distinguishable from the sedation induced through the use of sedatives or hypnotics. Major tranquilizers are potent agents exhibiting high potential of adverse reaction. Accordingly, the long-term use of these drugs is generally reserved for the treatment of major psychiatric illness, with their use occurring more frequently in an inpatient treatment environment.

Component Drugs

The major tranquilizers utilized by the institutions in this study include Thorazine and Stelazine. Each of the five institutions dispensed both of these drugs to their respective inmate populations.⁵

Actual Dosage Levels

The drugs comprising the major tranquilizer classifications were dispensed by the five institutions in various strengths as indicated in Table 9.

TABLE 9.—BUREAU OF PRISONS: ACTUAL DOSAGE LEVELS OF MAJOR TRANQUILIZERS DISPENSED AT 5 INSTITUTIONS, JULY 1, 1975 THROUGH JUNE 30, 1978

Institution	Thorazine					Stelazine					
	25 mg	50 mg	60 mg	75 mg	100 mg	150 mg	2 mg	4 mg	5 mg	10 mg	15 mg
FCI Alderson.....			○						○		
FCI Terminal Island.....		○		○	×				○		
USP Leavenworth.....		○				×	○		×	×	○
FCI El Reno.....		○									
FCI Lexington.....	×	○			×		×	○			

Note: A dosage strength which is circled (○) indicates the most frequently prescribed dosage strength at a particular institution.

⁵ Four of the institutions also utilized the major tranquilizer fluphenazine (Prolixin). Analysis of this data, which was requested subsequent to the analysis contained in this section, is found in Appendix C to this study.

Standard Dosage Units

The standard dosage units selected for the major tranquilizers class represent the most frequently prescribed dosage strengths in the United States during 1974-1975. The standard dosage unit selected for Thorazine was 25 mg; the standard dosage unit selected for Stelazine was 2 mg.

Utilization

1. *Quantities Dispensed.*—As illustrated in table 10, the utilization of these drugs as a class varied significantly between the five institutions in terms of actual dosages dispensed. The average number of actual dosages dispensed per inmate per year by the five institutions varied from a low of 1.44 dosages (FCI El Reno) to a high of 25.50 dosages (USP Leavenworth), a variation of almost 1800 percent. The remaining three institutions dispensed these drugs as follows: 5.25 dosages (FCI Alderson), 7.10 dosages (FCI Lexington), and 10.21 dosages (FCI Terminal Island).

TABLE 10.—BUREAU OF PRISONS: DISTRIBUTION OF ACTUAL DOSAGES OF MAJOR TRANQUILIZERS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	4,538	51.3	4,301	48.7	8,839	100	5.25
FCI Terminal Island.....	11,985	39.0	18,760	61.0	30,745	100	10.21
USP Leavenworth.....	48,715	31.1	107,710	68.9	156,425	100	25.50
FCI El Reno.....	1,335	26.7	3,674	73.3	5,009	100	1.44
FCI Lexington.....	2,775	13.4	17,909	86.6	20,675	100	7.10

In terms of standard dosage units dispensed per inmate per year (table 11) the average number of dosages ranged from a low of 2.92 dosages (FCI El Reno) to a high of 68.48 dosages (USP Leavenworth), a difference of over 2300 percent. The remaining three institutions dispensed these drugs as follows: 12.74 dosages (FCI Alderson), 14.17 (FCI Lexington), 29.19 (FCI Terminal Island).

TABLE 11.—BUREAU OF PRISONS: DISTRIBUTION OF STANDARD DOSAGE UNITS OF MAJOR TRANQUILIZERS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average standard dosage units dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	11,068	51.6	10,378	48.4	21,446	100	12.74
FCI Terminal Island.....	34,720	39.5	53,120	60.5	87,840	100	29.19
USP Leavenworth.....	124,410	29.6	295,960	70.4	420,370	100	68.48
FCI El Reno.....	2,860	28.4	7,224	71.6	10,084	100	2.92
FCI Lexington.....	5,550	13.4	35,735	86.6	41,275	100	14.17

As shown in table 12, the conversion of actual dosages dispensed to standard dosage units dispensed resulted in extreme increases in the utilization of these drugs by the five institutions. FCI Lexington showed the lowest percentage increase in dosages dispensed (99.6 per-

cent), while the greatest percentage increase occurred at FCI Terminal Island (185.9 percent). This conversion indicates that each of the five institutions utilized these drugs in dosage strengths for greater than the selected standard dosage units.

TABLE 12.—BUREAU OF PRISONS: PERCENT CHANGE IN DOSAGES OF MAJOR TRANQUILIZERS DISPENSED PER INMATE PER YEAR BY CONVERSION FROM ACTUAL DOSAGES TO STANDARD DOSAGE UNITS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Average dosages dispensed per inmate per year		Percent change
	Actual	Standard	
FCI Alderson.....	5.25	12.74	+142.7
FCI Terminal Island.....	10.21	29.19	+185.9
USP Leavenworth.....	25.50	68.48	+168.5
FCI El Reno.....	1.44	2.92	+102.8
FCI Lexington.....	7.10	14.17	+99.6

2. *Institutional Utilization.*—Of the five control-drug classifications, the use of major tranquilizers as a class ranked second in overall utilization, exceeded only by minor tranquilizers in all institutions except FCI Lexington when expressed in terms of actual dosages dispensed (see table 7). When the utilization of this class is expressed in terms of standard dosage units, however, utilization frequency rises to first place at all institutions except FCI Lexington (see table 8). In terms of standard dosage units dispensed the major tranquilizers accounted for over 45 percent of the control drugs dispensed at FCI El Reno and FCI Alderson, and over 53 percent of those dispensed at USP Leavenworth and FCI Terminal Island. They accounted for 25 percent of all control drugs dispensed at FCI Lexington.

3. *Inpatient-Outpatient Distribution.*—The percentage distribution of major tranquilizers between inpatients and outpatients varied among the five institutions in terms of both actual and standard dosage units. In terms of actual dosage units FCI Lexington dispensed the most major tranquilizers to outpatients (86.6 percent) while FCI El Reno, USP Leavenworth and FCI Terminal Island, dispensed 73.3 percent, 68.9 percent and 61.0 percent to outpatients, respectively. FCI Alderson distributed 48.7 percent to outpatients (see table 10). When the distribution of this class of drugs is expressed in terms of standard dosage units the relative position of the five institutions in dispensing these drugs to outpatients is unchanged. The percentage distribution to outpatients at FCI Terminal Island, FCI Alderson and FCI El Reno decreases slightly, while the distribution at the other three institutions increases slightly (see table 11).

ANTIDEPRESSANTS

Class Description

In some patients the use of antidepressants, accompanied by supportive therapy, accelerates the rate of improvement, diminished the intensity of symptoms, reduces the danger of suicide, and promotes social adjustment and occupational rehabilitation. The tricyclic class of antidepressants (of which Tofranil is a member) has generally

replaced amphetamines and methylphenidate (Ritalin) in the treatment of depression.

Component Drugs

Tofranil was the only antidepressant utilized by the five institutions.

Actual Dosage Levels

Tofranil was dispensed by the five institutions as illustrated in table 13.

TABLE 13.—BUREAU OF PRISONS: ACTUAL DOSAGE LEVELS OF ANTIDEPRESSANTS DISPENSED AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Tofranil, 25 mg
FCI Alderson.....	○
FCI Terminal Island.....	○
USP Leavenworth.....	○
FCI El Reno.....	○
FCI Lexington.....	○

Note: A dosage strength which is circled (○) indicates the most frequently prescribed dosage strength at a particular institution.

Standard Dosage Units

The standard dosage unit selected for Tofranil, 25 mg, represents the typical dosage strength for this drug.

Utilization

1. *Quantities Dispensed.*—As illustrated in table 14 the utilization of antidepressants (Tofranil) varied significantly between the five institutions in terms of actual dosage units. The average number of actual dosages dispensed per inmate per year by the five institutions varied from a low of 0.05 dosages (FCI El Reno) to a high of 2.44 dosages (USP Leavenworth) representing a variance of almost 4900 percent. The remaining three institutions dispensed Tofranil as follows: 0.13 dosages (FCI Terminal Island), 0.15 dosages (FCI Alderson), and 1.72 dosages (FCI Lexington).

In terms of standard dosage units dispensed per inmate per year, no change occurs in the level of utilization since each institution dispensed Tofranil in quantities equal to the standard dosage unit (tables 15 and 16).

TABLE 14.—BUREAU OF PRISONS: DISTRIBUTION OF ACTUAL DOSAGES OF ANTIDEPRESSANTS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—						Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients		Total dispensed		
	Number	Percent	Number	Percent	Number	Percent	
FCI Alderson.....	0	0	250	100	250	100	0.15
FCI Terminal Island.....	200	50	200	50	400	100	.13
USP Leavenworth.....	3,000	20	12,000	80	15,000	100	2.44
FCI El Reno.....	38	22	135	78	173	100	.05
FCI Lexington.....	1,000	20	4,000	80	5,000	100	1.72

TABLE 15.—BUREAU OF PRISONS: DISTRIBUTION OF STANDARD DOSAGE UNITS OF ANTIDEPRESSANTS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—						Average standard dosage units dispensed per inmate per year
	Inpatients		Outpatients		Total dispensed		
	Number	Percent	Number	Percent	Number	Percent	
FCI Alderson.....	0	0	250	100	250	100	0.15
FCI Terminal Island.....	200	50	200	50	400	100	.13
USP Leavenworth.....	3,000	20	12,000	80	15,000	100	2.44
FCI El Reno.....	38	22	135	78	173	100	.05
FCI Lexington.....	1,000	20	4,000	80	5,000	100	1.72

TABLE 16.—BUREAU OF PRISONS: PERCENT CHANGE IN DOSAGES OF ANTIDEPRESSANTS DISPENSED PER INMATE PER YEAR BY CONVERSION FROM ACTUAL DOSAGES TO STANDARD DOSAGE UNITS AT 5 INSTITUTIONS JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Average dosages dispensed per inmate per year		Percent change
	Actual	Standard	
FCI Alderson.....	0.15	0.15	0
FCI Terminal Island.....	.13	.13	0
USP Leavenworth.....	2.44	2.44	0
FCI El Reno.....	.05	.05	0
FCI Lexington.....	1.72	1.72	0

2. *Institutional Utilization.*—Of the five control-drug classifications, the actual dosage use of antidepressants (Tofranil) ranked fourth (after minor tranquilizers, major tranquilizers, and sedatives) at FCI Alderson and FCI Lexington. The actual dosage use of Tofranil ranked fifth in total utilization at FCI Terminal Island, USP Leavenworth, and FCI El Reno (see table 7). The overall utilization of Tofranil at the five institutions, relative to the other control-drug classifications, remains unchanged when expressed in terms of standard dosage units (see table 8). The use of Tofranil, as is the case with hypnotics, *infra*, is insignificant when contrasted to the use of the other three control-drug classifications. The greatest percentage utilization of Tofranil occurs at FCI Lexington (4.1 percent of all actual dosages, 3.1 percent of all standard dosage units) while the lowest percentage utilization occurs at FCI Terminal Island (0.4 percent of all actual dosages, 0.2 percent of all standard dosage units).

3. *Inpatient-Outpatient Distribution.*—The percentage distribution of antidepressants (Tofranil) between inpatients and outpatients varied greatly among the five institutions. As shown in table 14, FCI Alderson dispensed the most actual dosages to outpatients (100.0 percent) while FCI Terminal Island dispensed the least to outpatients (50.0 percent). The remaining three institutions dispensed Tofranil to outpatients as follows: 78.0 percent (FCI El Reno) and 80.0 percent (USP Leavenworth and FCI Lexington). Since all five institutions dispensed Tofranil in quantities equal to the standard dosage unit no change in the percentage distribution between outpatients and inpatients occurs upon conversion to standard dosage units (see tables 15 and 16).

HYPNOTICS

Class Description

Hypnotics are drugs used to induce sleep. They are closely related to the sedatives, *infra*, with the principal difference being the enhanced state of sedation produced by the hypnotics. Hypnotic drugs are composed of two subclasses: barbiturates and nonbarbiturates. Amobarbital, secobarbital, and pentobarbital belong to the former class while flurazepan⁶ (Dalmane) and chloral hydrate are members of the latter class.

Component Drugs

The hypnotics utilized by the institutions in this study include pentobarbital, chloral hydrate, and flurazepan (Dalmane). FCI Alderson reported no utilization of this class of drugs during the three-year period. Each of the remaining four institutions reported using both pentobarbital and chloral hydrate while FCI Terminal Island was the only institution to also use flurazepan (Dalmane).

Actual Dosage Levels

Hypnotics were dispensed by the five institutions in various strengths as indicated in table 17.

TABLE 17.—BUREAU OF PRISONS: ACTUAL DOSAGE LEVELS OF HYPNOTICS DISPENSED AT 5 INSTITUTIONS, JULY 1, 1975 THROUGH JUNE 30, 1978

Institution	Pentobarbital		Chloral hydrate, 500 mg	Flurazepan (Dalmane), 30 mg
	90 mg	100 mg		
FCI Alderson.....				
FCI Terminal Island.....				
USP Leavenworth.....	○		○	○
FCI El Reno.....			○	
FCI Lexington.....		○	○	

Note: A dosage strength which is circled (○) indicates the most frequently prescribed dosage strength at a particular institution.

Standard Dosage Units

The standard dosage units selected for the hypnotics class represent the most frequently prescribed dosage strengths in the United States during 1974 and 1975. The standard dosage units for the component drugs of this class are pentobarbital (100 mg.), chloral hydrate (500 mg.), and flurazepan (30 mg.).

Utilization

1. *Quantities Dispensed.*—The utilization of hypnotics as a class varied significantly between the five institutions in terms of actual dosages dispensed. As illustrated in table 18, the average number of actual dosages dispensed per inmate per year by the five institutions ranged from a low of no utilization (FCI Alderson) to a high of 3.93 dosages (USP Leavenworth).⁷ The remaining three institutions dispensed hypnotics as follows: 0.06 dosages (FCI El Reno), 0.28 dosages (FCI Lexington) and 0.79 dosages (FCI Terminal Island). The

⁶ Although flurazepan (Dalmane) is a minor tranquilizer, it is most often used to promote sleep and for purposes of this study has been classified as a hypnotic drug.
⁷ See note at bottom of table 45.

variance between the institutions reporting use of hypnotics is approximately 6400 percent.

TABLE 18.—BUREAU OF PRISONS: DISTRIBUTION OF ACTUAL DOSAGES OF HYPNOTICS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	0		0		0		0
FCI Terminal Island.....	1,175	49.9	1,178	50.1	2,453	100	0.79
USP Leavenworth.....	24,140	100.0	0		24,140	100	3.93
FCI El Reno.....	190	96.0	8	4.0	198	100	0.06
FCI Lexington.....	470	57.3	350	42.7	820	100	0.28

In terms of standard dosage units dispensed per inmate per year the average number of dosages ranged from a low of no utilization (FCI Alderson) to a high of 3.93 (USP Leavenworth). The remaining three institutions dispensed these drugs as follows: 0.06 dosages (FCI El Reno), 0.28 dosages (FCI Lexington), and 0.76 dosages (FCI Terminal Island) (table 19).

TABLE 19.—BUREAU OF PRISONS: DISTRIBUTION OF STANDARD DOSAGE UNITS OF HYPNOTICS DISPENSED AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average standard dosage units dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	0		0		0		0
FCI Terminal Island.....	1,112	49.1	1,151	50.9	2,263	100	0.76
USP Leavenworth.....	23,980	100.0	0		23,980	100	3.90
FCI El Reno.....	190	96.0	8	4.0	198	100	0.06
FCI Lexington.....	470	57.3	350	42.7	820	100	0.28

As shown in table 20, the conversion of actual dosages dispensed to standard dosage units dispensed resulted in no change in utilization of the hypnotics at two institutions (FCI Lexington, and FCI El Reno). This conversion indicates that FCI El Reno and FCI Lexington dispensed hypnotics in strengths equal to the standard dosage units; FCI Alderson reported no utilization of hypnotics. The utilization of hypnotics decreased at both USP Leavenworth (−0.8 percent) and FCI Terminal Island (−3.8 percent) when converted from actual to standard dosage units, indicating that these two institutions dispensed hypnotics as a class in strengths below that of the standard dosage units.

TABLE 20.—BUREAU OF PRISONS: PERCENT CHANGE IN DOSAGES OF HYPNOTICS DISPENSED PER INMATE PER YEAR BY CONVERSION FROM ACTUAL DOSAGES TO STANDARD DOSAGE UNITS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution/drug class	Dosages dispensed per inmate per year		Percent change
	Actual	Standard	
FCI Alderson.....	0	0	0
FCI Terminal Island.....	0.79	0.76	−3.8
USP Leavenworth.....	3.93	3.90	−0.8
FCI El Reno.....	0.06	0.06	0
FCI Lexington.....	0.28	0.28	0

2. *Institutional Utilization.*—Of the five control-drug classifications the use of hypnotics as a class is uniformly low when compared with the other four classifications. In terms of actual dosages dispensed, hypnotics accounted for less than 1 percent at FCI Lexington, less than 2 percent at FCI El Reno, less than 3 percent at FCI Terminal Island, and slightly more than 6 percent at USP Leavenworth. FCI Alderson did not dispense hypnotics during the 3-year period (see table 7). In terms of standard dosage units dispensed, hypnotics accounted for less than 1 percent of all control drugs dispensed at FCI Lexington and FCI El Reno, less than 2 percent at FCI Terminal Island, and 3.1 percent at USP Leavenworth (see table 8).

3. *Inpatient-Outpatient Distribution.*—The percentage distribution of hypnotics between inpatients and outpatients varied significantly among the five institutions when expressed in both actual and standard dosage units. As shown in table 18, FCI Terminal Island dispensed the most actual dosages of hypnotics (50.1 percent) to outpatients while USP Leavenworth dispensed no hypnotics to outpatients. The remaining two institutions utilizing this control-drug class dispensed hypnotics to outpatients as follows: 4.0 percent (FCI El Reno), and 42.7 percent (FCI Lexington). When the distribution of this class of drugs is expressed in terms of standard dosage units the percentage dispensed to outpatients remained unchanged at FCI Lexington, FCI El Reno, USP Leavenworth and FCI Alderson. The percentage dispensed to outpatients at FCI Terminal Island increased slightly (table 19).

SEDATIVES

Class Description

The object of sedative therapy is to relieve severe daytime anxiety without diminishing sensory perception, responsiveness to the environment, or alertness below safe functional levels. It should be noted that phenobarbital, the only sedative class drug dispensed by the five institutions, has considerable medical use as an anticonvulsant.

Component Drugs

Phenobarbital (in several forms) was the only sedative class drug dispensed by the five institutions.

Actual Dosage Levels

As shown in table 21, phenobarbital was dispensed by the five institutions in a wide range of strengths.

TABLE 21.—BUREAU OF PRISONS: ACTUAL DOSAGE LEVELS OF SEDATIVES DISPENSED AT 5 INSTITUTIONS, JULY 1 1975, THROUGH JUNE 30, 1978

Institution	Phenobarbital							
	15 mg	16 mg	20 mg	30 mg	32 mg	60 mg	100 mg	120 mg
FCI Alderson.....				○				
FCI Terminal Island.....	○			○				
USP Leavenworth.....								×
FCI El Reno.....				○		×		
FCI Lexington.....	×		○		×		×	

Note: A dosage strength which is circled (○) indicates the most frequently prescribed dosage strength at a particular institution.

Standard Dosage Units

The standard dosage unit selected for phenobarbital, 30 mg, represents the most commonly prescribed dosage strength in the United States during 1974 and 1975.

Utilization

1. *Quantities Dispensed.*—The utilization of sedatives (phenobarbital) varied significantly between the five institutions in terms of both actual dosages and standard dosage units dispensed. As shown in table 22, the average number of actual dosages dispensed per inmate per year by the five institutions ranged from a low of 0.47 dosages (FCI El Reno) to a high of 9.80 dosages (FCI Lexington), a difference of almost 2100 percent. The remaining three institutions dispensed sedatives as follows: 2.99 dosages (FCI Alderson), 4.64 dosages (USP Leavenworth) and 7.44 dosages (FCI Terminal Island).

TABLE 22.—BUREAU OF PRISONS: DISTRIBUTION OF ACTUAL DOSAGES OF SEDATIVES AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—						Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients		Total dispensed		
	Number	Percent	Number	Percent	Number	Percent	
FCI Alderson.....	64	1.3	4,970	98.7	5,034	100	2.99
FCI Terminal Island.....	535	2.4	21,833	97.6	22,368	100	7.44
USP Leavenworth.....	5,420	19.0	23,040	81.0	28,460	100	4.64
FCI El Reno.....	94	5.9	1,496	94.1	1,590	100	.47
FCI Lexington.....	2,630	9.2	25,929	90.8	28,559	100	9.80

In terms of standard dosage units dispensed per inmate per year, the average number of dosages ranged from a low of 0.50 dosages (FCI El Reno) to a high of 8.30 dosages (FCI Lexington), a difference of almost 1700 percent. The remaining three institutions dispensed sedatives (phenobarbital) as follows: 2.99 dosages (FCI Alderson) and 4.78 dosages (FCI Terminal Island and USP Leavenworth) (table 23).

TABLE 23.—BUREAU OF PRISONS: DISTRIBUTION OF STANDARD DOSAGE UNITS OF SEDATIVES AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—						Average standard dosage units dispensed per inmate per year
	Inpatients		Outpatients		Total Dispensed		
	Number	Percent	Number	Percent	Number	Percent	
FCI Alderson.....	64	1.3	4,970	98.7	5,034	100	2.99
FCI Terminal Island.....	334	2.3	14,034	97.7	14,368	100	4.78
USP Leavenworth.....	6,320	21.5	23,040	78.5	29,360	100	4.78
FCI El Reno.....	124	7.2	1,606	92.8	1,730	100	.50
FCI Lexington.....	2,153	8.9	22,035	91.1	24,188	100	8.30

As shown in table 24, the conversion of actual dosages dispensed to standard dosages dispensed resulted in significant decreases in overall utilization at FCI Terminal Island (—35.8 percent) and FCI Lexington (—15.3 percent), indicating that these two institutions dispensed phenobarbital in strengths below that of the standard dosage unit.

The conversion resulted in increases in overall utilization at FCI El Reno (6.4 percent) and USP Leavenworth (3.0 percent), indicating that these three institutions dispensed sedatives (phenobarbital) in strengths marginally greater than the standard dosage unit.

TABLE 24.—BUREAU OF PRISONS: PERCENT CHANGE IN DOSAGES OF SEDATIVES DISPENSED PER INMATE PER YEAR BY CONVERSION FROM ACTUAL DOSAGES TO STANDARD DOSAGE UNITS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Average dosages dispensed per inmate per year		Percent change
	Actual	Standard	
FCI Alderson.....	2.99	2.99	0
FCI Terminal Island.....	7.44	4.78	-35.8
USP Leavenworth.....	4.64	4.78	+3.0
FCI El Reno.....	.47	.50	+6.4
FCI Lexington.....	9.80	8.30	-15.3

2. *Institutional Utilization.*—Of the five control-drug classifications the use of sedatives (phenobarbital) ranked third at all five institutions behind minor tranquilizers and benzodiazepines and major tranquilizers when expressed in either actual dosages or standard dosage units. Actual dosages of sedatives accounted for 7.3 percent of all control drugs dispensed at USP Leavenworth, 11.8 percent at FCI El Reno, 18.5 percent at FCI Alderson, 23.5 percent at FCI Lexington, and 25.2 percent at FCI Terminal Island (see table 7). The relative positions of the institutions with respect to overall utilization of sedatives (phenobarbital) changes significantly when expressed in terms of standard dosage units. In standard dosage units, sedatives accounted for 3.7 percent of all control drugs dispensed at USP Leavenworth, 7.8 percent at FCI El Reno, 9.2 percent at FCI Terminal Island, 11.6 percent at FCI Alderson, and 15.1 percent at FCI Lexington (see table 8).

3. *Inpatient-Outpatient Distribution.*—The percentage distribution of sedatives (phenobarbital) between inpatients and outpatients varied somewhat among the five institutions. In terms of actual dosages dispensed (see table 22), FCI Alderson dispensed the most sedatives to outpatients (98.7 percent), while USP Leavenworth dispensed the least to outpatients (81.0 percent). The remaining three institutions dispensed sedatives to outpatients as follows: 90.8 percent (FCI Lexington), 81.1 percent (FCI El Reno), and 97.6 percent (FCI Terminal Island). When the distribution of sedatives (phenobarbital) is expressed in terms of standard dosage units the percentage dispensed to outpatients decreases slightly at FCI Terminal Island and FCI Lexington, and remains unchanged at FCI Alderson (see table 23).

NONCONTROL DRUGS

The noncontrol drugs dispensed by the five institutions have been divided into four classifications: (1) mild analgesics, (2) strong analgesics, (3) antidiarrheal agents, and (4) other noncontrol drugs. The analysis of dispensing practices of the five institutions is stated in terms of actual dosages dispensed per inmate per year. Because a patient's description of pain and a physician's perception of that pain are subjective in nature, no attempt was made to convert noncontrol drugs into standard dosage units for purposes of comparison.

The utilization of noncontrol drugs by the five institutions varied significantly. As shown in table 25, the average number of actual dosages dispensed per inmate per year varied from a low of 2.37 dosages (FCI El Reno) to a high of 15.85 dosages (FCI Lexington). The remaining three institutions dispensed noncontrol drugs as follows: 4.28 dosages (FCI Terminal Island), 4.99 (USP Leavenworth), and 9.10 (FCI Alderson). With the exception of USP Leavenworth, the institutions dispensed noncontrol drugs more frequently to outpatients than to inpatients. The smallest percentage of noncontrol drugs dispensed to outpatients occurred at USP Leavenworth (38.4 percent), while outpatients received the highest percentage distribution at FCI Alderson (79.3 percent). The remaining institutions dispensed actual dosages of noncontrol drugs to outpatients as follows: 54.8 percent (FCI Terminal Island), 70.2 percent (FCI El Reno), and 74.5 percent (FCI Lexington).

TABLE 25.—BUREAU OF PRISONS: DISTRIBUTION OF ACTUAL DOSAGES OF ALL "NONCONTROL" DRUGS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	3,170	20.7	12,153	79.3	15,323	100	9.10
FCI Terminal Island.....	5,805	45.2	7,047	54.8	12,852	100	4.28
USP Leavenworth.....	18,852	61.6	11,759	38.4	30,611	100	4.99
FCI El Reno.....	2,437	29.8	5,731	70.2	8,168	100	2.37
FCI Lexington.....	11,932	25.5	34,912	74.5	46,849	100	15.85

MILD ANALGESICS

Class Description

Codeine is a mild pain killer, chemically related to the strong analgesic morphine. Although useful in the relief of mild to moderate pain, codeine is of little use in the relief of severe pain regardless of dosage strength. As is the case with all narcotic drugs, codeine has a potential for producing both physical and psychological dependence; however the risk from usual oral dosages is considered minimal.

Propoxyphene containing substances are mild analgesics chemically related to the strong analgesics. In usual dosages it is less effective than codeine and is no more effective than aspirin.

Fiorinal is a combination drug containing an analgesic component and a barbiturate component. There is some evidence that this combination is more useful in treating tension headache than an analgesic by itself.

Component Drugs

The mild analgesics utilized by the five institutions include substances containing codeine (codeine [all institutions except FCI Alderson], APC codeine [FCI El Reno], codeine sulfate [FCI Alderson, USP Leavenworth], percogesic with codeine [FCI Terminal Island], Tylenol with codeine [FCI El Reno] and codeine phosphate [FCI, Lexington]), substances containing propoxyphene (Darvon [FCI, Lexington], Darvon-N and/or Darvon-N with aspirin [FCI Alderson, FCI El Reno, USP Leavenworth], Darvocet [FCI Alderson], and Darvocet-N [FCI Terminal Island, USP Leavenworth]), and Fiorinal (FCI Terminal Island, USP Leavenworth, FCI El Reno).

Actual Dosage Levels

Table 26 indicates the various dosage strengths of mild analgesics dispensed by the five institutions.

TABLE 26.—BUREAU OF PRISONS: ACTUAL DOSAGE LEVELS OF MILD ANALGESICS DISPENSED AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Substances containing codeine			Substances containing propoxyphene		Florinal 50 mg
	12.5 mg	30 mg	60 mg	50 mg	100 mg	
FCI Alderson.....		○			○	
FCI Terminal Island.....		○			○	○
USP Leavenworth.....		○			○	○
FCI El Reno.....	×	○	×	×	○	○
FCI Lexington.....		○			○	

Note: A dosage strength which is circled (○) indicates the most frequently dispensed strength at a particular institution.

Utilization

1. *Quantities Dispensed.*—As indicated in table 27, the utilization of mild analgesics varied significantly between the five institutions in terms of actual dosages dispensed. The average number of actual dosages dispensed per inmate per year ranged from a low of 1.98 dosages (FCI El Reno) to a high of 11.92 dosages (FCI, Lexington), yielding a variation of about 600 percent. The remaining three institutions dispensed mild analgesics as follows: 3.21 dosages (FCI Terminal Island), 3.49 dosages (USP Leavenworth) and 6.75 dosages (FCI Alderson),

TABLE 27.—BUREAU OF PRISONS: DISTRIBUTION OF ACTUAL DOSAGES OF MILD ANALGESICS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed	Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients			
	Number	Percent	Number	Percent		
FCI Alderson.....	2,305	20.3	9,053	79.7	11,358	6.75
FCI Terminal Island.....	2,705	28.1	6,925	71.9	9,631	3.21
USP Leavenworth.....	14,632	68.4	6,759	31.6	21,391	3.49
FCI El Reno.....	1,372	20.0	5,487	80.0	6,859	1.98
FCI Lexington.....	5,960	17.2	28,760	82.8	34,720	11.92

2. *Institutional Utilization.*—Of the four noncontrol drug classifications mild analgesics were the most frequently prescribed at each of the five institutions. The lowest percentage utilization occurred at USP Leavenworth (69.9 percent) while the highest percentage utilization was at FCI El Reno (84.0 percent). The remaining three institutions utilized mild analgesics between 74.2 percent and 75.2 percent of all noncontrol drugs (table 28).

TABLE 28.—BUREAU OF PRISONS: PERCENT DISTRIBUTION BY CLASS OF ACTUAL DOSAGES OF ALL "NONCONTROL" DRUGS DISPENSED AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Mild analgesics	Strong analgesics	Anti-diarrheal	All other noncontrol drugs
FCI Alderson.....	74.2	3.0	22.9	0
FCI Terminal Island.....	75.0	22.2	0	2.8
USP Leavenworth.....	69.9	11.2	18.0	.8
FCI El Reno.....	84.0	12.7	3.1	.1
FCI Lexington.....	75.2	16.5	7.1	1.2

3. *Inpatient-Outpatient Distribution.*—The percentage distribution of mild analgesics between inpatients and outpatients varied greatly among the five institutions. FCI Lexington dispensed the most mild analgesics to outpatients (82.8 percent) while USP Leavenworth dispensed the least to outpatients (31.6 percent). The remaining three institutions dispensed these drugs to outpatients as follows: FCI Terminal Island (71.9 percent), FCI Alderson (79.7 percent) and FCI El Reno (80.0 percent) (see table 27).

STRONG ANALGESICS

Class Description

Meperidine (Demerol) shares many of its pharmacologic properties and clinical indications with morphine; however, according to some research Meperidine is less effective in relieving severe pain regardless of dosage strength. Dosage levels of Meperidine should be reduced in patients receiving antipsychotic agents, sedative hypnotics, or other drugs which act to depress the central nervous system. Meperidine is useful in the treatment of moderate to severe pain and is considerably less effective orally than parenterally.

Methadone is a synthetic analgesic that differs chemically from morphine, but its actions are generally similar. It is slightly more potent than morphine per weight unit, and is relatively more effective orally, a property which makes this drug particularly useful in the treatment of chronic, painful conditions.

Morphine, the prototype of the narcotic analgesics, is used for the relief of severe pain. This analgesic must be given parenterally to assure reliable action, and is considerably less effective after oral administration. The use of morphine for chronic pain may result in the development of tolerance and dependence; however most patients are able to discontinue usage without great difficulty.

Hydromorphone, relatively more effective orally than morphine, is a semisynthetic derivative of morphine and has the same actions and uses. It is approximately eight times more potent on a weight basis in producing analgesic, as well as respiratory depression.

Fentanyl is similar to morphine in its effects but on a weight basis it is between 50 and 100 times more potent. Its duration of action is shorter than morphine and is often used for the relief of postoperative pain. It also is used as an adjunct for the induction and maintenance of conventional inhalation anesthesia and as a supplement to regional and spinal anesthesia.

Component Drugs

The strong analgesics utilized by the five institutions include substances containing Meperidine (Demerol [all institutions]), morphine (FCI Terminal Island, USP Leavenworth), methadone (FCI Terminal Island), methadone elixir (FCI Lexington), hydromorphone (FCI Lexington) and fentanyl (FCI Terminal Island, FCI El Reno).

Actual Dosage Levels

Table 29 shows the various dosage strengths of strong analgesics dispensed by the five institutions.

TABLE 29.—BUREAU OF PRISONS: ACTUAL DOSAGE LEVELS OF STRONG ANALGESICS DISPENSED AT 5 INSTITUTIONS, JULY 1, 1975 THROUGH JUNE 30, 1978

Institution	Substances containing Meperidine (Demerol)			Morphine				Methadone			Fentanyl, 0.1 mg	Hydromorphone	
	50 mg	75 mg	100 mg	3.75 mg	8 mg	10 mg	15 mg	5 mg	10 mg	20 mg		2 mg	4 mg
FCI Alderson.....	X		O										
FCI Terminal Island.....	O			X			O		O	X	O		
USP Leavenworth.....		O					O						
FCI El Reno.....	O	X	X								X		
FCI Lexington.....	O	X	X		X	O	X	O	X			X	O

Note: A dosage strength which is circled (O) indicates the most frequently dispensed strength at an institution.

Utilization

1. *Quantities Dispensed.* As indicated in table 30, the utilization of the strong analgesics varied significantly among five institutions. The average number of actual dosages dispensed per inmate per year ranged from a low of 0.27 dosages (FCI Alderson) to a high of 2.61 dosages (FCI Lexington), a difference of over 900 percent. The remaining three institutions dispensed strong analgesics as follows: 0.29 dosages (FCI El Reno), 0.56 dosages (USP Leavenworth), and 0.95 dosages (FCI Terminal Island).

TABLE 30.—BUREAU OF PRISONS: DISTRIBUTION OF ACTUAL DOSAGES OF STRONG ANALGESICS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	365	78.5	100	21.5	465	100	0.27
FCI Terminal Island.....	2,740	95.8	121	4.2	2,861	100	.95
USP Leavenworth.....	3,460	100.0	0	0	3,460	100	.56
FCI El Reno.....	1,041	100.0	0	0	1,041	100	.29
FCI Lexington.....	5,043	66.1	2,583	33.9	7,626	100	2.61

2. *Institutional Utilization.*—Of the four noncontrol drug classifications strong analgesics were the second most frequently prescribed at FCI Terminal Island (22.2 percent), FCI Lexington (16.5 percent) and FCI El Reno (12.7 percent). These drugs ranked third at USP Leavenworth (11.2 percent) and FCI Alderson (3.0 percent) (see table 28).

3. *Inpatient-Outpatient Distribution.*—The percentage distribution of strong analgesics between inpatients and outpatients at the five institutions varied greatly. FCI Lexington dispensed the most to outpatients (33.9 percent) while both USP Leavenworth and FCI El Reno dispensed all strong analgesics to inpatients. FCI Alderson dispensed 21.5 percent to outpatients while FCI Terminal Island dispensed 4.2 percent to outpatients (see table 30).

ANTIDIARRHEAL AGENTS

Class Description

Lomotil, because it is available in tablet form and has only slight abuse potential has displaced the opiates as the most widely used, effective, nonspecific antidiarrheal agent.

Paregoric is similarly a nonspecific antidiarrheal agent. It is more widely utilized than purified opium alkaloids and has about the same degree of effectiveness as Lomotil.

Component Drugs

The antidiarrheal agents utilized by the five institutions include Lomotil (FCI Alderson, USP Leavenworth, FCI El Reno, FCI Lexington) and paregoric (FCI El Reno, FCI Lexington). FCI Terminal Island reported no utilization of antidiarrheal agents during the 3-year period.

Actual Dosage Levels

Table 31 indicates the various dosage strengths of antidiarrheal agents utilized by the five institutions.

TABLE 31.—BUREAU OF PRISONS: ACTUAL DOSAGE LEVELS OF ANTIDIARRHEAL AGENTS DISPENSED AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Lomotil		Paregoric ¹	
	2.5 mg	5 mg	5 mg	15 ml
FCI Alderson.....	○			
FCI Terminal Island.....				
USP Leavenworth.....	○			
FCI El Reno.....		○		○
FCI Lexington.....	○		○	○

¹ Committee staff was unable to obtain milligram data on paregoric for FCI El Reno.

Note: A dosage strength which is circled (○) indicates the most frequently prescribed dosage strength at an institution.

Utilization

1. *Quantities Dispensed.*—As shown in table 32, the utilization of antidiarrheal agents differed significantly among the five institutions. The average number of actual dosages dispensed per inmate per year ranged from a low of 0.00 dosages (FCI Terminal Island) to a high of 2.08 dosages (FCI Alderson). The remaining three institutions utilized antidiarrheal agents as follows: 0.07 dosages (FCI El Reno), 0.90 dosages (USP Leavenworth), and 1.13 dosages (FCI Lexington).

TABLE 32.—BUREAU OF PRISONS: DISTRIBUTION OF ACTUAL DOSAGES OF ANTIDIARRHEAL AGENTS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	500	14.3	3,000	85.7	3,500	100	2.08
FCI Terminal Island.....	0	0	0	0	0	0	0
USP Leavenworth.....	500	9.1	5,000	90.9	5,500	100	.90
FCI El Reno.....	24	9.3	233	90.7	257	100	.07
FCI Lexington.....	260	7.9	3,019	92.1	3,279	100	1.13

2. *Institutional Utilization.*—Of the four noncontrol drug classifications antidiarrheal agents was the second most frequently prescribed class at FCI Alderson (22.9 percent) and USP Leavenworth (18.0 percent). These drugs ranked third in overall utilization at FCI Lexington (7.1 percent) and FCI El Reno (3.1 percent). FCI Terminal Island reported no use of antidiarrheal agents during the three year period (see table 28).

3. *Inpatient-Outpatient Distribution.*—The percentage distribution of antidiarrheal agents between inpatients and outpatients was generally consistent among the five institutions. Outpatients received between 85.7 percent and 92.1 percent of all such drugs dispensed at the four institutions reporting utilization (see table 32).

OTHER NONCONTROL DRUGS

Four of the five institutions reported dispensing noncontrol drugs not within the classifications described above. Only FCI Alderson reported no use of other noncontrol drugs during the three year period. The other noncontrol drugs dispensed by the institutions are shown in table 33.

TABLE 33.—BUREAU OF PRISONS: ACTUAL DOSAGE LEVELS OF OTHER "NONCONTROL" DRUGS DISPENSED AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Cocaine and cocaine HCL, 150 mg	Duragesic, 50 mg	Dextroamphetamine, 10 mg
FCI Terminal Island.....	○		
USP Leavenworth.....	○		
FCI El Reno.....		○	
FCI Lexington.....			○

Note: A dosage strength which is circled (○) indicates the most frequently dispensed dosage at an institution.

In terms of actual dosages dispensed per inmate per year none of the four institutions dispensed in excess of 0.19 dosages (table 34) and institutional utilization did not exceed 2.8 percent of all noncontrol drugs dispensed at any of these institutions (see table 28). All cocaine at FCI Terminal Island and USP Leavenworth was dispensed to inpatients while all duragesic at FCI El Reno and all dextroamphetamine at FCI Lexington was dispensed to outpatients (see table 34).

TABLE 34.—BUREAU OF PRISONS: DISTRIBUTION OF ACTUAL DOSAGES OF OTHER "NONCONTROL" DRUGS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	0	0	0	0	0	0	0
FCI Terminal Island.....	360	100	0	0	360	100	.12
USP Leavenworth.....	260	100	0	0	260	100	.04
FCI El Reno.....	0	0	11	100	11	100	(¹)
FCI Lexington.....	0	0	550	100	550	100	.19

¹ Less than 0.005.

INSTITUTIONS

FCI ALDERSON

Description of Institution

FCI Alderson is located near Alderson, W. Va., a semirural town with a population of approximately 400, and is the only all female institution examined in this study. Originally constructed in 1927, the institution is designed to accommodate 565 inmates. The average inmate population at FCI Alderson for the 3 year period covered in this study was 561, making it the only institution whose capacity was not exceeded by its population during this period.

FCI Alderson is a minimum security institution with narcotics and forgery offenses being most frequent among its inmate population. Inmates are generally between the ages of 22 and 29.

The ratio of correctional officers to inmates for the period covered in this study was 1:5. During this period data indicates that FCI Alderson experienced a turnover in correctional officers of approximately 50 percent.

Utilization of Control Drugs

FCI Alderson dispensed minor tranquilizers, major tranquilizers, antidepressants and sedatives to its inmate population during the 3

year period covered in this study. It was the only institution which did not dispense hypnotics to its inmate population.

1. *Actual Dosages.*—In terms of actual dosages dispensed per inmate per year FCI Alderson ranked fourth of the five institutions, dispensing 16.19 dosages. The most commonly prescribed class of control drugs at FCI Alderson was the minor tranquilizers (48.2 percent). Major tranquilizers accounted for 32.4 percent of all actual dosages dispensed. Sedatives, antidepressants, and hypnotics accounted for 18.5 percent, 0.9 percent and 0.0 percent, respectively, of all actual dosages dispensed at FCI Alderson. The distribution of actual dosages of control drugs between inpatients and outpatients at FCI Alderson was 36.6 percent and 63.4 percent, respectively, representing the lowest percentage distribution to outpatients among the five institutions (table 35).

TABLE 35.—FCI ALDERSON: DISTRIBUTION OF ACTUAL DOSAGES OF ALL "CONTROL" DRUGS, JULY 1, 1975 THROUGH JUNE 30, 1978
AVERAGE INSTITUTION POPULATION FOR PERIOD: 561

Drug class	Dosage unit (milligram)	Dispensed to		Total dispensed	Average actual dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Minor tranquilizers:						
Diazepam (Valium).....	5	3,687	2,763	6,450	3.83	.....
	10	1,409	2,091	3,500	2.08	.....
Chlordiazepoxide (Librium).....	10	27	154	181	.11	.....
	10	250	2,750	3,000	1.78	.....
Class total.....		5,373	7,758	13,131	7.80	48.2
Major tranquilizers:						
Thorazine.....	150	98	41	139	.08	.....
	60	2,280	3,540	5,820	3.46	.....
Stelazine.....	5	2,160	720	2,880	1.71	.....
Class total.....		4,538	4,301	8,829	5.25	32.4
Antidepressants: Tofranil.....	25	0	250	250	.15	.9
Hypnotics (Institution reports no usage of this class during period).....						0
Sedatives: Phenobarbital.....	30	64	4,970	5,034	2.99	18.5
Total.....		9,976	17,279	27,255	16.19	100.0
Percent.....		36.6	63.4	100.0		

¹ Injection.

2. *Standard Dosage Units.*—In terms of standard dosage units dispensed per inmate per year FCI Alderson again ranked fourth of the five institutions, dispensing 25.87 dosages. The most commonly prescribed class of drugs at FCI Alderson, expressed in terms of standard dosage units dispensed, was the major tranquilizers (49.2 percent). Minor tranquilizers accounted for 38.6 percent of all standard dosage units dispensed. Sedatives, antidepressants and hypnotics accounted for 11.6 percent, 0.6 percent and 0.0 percent, respectively, of all standard dosage units dispensed at FCI Alderson. The distribution of standard dosage units of control drugs between inpatients and outpatients at FCI Alderson was 42.8 percent and 57.2 percent, respectively, again representing the lowest percentage distribution to outpatients among the five institutions (table 36).

TABLE 36.—FCI ALDERSON: DISTRIBUTION OF STANDARD DOSAGE, UNITS OF ALL "CONTROL" DRUGS, JULY 1, 1975 THROUGH JUNE 30, 1978

Drug class	Standard dosage unit (milligram)	Dispensed to		Total dispensed	Average actual dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Minor tranquilizers:						
Diazepam (Valium).....	5	7,253	6,559	13,812	8.21	.....
Chlordiazepoxide (Librium).....	10	250	2,750	3,000	1.78	.....
Class total.....		7,503	9,309	16,812	9.99	38.6
Major tranquilizers:						
Thorazine.....	25	5,668	8,578	14,246	8.46	.....
Stelazine.....	2	5,400	1,800	7,200	4.28	.....
Class total.....		11,068	10,378	21,446	12.74	49.2
Antidepressants: Tofranil.....	25	0	250	250	.15	.6
Hypnotics (Institution reports no usage of this class during period).....						0
Sedatives phenobarbital.....	30	64	4,970	5,034	2.99	11.6
Total.....		18,635	24,907	43,542	25.87	100.0
Percent.....		42.8	57.2	100.0		

The conversion from actual dosages to standard dosage units resulted in an increase of 59.8 percent in the number of control-drug dosages dispensed per inmate per year at FCI Alderson (table 37). This increase, although only fourth highest among the five institutions, indicates that the strengths of the actual dosages dispensed at FCI Alderson exceeded the standard dosage units. With respect to minor tranquilizers, the percentage increase at FCI Alderson (28.1 percent) was the lowest of the five institutions, indicating that actual dosages of this class of drugs dispensed at FCI Alderson more closely approximated the strengths of the standard dosage units than at the other four institutions (see table 6).

TABLE 37.—BUREAU OF PRISONS: PERCENT CHANGE IN DOSAGES OF ALL "CONTROL" DRUGS DISPENSED PER INMATE PER YEAR BY CONVERSION FROM ACTUAL DOSAGES TO STANDARD DOSAGE UNITS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Average dosages dispensed per inmate per year		Percent change
	Actual	Standard	
FCI Alderson.....	16.19	25.87	+59.8
FCI Terminal Island.....	29.57	52.14	+76.3
USP Leavenworth.....	63.93	127.49	+99.4
FCI El Reno.....	3.97	6.40	+61.2
FCI Lexington.....	41.62	55.06	+32.3

Utilization of Noncontrol Drugs

FCI Alderson dispensed mild analgesics, strong analgesics and anti-diarrheal agents to its inmate population during the 3 year period examined in this study. Of the five institutions FCI Alderson was the only one which did not dispense drugs in the "other" classification of noncontrol drugs during the period.

In terms of actual dosages of noncontrol drugs dispensed per inmate per year, FCI Alderson ranked second highest among the five institutions, dispensing 9.10 dosages. In total utilization of noncontrol drugs

at FCI Alderson the mild analgesics ranked first (74.2 percent), followed by antidiarrheal agents (22.9 percent) and strong analgesics (3.0 percent). FCI Alderson dispensed the greatest percentage of non-control drugs to outpatients (79.3 percent) among the five institutions (table 38). The percentage utilization of antidiarrheal agents was the highest among the five institutions while the percentage utilization of strong analgesics was the lowest (see table 38).

TABLE 38.—FCI ALDERSON: DISTRIBUTION OF ACTUAL DOSAGES OF ALL "NONCONTROL" DRUGS, JULY 1, 1975, THROUGH JUNE 30, 1978

AVERAGE INSTITUTION POPULATION FOR PERIOD: 561

Drug class	Dosage unit (milligram)	Dispensed to		Total dispensed	Average actual dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Mild analgesics:						
Substances containing codeine:						
AP codeine.....	30.0	100	775	875	0.52	-----
Codeine sulfate.....	30.0	400	3,300	3,700	2.20	-----
Substances containing propoxyphene:						
Darvon-N and with aspirin....	100.0	965	3,229	4,194	2.49	-----
Darvocet.....	100.0	840	1,749	2,589	1.54	-----
Total mild analgesics.....		2,305	9,053	11,358	6.75	74.2
Strong analgesics:						
Substances containing meperidine:						
Demerol.....	50.0	40	0	40	.02	-----
Demerol hydrochloride.....	50.0	75	100	175	.10	-----
Total strong analgesics.....		365	100	465	.27	3.0
Antidiarrheal agents: Lomotil.....	2.5	500	3,000	3,500	2.08	22.9
Total.....		3,170	12,153	15,323	9.10	100.0
Percent.....		20.7	79.3	100.0		

Total Utilization of Control and Noncontrol Drugs

1. *Actual Dosages.*—FCI Alderson dispensed 15.29 combined dosages of control and noncontrol drugs per inmate per year over the 3-year period when the control drugs are expressed in actual dosages. This number of dosages was the second lowest among the five institutions. Actual dosages of control drugs accounted for 64.0 percent of all drug dosages dispensed at FCI Alderson (table 39).

Outpatients received 69.1 percent of all noncontrol and actual dosage control drugs dispensed at FCI Alderson, placing it in a tie with USP Leavenworth for the lowest distribution of all drugs to outpatients. FCI Alderson dispensed the lowest percentage of control drugs to outpatients (63.4 percent) among the five institutions, while it dispensed the greatest percentage (79.3 percent) of noncontrol drugs to outpatients, than did any of the other institutions (table 40).

2. *Standard Dosage Units.*—FCI Alderson dispensed 34.97 combined dosages of control and noncontrol drugs per inmate per year over the 3-year period when the control drugs are expressed in standard dosage units, again ranking FCI Alderson second lowest among the five institutions. Standard dosages of control drugs accounted for 74.0 percent of all drug dosages dispensed at FCI Alderson (table 39).

TABLE 39.—BUREAU OF PRISONS: TOTAL DISTRIBUTION OF "CONTROL" AND "NONCONTROL" DRUGS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Actual dosages				
	Average dispensed per inmate per year			Percent	
	Control drugs	Noncontrol drugs	Total	Control drugs	Noncontrol drugs
FCI Alderson.....	16.19	9.10	15.29	64.0	36.0
FCI Terminal Island.....	29.57	4.28	33.85	87.4	12.6
USP Leavenworth.....	63.93	4.99	68.92	92.8	7.2
FCI El Reno.....	3.97	2.37	6.34	62.6	37.4
FCI Lexington.....	41.62	15.85	57.47	72.4	27.6
Standard dosages¹					
FCI Alderson.....	25.87	9.10	34.97	74.0	26.0
FCI Terminal Island.....	52.14	4.28	56.42	92.4	7.6
USP Leavenworth.....	127.49	4.99	132.48	96.2	3.8
FCI El Reno.....	6.40	2.37	8.77	73.0	27.0
FCI Lexington.....	55.06	15.85	70.91	77.6	22.4

¹ Noncontrol drugs expressed in actual dosages per inmate per year as there was no conversion to standard dosage units.

Outpatients received 61.9 percent of all noncontrol and standard dosage control drugs dispensed at FCI Alderson, the lowest percentage distribution to outpatients among the five institutions. FCI Alderson again dispensed the lowest percentage (57.2 percent) of control drugs to outpatients among the five institutions. As indicated above, FCI Alderson dispensed a greater percentage of its noncontrol drugs to outpatients than did the remaining four institutions (table 40).

TABLE 40.—BUREAU OF PRISONS: TOTAL DISTRIBUTION OF "CONTROL" AND "NONCONTROL" DRUGS TO INPATIENTS AND OUTPATIENTS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Actual dosages					
	Percent dispensed to inpatients		Percent dispensed to outpatients		Control and noncontrol percent dispensed to—	
	Control drugs	Noncontrol drugs	Control drugs	Noncontrol drugs	Inpatients	Outpatients
FCI Alderson.....	36.6	20.7	63.4	79.3	30.9	69.1
FCI Terminal Island.....	16.6	45.2	83.4	54.8	20.3	79.7
USP Leavenworth.....	28.5	61.6	71.5	38.4	30.9	69.1
FCI El Reno.....	15.7	29.8	84.3	70.2	21.0	79.0
FCI Lexington.....	16.5	25.5	83.5	74.5	19.0	81.0
Standard dosages¹						
FCI Alderson.....	42.8	20.7	57.2	79.3	38.1	61.9
FCI Terminal Island.....	24.1	45.2	75.9	54.8	25.7	74.3
USP Leavenworth.....	26.8	61.6	73.2	38.4	28.1	71.9
FCI El Reno.....	17.4	29.8	82.6	70.2	20.8	79.2
FCI Lexington.....	16.5	25.5	83.5	74.5	18.5	81.5

¹ Noncontrol drugs expressed in actual dosages per inmate per year as there was no conversion to standard dosage units.

FCI TERMINAL ISLAND

Description of Institution

FCI Terminal Island is located in the Los Angeles Harbor, about 20 miles south of Los Angeles and adjacent to both San Pedro and Long Beach. During the period 1975 to 1977 the institution was co-correctional, housing both male and female prisoners. In late 1977,

however, the facility was converted to all-male due to overcrowding. FCI Terminal Island was built in 1938 and has a present operating capacity of 950. The average inmate population at FCI Terminal Island for the 3 year period covered in this study was 1,003, representing an overpopulation of 6 percent. Housing at FCI Terminal Island consists of open dormitories and single rooms, with an average number of two inmates per cell or dormitory cubicle.

FCI Terminal Island is a medium-to-minimum security institution with drug violations being the most frequent among its inmate population. The second most common offense for inmates at this institution was robbery. Approximately 20 percent of the inmate population was between 22 and 29 years of age with the balance being over 30.

The ratio of correctional officers to inmates for the period covered in this study was approximately 1:9.2. Based on data available to the Committee, FCI Terminal Island experienced a turnover in correctional officers in excess of 50 percent during this period.

Utilization of Control Drugs

FCI Terminal Island dispensed drugs in each of the five control-drug classifications.

1. *Actual Dosages.*—In terms of average actual dosages dispensed per inmate per year FCI Terminal Island ranked third among the five institutions, dispensing 29.57 dosages. The most commonly prescribed class of control drugs at FCI Terminal Island, based on actual dosages dispensed, was the minor tranquilizer class (37.2 percent). Major tranquilizers accounted for 34.5 percent of all actual dosages dispensed. Sedatives, hypnotics, and antidepressants accounted for 25.2 percent, 2.7 percent and 0.4 percent, respectively, of all actual dosages dispensed at FCI Terminal Island. The distribution of actual dosages of control drugs between inpatients and outpatients at FCI Terminal Island was 16.6 percent and 83.4 percent, respectively (table 41).

2. *Standard Dosage Units.*—In terms of standard dosage units dispensed per inmate per year FCI Terminal Island ranked third among the five institutions, dispensing 52.14 dosages. The most commonly prescribed class of drugs at FCI Terminal Island, based upon standard dosage units dispensed, was the major tranquilizers (56.0 percent). Minor tranquilizers and benzodiazepines accounted for 33.1 percent. Sedatives, hypnotics, and antidepressants accounted for 9.2 percent, 1.5 percent, and 0.2 percent, respectively, of all standard dosage units dispensed at FCI Terminal Island. The distribution of standard dosage units of control drugs between inpatients and outpatients was 24.1 percent and 75.9 percent, respectively (table 42).

The conversion from actual dosages to standard dosage units resulted in an increase of 76.3 percent in the number of control-drug dosages dispensed per inmate per year at FCI Terminal Island (table 37). This increase, second highest among the five institutions, indicates that the strengths of the actual dosages dispensed at FCI Terminal Island exceeded the standard dosage units. With respect to major tranquilizers, the percentage increase at FCI Terminal Island (185.9 percent) was the greatest of the five institutions, indicating that actual dosages of this class of drugs dispensed at FCI Terminal Island far exceeded the strengths of the standard dosage units as well as actual dosages dis-

pensed by the other four institutions (see table 12). Conversely, the conversion to standard dosage units resulted in the greatest decrease in the utilization of both hypnotics (—3.8 percent) and sedatives (—35.8 percent) among the five institutions, indicating that the strengths of actual dosages of these drug classes were less than the standard dosage units (see tables 20 and 24).

TABLE 41.—FCI TERMINAL ISLAND: DISTRIBUTION OF ACTUAL DOSAGES OF ALL "CONTROL" DRUGS, JULY 1, 1975, THROUGH JUNE 30, 1978

AVERAGE INSTITUTION POPULATION FOR PERIOD: 1,003

Drug class	Dosage unit (milligram)	Dispensed to		Total dispensed	Average actual dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Minor tranquilizers:						
Diazepam (Valium).....	2	105	1,290	1,395	0.46	-----
	10	384	17,113	17,497	5.81	-----
	15	50	228	278	.09	-----
Chlordiazepoxide (Librium).....	5	126	2,642	2,768	.92	-----
	10	31	1,969	2,000	.66	-----
	25	52	1,948	2,000	.66	-----
Meprobamate.....	400	175	7,036	7,211	2.40	-----
Class total.....		923	32,226	33,149	11.00	37.2
Major tranquilizers:						
Thorazine.....	50	1,000	1,000	2,000	.66	-----
	75	9,600	13,440	23,040	7.66	-----
	100	305	0	305	.10	-----
Stelazine.....	5	1,080	4,320	5,400	1.79	-----
Class total.....		11,985	18,760	30,745	10.21	34.5
Antidepressants: Tofranil.....	25	200	200	400	.13	.4
Hypnotics:						
Pentobarbital.....	90	631	270	901	.30	-----
Chloral hydrate.....	500	298	383	681	.23	-----
Flurazepam (Dalmane).....	30	246	525	771	.26	-----
Class total.....		1,175	1,178	2,353	.79	2.7
Sedatives:						
Phenobarbital.....	30	133	6,235	6,368	2.12	-----
	15	402	15,598	16,000	5.32	-----
Class total.....		535	21,833	22,368	7.44	25.2
Total.....		14,818	74,197	89,015	29.57	100.0
Percent.....		16.6	83.4	100.0		-----

¹ Injection.

Utilization of Noncontrol Drugs

FCI Terminal Island dispensed mild analgesics, strong analgesics and "other" noncontrol drugs to its inmate population during the 3 year period examined in this study. Of the five institutions, FCI Terminal Island was the only one which did not dispense antidiarrheal agents during the period.

In terms of actual dosages of noncontrol drugs dispensed per inmate per year, FCI Terminal Island ranked second lowest among the five institutions, dispensing 4.28 dosages. In total utilization of non-control drugs at FCI Terminal Island the mild analgesics were the most frequently prescribed classification (75.0 percent). Strong analgesics accounted for 22.2 percent and "other" noncontrol drugs 2.8 percent. FCI Terminal Island did not dispense any antidiarrheal

agents during the 3 year period. FCI Terminal Island dispensed 54.8 percent of all noncontrol drugs to outpatients resulting in the second highest percentage distribution to inpatients (table 43). All "other" noncontrol drugs (cocaine) were dispensed exclusively to inpatients (see table 34); 95.8 percent of the strong analgesics were dispensed to inpatients (see table 30). FCI Terminal Island also exhibited the highest percentage utilization of strong analgesics among the five institutions, as well as the highest utilization of "other" noncontrol drugs (see table 28).

TABLE 42.—FCI TERMINAL ISLAND: DISTRIBUTION OF STANDARD DOSAGE UNITS OF ALL "CONTROL" DRUGS, JULY 1, 1975, THROUGH JUNE 30, 1978
AVERAGE INSTITUTION POPULATION FOR PERIOD: 1,003

Drug class	Standard Dosage unit (milligram)	Dispensed to		Total dispensed	Average standard dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Minor tranquilizers:						
Diazepam (Valium).....	5	960	35,426	36,386	12.09	.....
Chlordiazepoxide (Librium).....	10	224	8,160	8,384	2.79	.....
Meprobamate.....	400	175	7,036	7,211	2.40	.....
Class total.....		1,359	50,622	51,981	17.28	33.1
Major tranquilizers:						
Thorazine.....	25	32,020	42,320	74,340	24.70	.....
Stelazine.....	2	2,700	10,800	13,500	4.49	.....
Class total.....		34,720	53,120	87,840	29.19	56.0
Antidepressants: Tofranil.....						
	25	200	200	400	.13	.2
Hypnotics:						
Pentobarbital.....	100	568	243	811	.27	.....
Chloral hydrate.....	500	298	383	681	.23	.....
Flurazepam (Dalmane).....	30	246	525	771	.26	.....
Class total.....		1,112	1,151	2,263	.76	1.5
Sedatives: Phenobarbital.....						
	30	334	14,034	14,368	4.78	9.2
Total.....		37,725	119,127	156,852	52.14	100.0
Percent.....		24.1	75.9	100.0		

Total Utilization of Control and Noncontrol Drugs

1. *Actual Dosages.*—FCI Terminal Island dispensed 33.85 combined dosages of control and noncontrol drugs per inmate per year over the 3-year period when the control drugs are expressed in actual dosages dispensed. This number of dosages was the third highest among the five institutions. Actual dosages of control drugs accounted for 87.4 percent of all drug dosages dispensed at FCI Terminal Island, second highest among the five institutions (table 39).

Outpatients received 79.7 percent of all noncontrol and actual dosage control drugs dispensed at FCI Terminal Island, the second highest percentage distribution to outpatients among the five institutions. Outpatients received 54.8 percent of all noncontrol drugs dispensed at FCI Terminal Island, the second lowest percentage distribution of noncontrol drugs to outpatients (table 40).

2. *Standard Dosage Units.*—FCI Terminal Island dispensed 56.42 combined dosages of control and noncontrol drugs per inmate per year over the 3-year period when the control drugs are expressed in standard dosage units, again ranking FCI Terminal Island third high-

TABLE 43.—FCI TERMINAL ISLAND: DISTRIBUTION OF ACTUAL DOSAGES OF ALL "NONCONTROL" DRUGS, JULY 1, 1975 THROUGH JUNE 30, 1978
AVERAGE INSTITUTION POPULATION FOR PERIOD: 1,003

Drug class	Dosage unit (milligram)	Dispensed to		Total dispensed	Average actual dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Mild analgesics:						
Substances containing codeine:						
Codeine.....	30	110	0	110	0.04	.....
Percogesic with Codeine.....	30	2,118	1,364	3,482	1.16	.....
Substances containing Propoxyphene:						
Darvocet-N.....	100	137	2,650	2,787	.93	.....
Florinal.....	50	340	2,912	3,252	1.08	.....
Total mild analgesics.....		2,705	6,925	9,631	3.21	75.0
Strong analgesics:						
Substances containing Meperidine: Demerol.....						
	50	1,905	79	1,984	.66	.....
Morphine.....	3.75	100	0	100	.03	.....
	15	510	0	510	.17	.....
Methadone.....	10	170	34	204	.07	.....
	20	10	8	18	.01	.....
Fentanyl.....	.1	45	0	45	.01	.....
Total strong analgesics.....		2,740	121	2,861	.95	22.2
Other drugs: Cocaine.....						
	150	360	0	360	.12	2.8
Total.....		5,805	7,047	12,852	4.28	100.0
Percent.....		45.2	54.8	100.0		

est among the five institutions. Standard dosages of control drugs accounted for 92.4 percent of all drug dosages dispensed at FCI Terminal Island, the second highest utilization among the institutions (table 39).

Outpatients received 74.3 percent of all noncontrol and standard dosage control drugs dispensed at FCI Terminal Island. FCI Terminal Island dispensed 75.9 percent of all standard dosage units of control drugs to outpatients, third highest among the five institutions (table 40).

USP LEAVENWORTH

Description of Institution

USP Leavenworth is located in Leavenworth, Kans., which has a population of approximately 30,000, including the U.S. Army facility at Fort Leavenworth. The construction of USP Leavenworth began in 1897 and was completed in 1927, and the institution is designed to accommodate 1,382 inmates. The average inmate population at USP Leavenworth for the 3-year period covered in this study was 2,046, representing an overpopulation of 48 percent. Housing at USP Leavenworth consists of four cellhouses and three open dormitory living quarters. USP Leavenworth is an all-male penal institution.

USP Leavenworth is a maximum security institution with the offense of bank robbery being the most frequent among its inmate population. The average age of the inmate population is approximately 36 and the average length of sentence is about 14 years.

During the 3-year period covered in this study approximately 142 correctional officer positions turned over as a result of promotions, transfers, resignations or terminations. The Committee was unable to

obtain precise data on the ratio of correctional officers to inmates at USP Leavenworth for the 3-year period covered in this study. However, data does indicate that in early 1978 the ratio was approximately 1 to 10.2, which decreased to 1 to 7.8 in November of that year when there were 186 correctional officers at USP Leavenworth. This decrease in the ratio of correctional officers to inmates reflects a declining inmate population at USP Leavenworth.

Utilization of Control Drugs

USP Leavenworth dispensed drugs in each of the five control-drug classifications.

1. *Actual Dosages.*—In terms of actual dosages dispensed per inmate per year USP Leavenworth ranked highest among the five institutions, dispensing 63.93 dosages. USP Leavenworth dispensed more actual dosages per inmate per year in each of the control-drug classifications, except sedatives, than did any of the other institutions. The most commonly prescribed class of control drugs at USP Leavenworth, based on actual dosages dispensed, was the minor tranquilizers (42.9 percent). Major tranquilizers accounted for 39.9 percent of all actual dosages dispensed. Sedatives, hypnotics, and antidepressants accounted for 7.3 percent, 6.1 percent, and 3.8 percent, respectively, of all actual dosages dispensed at USP Leavenworth. The distribution of actual dosages of control drugs between inpatients and outpatients at USP Leavenworth was 28.5 percent and 71.5 percent, respectively (table 44).

TABLE 44.—USP LEAVENWORTH: DISTRIBUTION OF ACTUAL DOSAGES OF ALL "CONTROL" DRUGS, JULY 1, 1975, THROUGH JUNE 30, 1978

Drug class	Dosage unit (milligram)	Dispensed to		Total dispensed	Average actual dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Minor tranquilizers:						
Diazepam (Valium).....	5.0	8,000	33,000	41,000	6.68	-----
Chlordiazepoxide (Librium).....	10.0	21,090	102,500	123,590	20.14	-----
Tranxene.....	25.0	0	1,500	1,500	.24	-----
	7.5	1,000	900	1,000	.16	-----
	22.5	264	0	264	.04	-----
Class total.....		30,454	137,900	168,354	27.42	42.9
Major tranquilizers:						
Thorazine.....	50.0	43,200	91,200	134,400	21.90	-----
Stelazine.....	50.0	555	30	585	.10	-----
	5.0	0	2,000	2,000	.33	-----
	10.0	120	40	160	.03	-----
	15.0	4,840	14,440	19,280	3.14	-----
Class total.....		48,715	107,710	156,425	25.50	39.9
Antidepressants: Tofranil.....	25.0	3,000	12,000	15,000	2.44	3.8
Hypnotics:						
Pentobarbital.....	90.0	1,600	0	1,600	.26	-----
Chloral hydrate.....	500.0	22,540	0	22,540	3.67	-----
Class total.....		24,140	0	24,140	3.93	6.1
Sedatives:						
Phenobarbital.....	30.0	5,120	23,040	28,160	4.59	-----
	120.0	300	0	300	.05	-----
Class total.....		5,420	23,040	28,460	4.64	7.3
Total.....		111,729	280,650	392,379	63.93	100.0
Percent.....		28.5	71.5	100.0		

¹ Injection

2. *Standard Dosage Units.*—In terms of standard dosage units dispensed per inmate per year USP Leavenworth ranked highest among the five institutions, dispensing 127.49 dosages.

The most commonly prescribed class of drugs at USP Leavenworth, based upon standard dosage units dispensed, was the major tranquilizers (53.7 percent). Minor tranquilizers accounted for 37.6 percent. Sedatives, hypnotics, and antidepressants accounted for 3.7 percent, 3.1 percent and 1.9 percent, respectively, of all standard dosage units dispensed at USP Leavenworth. The distribution of standard dosage units of control drugs between inpatients and outpatients was 26.8 percent and 73.2 percent, respectively (table 45). The conversion from actual dosages to standard dosage units resulted in the highest increase (99.4 percent) in the number of control-drug dosages dispensed per inmate per year among the five institutions, indicating that USP Leavenworth dispensed actual dosages of control drugs in strengths far greater than both standard dosage units and the other four institutions (table 37). With respect to minor tranquilizers, the percentage increase at USP Leavenworth (74.7 percent) was the highest of the five institutions (see table 6). Conversely, USP Leavenworth dispensed fewer (—0.8 percent) standard dosage units of hypnotics than it did actual dosages, indicating that its utilization of hypnotics was in strengths below that of the standard dosage units (see table 20). USP Leavenworth dispensed more standard dosage units per inmate per year in each of the control-drug classifications with the exception of the sedatives, than any of the other institutions.

TABLE 45.—USP LEAVENWORTH: DISTRIBUTION OF STANDARD DOSAGE UNITS OF ALL "CONTROL" DRUGS, JULY 1, 1975, THROUGH JUNE 30, 1978
AVERAGE INSTITUTION POPULATION FOR PERIOD: 2,046

Drug class	Dosage unit (milligram)	Dispensed to		Total dispensed	Average standard dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Minor tranquilizers:						
Diazepam (Valium).....	5.0	50,180	238,000	288,180	46.95	-----
Chlordiazepoxide (Librium).....	10.0	250	3,750	4,000	.65	-----
Tranxene.....	7.5	1,792	0	1,792	.29	-----
Class total.....		52,222	241,750	293,972	47.89	37.6
Major tranquilizers:						
Thorazine.....	25.0	87,510	182,460	269,970	43.98	-----
Stelazine.....	2.0	36,900	113,500	150,400	24.50	-----
Class total.....		124,410	295,960	420,370	68.48	53.7
Antidepressants: Tofranil.....	25.0	3,000	12,000	15,000	2.44	1.9
Hypnotics:						
Pentobarbital.....	100.0	1,440	0	1,440	.23	-----
Chloral hydrate ¹	500.0	22,540	0	22,540	3.67	-----
Class total.....		23,980	0	23,980	3.90	3.1
Sedatives: Phenobarbital.....	30.0	6,320	23,040	29,360	4.78	3.7
Total.....		209,932	572,750	782,682	127.49	100.0
Percent.....		26.8	73.2	100.0		

¹ Of these dosages, 9,100 were in the form of 500 mg capsules. In addition, USP Leavenworth reported dispensing 210 pints of liquid chloral hydrate, each pint containing 480 cc. The dosage reported for liquid chloral hydrate was 500 mg per 5 cc. The Bureau of Prisons claims that the 210 pints equal 13,440 dosages while committee staff believes the number of dosages to be 20,160. This study utilizes the 13,440 dosage figure. Utilization of hypnotics at USP Leavenworth would increase by 1.09 dosages per inmate per year (actual and standard) based upon 20,160 dosages.

Utilization of Noncontrol Drugs

USP Leavenworth dispensed mild analgesics, strong analgesics, anti-diarrheal agents, and "other" noncontrol drugs to its inmate population during the 3-year period examined in this study.

In terms of actual dosages of noncontrol drugs dispensed per inmate per year, USP Leavenworth ranked third highest among the five institutions, dispensing 4.99 dosages.

Mild analgesics were the most frequently prescribed noncontrol drug classification at USP Leavenworth (69.9 percent); however, this level of utilization was the lowest among the five institutions. Anti-diarrheal agents were the second most frequently prescribed classification at USP Leavenworth (18.0 percent), followed by strong analgesics (11.2 percent) and "other" noncontrol drugs (cocaine HCL), comprising 0.8 percent of all noncontrol drugs dispensed at that institution.

Of the five institutions, USP Leavenworth dispensed the greatest percentage (61.6 percent) of noncontrol drugs to inpatients (table 46). It was the only institution to dispense in excess of 50 percent of noncontrol drugs in this manner. All of the strong analgesics (see table 30) and "other" noncontrol drugs (see table 34) at USP Leavenworth were dispensed to inpatients. USP Leavenworth dispensed more mild analgesics to inpatients (68.4 percent) than did any of the remaining four institutions (see table 27) and was the only institution to dispense more than 50 percent of mild analgesics in this manner. Almost 91 percent of the anti-diarrheal agents were dispensed to outpatients at USP Leavenworth (table 32).

TABLE 46.—USP LEAVENWORTH: DISTRIBUTION OF ACTUAL DOSAGES OF ALL "NONCONTROL" DRUGS, JULY 1, 1975, THROUGH JUNE 30, 1978

AVERAGE INSTITUTION POPULATION FOR PERIOD: 2,046

Drug	Dosage unit (milligram)	Dispensed to		Total dispensed	Average actual dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Mild analgesics:						
Substances containing codeine: Codeine sulfate (oral and HT).....	30.0	3,520	0	3,520	0.57	-----
Substances containing propoxyphene:						
Darvon-N.....	100.0	4,000	5,759	9,759	1.59	-----
Darvocet-N.....	50.0	2,612	0	2,612	.43	-----
.....	100.0	2,500	0	2,500	.41	-----
Fiorinal.....	50.0	2,000	1,000	3,000	.49	-----
Total mild analgesics.....		14,632	6,759	21,391	3.49	69.9
Strong analgesics:						
Substances containing meperidine: Demerol.....	75.0	3,200	0	3,200	.52	-----
Morphine sulfate.....	15.0	260	0	260	.04	-----
Total strong analgesics.....		3,460	0	3,460	.56	11.2
Antidiarrheal agents: Lomotil.....	2.5	500	5,000	5,500	.90	18.0
Other drugs: Cocaine HCL.....	150.0	260	0	260	.04	.8
Total.....		18,852	11,759	30,611	4.99	100.0
Percent.....		61.6	38.4	100.0		-----

Total Utilization of Control and Noncontrol Drugs

1. *Actual Dosages.*—USP Leavenworth dispensed 68.92 combined dosages of control and noncontrol drugs per inmate per year over the 3-year period when the control drugs are expressed in actual dosages dispensed. Control drugs accounted for 92.8 percent of all drug dosages dispensed at USP Leavenworth, representing the highest percentage utilization of these drugs (table 39).

Outpatients received 69.1 percent of all noncontrol and actual dosage control drugs dispensed at USP Leavenworth, placing it in a tie with FCI Alderson for the lowest percentage distribution of all drugs to outpatients. USP Leavenworth dispensed 71.5 percent of all control drugs to outpatients, the second lowest percentage among the five institutions. The smallest percentage of noncontrol drugs dispensed to outpatients occurred at USP Leavenworth (38.4 percent) (table 40).

2. *Standard Dosage Units.*—USP Leavenworth dispensed 131.09 combined dosages of control and noncontrol drugs per inmate per year over the 3-year period when the control drugs are expressed in standard dosage units. This level of dosages was the highest among the five institutions. Standard dosages of control drugs accounted for 96.2 percent of all drug dosages dispensed at USP Leavenworth, the highest percentage utilization of standard dosage control drugs among the five institutions (table 39).

Outpatients received 71.9 percent of all noncontrol and standard dosage control drugs dispensed at USP Leavenworth, representing the second lowest percentage distribution to outpatients. USP Leavenworth dispensed 73.2 percent of all control drugs to outpatients, again the second lowest percentage distribution among the five institutions (table 40).

FCI EL RENO

Description of Institution

FCI El Reno is located outside El Reno, Okla., an agricultural and commuter town with a population of approximately 14,000. Originally constructed in 1934, FCI El Reno is designed to accommodate 925 inmates. The average inmate population at FCI El Reno for the 3-year period covered in this study was 1,151, representing an over-population of 24 percent.

FCI El Reno is a medium security institution. During the period covered by this study the average age of the inmate population at FCI El Reno gradually increased. In mid-1975 almost all inmates at the institution were in the 18–26 age group; approximately half the population was over 27 by the end of 1978. This change in age was accompanied by longer sentences for more sophisticated and serious offenses.

The ratio of correctional officers to inmates for the period covered in this study ranged from 1:6.6 to 1:8.8, reflecting an increase in institutional population with little corresponding change in staff. During this period FCI El Reno experienced a turnover in correctional officers numbering 92. Based on data available to the committee this is equivalent to a turnover rate of approximately 71 percent during the 3-year period.

Utilization of Control Drugs

FCI El Reno dispensed drugs in each of the five control-drug classifications.

1. *Actual Dosages.*—In terms of actual dosages dispensed per inmate per year FCI Terminal Island ranked lowest among the five institutions, dispensing 3.97 dosages. FCI El Reno dispensed fewer actual dosages per inmate per year in each of the control-drug classifications except hypnotics (FCI Alderson dispensed no hypnotics) than did any of the other institutions. The most commonly prescribed class of control drugs at FCI El Reno, based on actual dosages dispensed, was the minor tranquilizers (49.1 percent). Major tranquilizers accounted for 36.3 percent of all actual dosages dispensed. Sedatives, antidepressants and hypnotics accounted for 11.8 percent, 1.3 percent and 1.5 percent, respectively, of all actual dosages dispensed at FCI El Reno. The distribution of actual dosages of control drugs between inpatients and outpatients at FCI El Reno was 15.7 percent and 84.3 percent, respectively, representing the highest percentage dispensed to outpatients of all five institutions (table 47).

TABLE 47.—FCI EL RENO: DISTRIBUTION OF ACTUAL DOSAGES OF ALL "CONTROL" DRUGS, JULY 1, 1975, THROUGH JUNE 30, 1978

AVERAGE INSTITUTION POPULATION FOR PERIOD: 1,151

Drug class	Dosage unit (milligram)	Dispensed to		Total dispensed	Average actual dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Minor tranquilizers:						
Diazepam (Valium).....	5.0	202	1,750	1,952	0.57	
	10.0	43	2,876	2,919	.85	
Chlordiazepoxide (Librium).....	5.0	122	0	122	.04	
	25.0	112	130	242	.07	
Meprobamate.....	400.0	0	89	89	.03	
Tranxene.....	7.5	0	1,348	1,348	.39	
Class total.....		479	6,193	6,672	1.95	49.1
Major tranquilizers:						
Thorazine.....	50.0	1,125	3,375	4,500	1.30	
	150.0	60	25	85	.02	
Stelazine.....	150.0	68	30	98	.03	
	2.0	82	244	326	.09	
Class total.....		1,335	3,674	5,009	1.44	36.3
Antidepressants: Tofranil.....	25.0	38	135	173	.05	1.3
Hypnotics:						
Pentobarbital.....	100.0	140	0	140	.04	
Chloral hydrate.....	500.0	50	8	58	.02	
Class total.....		190	8	198	.06	1.5
Sedatives:						
Phenobarbital.....	30.0	64	1,386	1,450	.42	
	60.0	30	110	140	.05	
Class total.....		94	1,496	1,590	.47	11.8
Total.....		2,136	11,506	13,642	3.97	100.0
Percent.....		15.7	84.3	100.0		

¹ Injection.
² Spansule.

2. *Standard Dosage Units.*—In terms of standard dosage units dispensed per inmate per year FCI El Reno ranked lowest (fifth) among

the five institutions, dispensing 6.40 dosages. The most commonly prescribed class of control drugs at FCI El Reno, based on standard dosage units dispensed, was the major tranquilizers (45.6 percent). Minor tranquilizers accounted for 44.8 percent of all standard dosage units dispensed. Sedatives, hypnotics and antidepressants accounted for 7.8 percent, 0.9 percent and 0.8 percent, respectively, of all standard dosage units dispensed at FCI El Reno. The distribution of standard dosage units of control drugs between inpatients and outpatients was 17.4 percent and 82.6 percent, respectively (table 48). The conversion from actual dosages to standard dosage units resulted in an increase of 61.2 percent in the number of control-drug dosages dispensed per inmate per year at FCI El Reno. This increase, although second lowest among the five institutions, indicates that the strengths of the actual dosages dispensed at FCI El Reno exceeded the standard dosage units (table 37). FCI El Reno dispensed fewer standard dosage units per inmate per year in each of the control-drug classifications with the exception of hypnotics (FCI Alderson dispensed no hypnotics) than did any of the other institutions.

TABLE 48.—FCI EL RENO: DISTRIBUTION OF STANDARD DOSAGE UNITS OF ALL "CONTROL" DRUGS, JULY 1, 1975, THROUGH JUNE 30, 1978

AVERAGE INSTITUTION POPULATION FOR PERIOD: 1,151

Drug class	Dosage unit (milligram)	Dispensed to		Total dispensed	Average actual dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Minor tranquilizers:						
Diazepam (Valium).....	5.0	288	7,502	7,790	2.26	
Chlordiazepoxide (Librium).....	10.0	341	325	666	.19	
Meprobamate.....	400.0	0	89	89	.03	
Tranxene.....	7.5	0	1,348	1,348	.39	
Class total.....		629	9,264	9,893	2.87	44.8
Major tranquilizers:						
Thorazine.....	25.0	2,778	6,980	9,758	2.83	
Stelazine.....	2.0	82	244	326	.09	
Class total.....		2,860	7,224	10,084	2.92	45.6
Antidepressants: Tofranil.....	25.0	38	135	173	.05	.8
Hypnotics:						
Pentobarbital.....	100.0	140	0	140	.04	
Chloral hydrate.....	500.0	50	8	58	.02	
Class total.....		190	8	198	.06	.9
Sedatives: Phenobarbital.....	30.0	124	1,606	1,730	.50	7.8
Total.....		3,841	18,237	22,078	6.40	100.0
Percent.....		17.4	82.6	100.0		

Utilization of Noncontrol Drugs

FCI El Reno dispensed mild analgesics, strong analgesics, anti-diarrheal agents, and "other" noncontrol drugs to its inmate population during the 3-year period examined in this study.

In terms of actual dosages of noncontrol drugs dispensed per inmate per year, FCI El Reno dispensed 2.37 dosages, the lowest among the five institutions.

FCI El Reno dispensed mild analgesics more frequently than any other noncontrol drug classification (84.0 percent), the highest per-

centage utilization among the five institutions. Strong analgesics made up 12.7 percent of all noncontrol drugs dispensed followed by antidiarrheal agents (3.1 percent) and "other" noncontrol drugs (0.1 percent). FCI El Reno dispensed 70.2 percent of all noncontrol drugs to outpatients, ranking third highest among the five institutions (table 49). FCI El Reno prescribed 80.0 percent of all mild analgesics to outpatients, second highest among the institutions (see table 27). All strong analgesics were dispensed to inpatients at FCI El Reno (see table 30), while all of the "other" noncontrol drugs (duragesic) was dispensed to outpatients (see table 34). Almost 91 percent of antidiarrheal agents were dispensed to outpatients (table 32).

TABLE 49.—FCI EL RENO: DISTRIBUTION OF ACTUAL DOSAGES OF ALL "NONCONTROL" DRUGS, JULY 1, 1975, THROUGH JUNE 30, 1978

AVERAGE INSTITUTION POPULATION FOR PERIOD: 1,151

Drug	Dosage unit (milligram)	Dispensed to		Total dispensed	Average actual dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Mild analgesics:						
Substances containing codeine:						
APC with codeine.....	30.0	486	1,420	1,906	0.55	.....
Codeine.....	60.0	12	0	12	(¹)	.....
Tylenol with codeine.....	30.0	795	1,097	1,892	.55	.....
Tylenol elixir with codeine.....	12.5					
Substances containing propoxyphene:						
Darvon-N and with aspirin.....	100.0	29	745	774	.22	.....
Florinal.....	50.0	50	2,225	2,275	.66	.....
Total mild analgesics.....		1,372	5,487	6,859	1.99	84.0
Strong analgesics:						
Substances containing meperidine:						
Demerol.....	50.0	563	0	563	.16	.....
	75.0	175	0	175	.05	.....
	100.0	275	0	275	.08	.....
Fentanyl.....	.1	28	0	28	(¹)	.....
Total strong analgesics.....		1,041	0	1,041	.30	12.7
Antidiarrheal agents:						
Lomotil.....	5.0	24	226	250	.07	.....
Paregoric.....	15.0	0	7	7	(¹)	.....
Total antidiarrheal agents.....		24	233	257	.07	3.1
Other drugs: Duragesic.....	50.0	0	11	11	(¹)	0.1
Total.....		2,437	5,731	8,168	2.37	100.0
Percent.....		29.8	70.2	100.0		

¹ Less than 0.005.
² Milliliter.

Total Utilization of Control and Noncontrol Drugs

1. *Actual Dosages.*—FCI El Reno dispensed 6.34 combined dosages of control and noncontrol drugs per inmate per year over the 3-year period when the control drugs are expressed in actual dosages dispensed. This level of dosages represents the lowest among the five institutions. Actual dosages of control drugs accounted for 62.6 percent of all drug dosages dispensed at FCI El Reno, the lowest percentage among the five institutions (table 39).

Outpatients received 79.0 percent of all noncontrol and actual dosage control drugs at FCI El Reno, the second highest distribution

to outpatients among the five institutions. FCI El Reno dispensed a greater percentage of control drugs to outpatients (84.3 percent) than the remaining four institutions. Outpatients received 70.2 percent of all noncontrol drugs dispensed at FCI El Reno (table 40).

2. *Standard Dosage Units.*—FCI El Reno dispensed 8.77 combined dosages of control and noncontrol drugs per inmate per year over the 3-year period when the control drugs are expressed in standard dosage units, again representing the lowest total utilization among the five institutions. Standard dosages of control drugs accounted for 73.0 percent of all drug dosages dispensed at FCI El Reno, representing the lowest utilization among the five institutions (table 39).

Outpatients received 79.2 percent of all noncontrol and standard dosage control drugs dispensed at FCI El Reno, the second highest percentage among the five institutions. FCI El Reno dispensed 82.6 percent of control drugs to outpatients. As indicated above, outpatients received 70.2 percent of all noncontrol drugs dispensed at FCI El Reno (table 40).

FCI LEXINGTON

Description of Institution

FCI Lexington is located within 4 miles of downtown Lexington, Ky., a city having a population of approximately 200,000. Originally constructed between 1932 and 1934, FCI Lexington is designed to accommodate 952 inmates. During the 3-year period covered in this study the average inmate population at FCI Lexington was 971, representing an overpopulation of 2 percent.

FCI Lexington is a minimum security institution with drug law violations, larceny, theft, and forgery offenses being most frequent among its inmate population. FCI Lexington is a cocrrectional institution, with a 40 percent female inmate population. During the period of this study, approximately one-third of the male inmate population at FCI Lexington fell into each of the age ranges 22-29, 30-39, and 40-and-over. Almost 60 percent of the female inmate population was between 22 and 29 years of age while almost 20 percent fell in each of the age ranges 21- and younger and 30-39. A small percentage of female prisoners were 40-and-older.

The ratio of correctional officers to inmates for the period covered in this study ranged from 1:4.8 to 1:8.6, reflecting primarily an increase in the number of inmates at FCI Lexington rather than a decrease in correctional staffing. The correctional staffing had a total turnover of 27 officers during the 3-year period, representing a rate of approximately 19 percent.

Utilization of Control Drugs

FCI Lexington dispensed drugs in each of the five control-drug categories.

1. *Actual Dosages.*—In terms of actual dosages dispensed per inmate per year FCI Lexington ranked second highest among the five institutions, dispensing 41.62 dosages. FCI Lexington dispensed more actual dosages of sedatives per inmate per year than did any of the other four institutions. The most commonly prescribed class of control drugs at FCI Lexington, based on actual dosages dispensed, was the minor tranquilizers (54.6 percent). Major tranquilizers accounted

for 17.1 percent of all actual dosages dispensed. Sedatives, anti-depressants, and hypnotics accounted for 23.5 percent, 4.1 percent, and 0.7 percent, respectively, of all actual dosages dispensed at FCI Lexington. The distribution of actual dosages of control drugs between inpatients and outpatients at FCI Lexington was 16.5 percent and 83.5 percent, respectively (table 50).

TABLE 50.—FCI LEXINGTON: DISTRIBUTION OF ACTUAL DOSAGES OF ALL "CONTROL" DRUGS, JULY 1, 1975, THROUGH JUNE 30, 1978

Drug class	Dosage unit (milligram)	Dispensed to		Total dispensed	Average actual dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Minor tranquilizers:						
Diazepam (Valium).....	2	125	893	1,108	0.38	-----
	5	7,025	22,303	29,238	10.07	-----
	10	4,000	17,210	21,210	7.28	-----
	10	242	0	422	.08	-----
Chlordiazepoxide (Librium).....	10	840	6,582	7,422	2.55	-----
	25	60	1,426	1,486	.51	-----
Meprobamate.....	400	800	4,592	5,392	1.85	-----
Class total.....		13,092	53,006	66,098	22.72	54.6
Major tranquilizers:						
Thorazine.....	25	0	45	45	.02	-----
	50	75	50	125	.04	-----
	150	2,400	16,800	19,200	6.59	-----
	100	0	25	25	.01	-----
Stelazine.....	2	0	80	80	.03	-----
	4	300	900	1,200	.41	-----
Class total.....		2,775	17,900	20,675	7.10	17.1
Antidepressants: Tofranil.....	25	1,000	4,000	5,000	1.72	4.1
Hypnotics:						
Pentobarbital.....	100	50	0	50	.02	-----
Chloral hydrate.....	500	420	350	770	.26	-----
Class total.....		470	350	820	.28	0.7
Sedatives:						
Phenobarbital.....	16	0	924	934	.32	-----
	20	2,480	22,650	25,140	8.63	-----
	32	0	597	597	.20	-----
	100	150	1,738	1,888	.65	-----
Class total.....		2,630	25,929	28,559	9.80	23.5
Total.....		19,967	101,185	121,152	41.62	100.0
Percent.....		16.5	83.5	100.0		

1 Injection.

2. *Standard Dosage Units.*—In terms of standard dosage units dispensed per inmate per year FCI Lexington ranked second highest among the five institutions, dispensing 55.06 dosages. The most commonly prescribed class of control drugs at FCI Lexington, based upon standard dosage units dispensed, was the minor tranquilizers (55.6 percent), making FCI Lexington the only one of the five institutions to dispense more of this classification than major tranquilizers (25.7 percent). Sedatives, antidepressants, and hypnotics accounted for 15.1 percent, 3.1 percent, and 0.5 percent, respectively, of all standard dosage units dispensed at FCI Lexington. The distribution of standard dosage units of control drugs between inpatients and outpatients was 16.5 percent and 83.5 percent, respectively, representing the highest percentage distribution of standard dosage units to

outpatients among the five institutions (table 51). The conversion from actual dosages to standard dosage units resulted in an increase of 32.3 percent in the number of dosages dispensed per inmate per year at FCI Lexington. This increase, the lowest among the five institutions, indicates that although the strengths of actual dosages exceeded the standard dosage units, FCI Lexington utilized control drugs at a level more closely approximating the standard dosage units than did any of the other four institutions (table 37). Similarly, FCI Lexington experienced the lowest percentage increases in the utilization of minor tranquilizers (34.6 percent) and major tranquilizers (99.6 percent) among the five institutions, indicating that it dispensed actual dosages of these two control drug classes in strengths below that of the other four institutions (see tables 8 and 12). With respect to sedatives, the conversion to standard dosage units resulted in a decrease (—15.3 percent) in the number of dosages dispensed per inmate per year, indicating that FCI Lexington dispensed sedatives in dosage strengths below that of the standard dosage unit (see table 24). FCI Lexington dispensed more standard dosage units of sedatives per inmate per year than did any of the other four institutions.

TABLE 51.—FCI LEXINGTON: DISTRIBUTION OF STANDARD DOSAGE UNITS OF ALL "CONTROL" DRUGS, JULY 1, 1975, THROUGH JUNE 30, 1978

AVERAGE INSTITUTION POPULATION FOR PERIOD: 971

Drug class	Dosage unit (milligram)	Dispensed to		Total dispensed	Average standard dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Minor tranquilizers:						
Diazepam (Valium).....	5	15,559	57,080	72,639	24.92	-----
Chlordiazepoxide (Librium).....	10	990	10,147	11,137	3.82	-----
Meprobamate.....	400	800	4,592	5,392	1.85	-----
Class total.....		17,349	71,819	89,168	30.59	55.6
Major tranquilizers:						
Thorazine.....	25	4,950	33,845	38,795	13.32	-----
Stelazine.....	2	600	1,880	2,480	.85	-----
Class total.....		5,550	35,735	41,275	14.17	25.7
Antidepressants: Tofranil.....	25	1,000	4,000	5,000	1.72	3.1
Hypnotics:						
Pentobarbital.....	100	50	0	50	.02	-----
Chloral hydrate.....	500	420	350	770	.26	-----
Class total.....		470	350	820	.28	.5
Sedatives: Phenobarbital.....	30	2,153	22,035	24,188	8.30	15.1
Total.....		26,522	133,939	160,461	55.06	100.0
Percent.....		16.5	83.5	100.0		

Utilization of Noncontrol Drugs

FCI Lexington dispensed mild analgesics, strong analgesics, anti-diarrheal agents, and "other" noncontrol drugs to its inmate population during the 3-year period examined in this study.

In terms of actual dosages of noncontrol drugs dispensed per inmate per year, FCI Lexington dispensed 15.85 dosages, the highest among the five institutions.

Mild analgesics were the most frequently utilized classification of noncontrol drugs at FCI Lexington (75.2 percent), followed by strong

analgesics (16.5 percent), antidiarrheal agents (7.1 percent) and "other" noncontrol drugs (1.2 percent).

FCI Lexington dispensed more noncontrol drugs per inmate per year in all categories, except antidiarrheal agents, than did any of the other four institutions. Outpatients received 74.5 percent of all noncontrol drugs dispensed at FCI Lexington, the second highest percentage among the five institutions (table 52). FCI Lexington dispensed the greatest percentage of mild analgesics (82.8 percent), strong analgesics (33.9 percent), and antidiarrheal agents (92.1 percent) to outpatients than did any of the other four institutions. All of the "other" noncontrol drugs (dextroamphetamine) was dispensed to outpatients.

TABLE 52.—FCI LEXINGTON: DISTRIBUTION OF ACTUAL DOSAGES OF ALL "NONCONTROL" DRUGS JULY 1, 1975, THROUGH JUNE 30, 1978

AVERAGE INSTITUTION POPULATION FOR PERIOD: 971

Drug	Dosage unit (milligram)	Dispensed to		Total dispensed	Average actual dosages dispensed per inmate per year	Percent
		Inpatients	Outpatients			
Mild analgesics:						
Substances containing codeine:						
Codeine phosphate elixir.....	30.0	2,825	15,175	18,000	6.18	-----
Codeine.....	30.0	310	0	310	.11	-----
Substances containing propoxyphene: Darvon.....	100.0	2,825	13,585	16,410	5.63	-----
Total mild analgesics.....		5,960	28,760	34,720	11.92	75.2
Strong analgesics:						
Substances containing meperidine:						
Demerol.....	50.0	848	0	848	.29	-----
	75.0	400	0	400	.14	-----
	100.0	230	0	230	.08	-----
Morphine.....	8.0	490	0	490	.17	-----
	10.0	1,950	0	1,950	.67	-----
	15.0	230	0	230	.08	-----
Methadone elixir.....	5.0	500	1,050	1,550	.53	-----
	10.0	300	1,050	1,350	.46	-----
Hydromorphone (Dilaudid)....	2.0	70	0	70	.02	-----
	4.0	25	483	508	.17	-----
Total strong analgesics.....		5,403	2,583	7,626	2.61	15.6
Antidiarrheal agents:						
Lomotil.....	2.5	200	2,999	3,199	1.10	-----
Paregoric.....	5.0	60	20	80	.03	-----
Total antidiarrheal agents.....		260	3,019	3,279	1.13	7.1
Other drugs: Dextroamphetamine.....	10.0	0	550	550	.19	1.2
Total.....		11,932	34,912	46,849	15.85	100.0
Percent.....		25.5	74.5	100.0		

Total Utilization of Control and Noncontrol Drugs

1. *Actual Dosages.*—FCI Lexington dispensed 57.47 combined dosages of control and noncontrol drugs per inmate per year over the 3-year period when the control drugs are expressed in actual dosages dispensed. This number of dosages was the second highest among the five institutions. Actual dosages of control drugs accounted for 72.4 percent of all drug dosages dispensed at FCI Lexington (table 39).

Outpatients received 81.0 percent of all noncontrol and actual dosage control drugs dispensed at FCI Lexington, the highest distri-

bution to outpatients among the five institutions. FCI Lexington dispensed 83.5 percent of control drugs to outpatients while dispensing 74.5 percent of noncontrol drugs to outpatients (table 40).

2. *Standard Dosage Units.*—FCI Lexington dispensed 70.91 combined dosages of control and noncontrol drugs per inmate per year over the 3-year period when the control drugs are expressed in standard dosage units, the second highest level of dosages among the five institutions. Standard dosages of control drugs accounted for 77.6 percent of all drug dosages dispensed at FCI Lexington (table 39).

Outpatients received 81.5 percent of all noncontrol and standard dosage control drugs dispensed at FCI Lexington, the highest percentage distribution to outpatients among the five institutions. FCI Lexington dispensed the highest percentage of control drugs to outpatients (83.5 percent) and dispensed the second highest percentage of noncontrol drugs (74.5 percent) to outpatients (table 40).

FINDINGS AND CONCLUSIONS

Findings and conclusions to be drawn from the data presented in this study must be viewed with caution. All data presented represent institutional averages and do not necessarily reflect individual patient case histories. Furthermore, it can be reasonably assumed that some differences in prescribing practices will result from differing inmate population characteristics such as age and sex, as well as the prescribing physician's preference for certain drugs and appropriate dosage strengths.

Questions arise, however, from the extreme variations in prescribing practices as revealed by the data. For example, with respect to the control-drugs, it is unclear why FCI El Reno dispensed only 3.97 actual dosages (6.40 standard dosage units) per inmate per year while USP Leavenworth dispensed 63.93 actual dosages (127.49 standard dosage units) per inmate per year. Similarly, such factors as those referenced above would not seem to account for the fact that FCI Alderson dispensed 57.2 percent of all standard dosage units of control-drugs to outpatients while FCI Lexington dispensed 83.5 percent to outpatients. Extreme differences such as these prevail throughout the data, particularly with respect to the control-drugs.

Of particular interest is the apparent strong reliance by prescribing physicians at the five institutions on the major tranquilizers. As previously noted, major tranquilizers are potent agents exhibiting a high potential for adverse reaction and their long-term use in generally reserved for the treatment of psychiatric illness. Similarly, long-term use of the major tranquilizers generally occurs more frequently in an inpatient treatment environment where the patient can be carefully monitored. Although the data does not reveal the duration of major tranquilizer treatment, it can be noted that only one of the five institutions surveyed dispensed more of this class of control-drugs to inpatients than it did to outpatients. With regard to Prolixin, the strongest of the major tranquilizers, FCI Terminal Island dispensed all dosages to inpatients while FCI El Reno dispensed in excess of 90 percent to outpatients (see appendix C). Furthermore, upon conversion from actual dosages to standard dosage units, the utilization of major tranquilizers exceeds that of minor tranquilizers

at four of the five institutions. The data also indicate that although there was significant variation in the number of dosages dispensed per inmate per year with respect to both antidepressants and hypnotics, their overall utilization within the five institutions was uniformly low and in each instance these drugs were prescribed at levels equal to or less than the standard dosage unit. This fact contrasts sharply to the utilization of the major tranquilizers where reliance on dosage strengths approximating the standard dosage was virtually nonexistent.

To a somewhat lesser degree, the variations with respect to the non-control drugs are also significant. For example, with respect to the strong analgesics, both USP Lexington and FCI El Reno dispensed all such drugs to inpatients while 33.9 percent and 21.5 percent of these drugs were dispensed to outpatients at FCI Lexington and FCI Alderson, respectively. The data also indicate that only FCI Terminal Island did not dispense any antidiarrheal agents to its inmate population during the 3 year period reviewed. Another point of interest is the use of dextroamphetamine at FCI Lexington, as this drug is only indicated for narcolepsy (extremely rare), hyperactivity in children (nonexistent in a prison setting), and non-glandular obesity where accepted usage is limited to six weeks.⁸ In addition, dextroamphetamine exhibits an extremely high potential for psychological dependence and abuse.

The data strongly suggest the absence of standardized prescribing procedures within the Bureau of Prisons. Accordingly, with each institution free to determine the basis for the dispensing of drugs, there exists a significant potential for abuse particularly with respect to those drugs in the control classification. For this reason, there is concern about the apparent high level of control-drugs dispensed at USP Leavenworth and cause to examine further whether such high utilization levels reflect sound medical practice under adequate supervision. This concern is exacerbated by communications received from inmates at USP Leavenworth complaining of the indiscriminate use of control-drugs at that institution.⁹

In December 1979, the Select Committee requested that the Bureau of Prisons provide certain information relating to the assignment of inmates determined to require psychiatric care, the extent of medical staff and facilities at certain institutions and the security classification of certain institutions. The inquiry of the Select Committee and the response of the Bureau of Prisons are contained in Appendices F and G.

According to the Bureau of Prisons, inmates determined to require psychiatric care were generally assigned to five specific institutions during the period July 1, 1975 through June 30, 1978. Within this group of five institutions are three institutions analyzed in this report: FCI Alderson, FCI Lexington, and FCI Terminal Island. In view of the seemingly high utilization of control drugs at USP Leavenworth, it is somewhat surprising to find that USP Leavenworth was not among

⁸ The Food and Drug Administration is presently seeking to remove the indication of obesity as a legitimate use for amphetamines. The use of amphetamines for the treatment of depression has not been accepted medical practice for the past decade.

⁹ Copies of some of these communications are contained in Appendix D to this study.

the group of institutions to which inmates requiring psychiatric care were generally assigned during the 3 year period. Because drugs within the control drug classification are generally associated with various degrees of psychiatric care, the committee compared the utilization of these drugs at the three institutions with the utilization at USP Leavenworth.

Table 53 compares the average number of dosages of control drugs (actual and standard dosage units) dispensed by the three institutions to which inmates requiring psychiatric care were generally assigned with the average number of dosages dispensed at USP Leavenworth. With respect to all control drugs (except Prolixin), USP Leavenworth dispensed far more actual dosages per inmate per year (63.93 dosages) than the average of the three institutions (29.13), representing a utilization level 119.5 percent greater than the average of the three institutions. With the sole exception of sedatives, USP Leavenworth dispensed far more actual dosages per inmate per year in each of the control drug classifications (as well as in the case of Prolixin) than did the three institutions to which inmates requiring psychiatric care were assigned during the 3 year period: Prolixin (2100.0 percent more), hypnotics (991.7 percent more), antidepressants (264.2 percent more), major tranquilizers (293.1 percent more) and minor tranquilizers (98.1 percent more). In the case of sedatives, however, USP Leavenworth dispensed 31.2 percent less average dosages per inmate per year than did the three institutions.

TABLE 53.—COMPARISON OF "CONTROL" DRUG UTILIZATION BETWEEN 3 INSTITUTIONS TO WHICH INMATES REQUIRING PSYCHIATRIC CARE ARE ASSIGNED AND USP LEAVENWORTH, JULY 1, 1975, TO JUNE 30, 1978

Drug class	Average actual dosages per inmate per year			Average standard dosage units per inmate per year		
	3 Institutions ¹	USP Leavenworth	Percent difference	3 Institutions	USP Leavenworth	Percent difference
All control (except Prolixin).....	29.13	63.93	+119.5	44.36	127.49	+187.4
Minor tranquilizers.....	13.84	27.42	+98.1	19.29	47.89	+148.3
Major tranquilizers.....	7.52	25.50	+239.1	18.70	68.48	+266.2
Prolixin.....	.06	1.32	+2,100.0	.05	1.91	+3,720.0
Antidepressants.....	.67	2.44	+264.2	.67	2.44	+264.2
Hypnotics.....	.36	3.93	+991.7	.35	3.90	+1,014.3
Sedatives.....	6.74	4.64	-31.2	5.36	4.78	-10.8

¹ FCI Alderson, FCI Lexington and FCI Terminal Island.

When the measure of comparison between USP Leavenworth and the three institutions is stated in terms of standard dosage units dispensed per inmate per year, the difference in prescribing practices becomes even greater. With respect to all control drugs (except Prolixin), USP Leavenworth dispensed far more standard dosage units per inmate per year (127.49) than the average of the three institutions (44.36 dosages), representing a utilization level 187.4 percent greater than the average of the three institutions. Again, with the sole exception of sedatives, USP Leavenworth dispensed far greater standard dosage units per inmate per year in each of the control drug classifications (as well as in the case of Prolixin) than did the three institutions to which requiring psychiatric care were assigned during the 3 year period: Prolixin (3700.0 percent more), hypnotics (1014.3 percent more), major tranquilizers (266.2 percent more), antidepressants

(264.2 percent more) and minor tranquilizers (148.3 percent more). In the case of sedatives, USP Leavenworth dispensed 10.8 percent less standard dosage units per inmate per year than the average of the three institutions.

As previously indicated, an index of an institution's reliance on standard dosage units is the percentage change in the average number of dosages dispensed per inmate per year upon conversion from actual dosages to standard dosage units. Table 54 compares the average change in control drug dosages dispensed per inmate per year at the three institutions and USP Leavenworth upon conversion from actual to standard dosage units. With respect to all control drugs (except Prolixin), this conversion resulted in 99.4 percent more dosages dispensed per inmate per year at USP Leavenworth compared to a 52.6 percent increase in the average number of dosages dispensed by the three institutions to which inmates requiring psychiatric care were assigned during the 3 year period. These data indicate that USP Leavenworth relied more upon control drug dosages in strengths greater than the selected standard dosage units than did the three institutions. This pattern continues with respect to all control drug classifications with the exception of antidepressants where all four institutions relied upon the selected standard dosage unit. In the case of Prolixin and sedatives, the three institutions to which inmates requiring psychiatric care were assigned, relied upon actual dosage strengths below that of the standard dosage unit while USP Leavenworth relied upon actual dosage strengths greater than the standard dosage unit.

TABLE 54.—COMPARISON OF CONVERSION FROM ACTUAL TO STANDARD DOSAGE UNITS OF "CONTROL" DRUGS BETWEEN 3 INSTITUTIONS TO WHICH INMATES REQUIRING PSYCHIATRIC CARE ARE ASSIGNED AND USP LEAVENWORTH, JULY 1, 1975, THROUGH JUNE 30, 1978

Drug class	Percent change in dosages dispensed per inmate per year upon conversion from actual dosages to standard dosage units		Difference
	3 institutions ¹	USP Leavenworth	
All control (except prolixin).....	+52.6	+99.4	+46.8
Minor tranquilizers.....	+39.4	+74.7	+35.3
Major tranquilizers.....	+148.7	+168.5	+19.8
Prolixin.....	² -11.1	+44.7	+55.8
Antidepressants.....	0	0	0
Hypnotics.....	² -3.7	-.8	+2.9
Sedatives.....	-20.5	+3.0	+23.5

¹ FCI Alderson, FCI Lexington, and FCI Terminal Island

² Dispensed by 2 of the 3 institutions

The response of the Bureau of Prisons to the inquiry of the Select Committee also reveals a significant variation in the ratio of inmates to full-time medical staff at USP Leavenworth as compared to the three institutions to which inmates requiring psychiatric care were generally assigned during the 3 year period. The ratio of inmates to full-time medical staff was 682:1 at USP Leavenworth, while it was 194:1 at FCI Lexington, 251:1 at FCI Terminal Island and 281:1 at FCI Alderson. Although hardly conclusive, the data suggest that the medical staff at Leavenworth is over-burdened as compared to the three institutions and further suggests that the USP Leavenworth

medical staff may have responded to this situation by instituting a more liberal dispensing policy with respect to control drugs. This suggestion is perhaps further supported by the fact that actual dosages of control drugs constituted 92.8 percent of all drugs dispensed at USP Leavenworth, while they accounted for only 74.9 percent of all drugs dispensed at the three institutions to which inmates requiring psychiatric care were generally assigned. In terms of standard dosage units, control drugs accounted for 96.2 percent of all drugs dispensed at USP Leavenworth, compared to only 82.0 percent of all drugs dispensed at the three institutions.

Following the initial analysis of the data and after it appeared that USP Leavenworth was prescribing control-drugs far in excess of the levels utilized by any of the other four institutions, the Committee made the preliminary analysis available to the Bureau of Prisons for inspection. In response to questions raised by this data, the Bureau of Prisons Central Office undertook an on-site review of the use of specific medications at the USP Leavenworth hospital. The review concluded that "it is our opinion that these pharmaceuticals are being utilized within the parameters of acceptable medical practice."¹⁰ The review also noted that "all of the health records reviewed contained evidence of careful documentation concerning diagnosis for psychiatric conditions, treatment plans, prescription of medications, and medical surveillance and follow-up of medication reactions. In addition, we looked carefully for indications that certain medications might be used on an ad hoc basis solely for the purpose of controlling behavior, and found that in no instance were medications used in that manner. It was most apparent that when considering the current number of patients that were being treated on the days of our visit, and realizing that this current case load reflects the substantial decline in the institution's population, the medication utilization statistics were consistent with the data submitted to the House committee for the 3 year period requested (July 1975 to June 1978). Also, taking the modus operandi of the Leavenworth psychiatric service into consideration, the level of medication usage was in accord with the size of the psychiatric case load."

Unfortunately, the data used by the Select Committee is raw and rather inconclusive, at best. A more concrete determination on the basis of these data is impossible because of the broad flexibility ascribed to medical practitioners in the use of these drugs. Nonetheless, based on the data contained in this study, the above conclusions must be questioned with an eye toward a more complete evaluation by an independent authority.

Just as the data provide a basis for questioning the prescribing practices at USP Leavenworth, it also provides a basis to question these practices at FCI El Reno. In this regard, there is concern that in view of the extremely low level of control-drug utilization, whether inmates at this facility are being afforded adequate medical care.

On the basis of the data contained in this study, the conclusion can be reached that no or inadequate guidelines for the prescription utilization of scheduled (and some potent nonscheduled) drugs exist within the Bureau of Prisons. This potential lack of standards is partic-

¹⁰ The report of the on-site inspection of the USP Leavenworth facility is contained in Appendix E to this study.

ularly noticeable with respect to the control-drug classification. The Bureau of Prisons, in conjunction with the Public Health Service, should thoroughly review the prescribing practices at each of its institutions and formulate standards for the prescription dispensing of controlled substances as well as potent noncontrolled substances. Such a review should consider placing limitations on dosage strengths, the establishment of a central formulary and stock inventory, and the implementation of a centralized, on-going drug utilization model. In addition, this review should also consider the creation of a medical education program for physicians assigned to the prison setting.

The information collected in this study indicates that a review, independent of the Bureau of Prisons, of prescribing practices should be undertaken by a body of medical experts. The review could be conducted by the National Academy of Sciences, by a study similar to that accomplished on the Veterans Administration's hospital system.

APPENDIX A

U.S. GOVERNMENT MEMORANDUM

Date: 3/15/78.

From: L. G. Grossman, Warden, FCI, Terminal Island.

Subject: Drug Abuse Task Force.

To: Norman A. Carlson, Director Bureau of Prisons.

The following summary of recommendations is the result of the concerns of the Drug Abuse Task Force. The areas concentrated on are detailed in a full report.

Our charge included reviewing the quality of program offerings, staffing and integrity in management of resources.

Recommendations:

1. Alcohol Abuse, Clinical Abuse, NARA and Drug Abuse Units will be defined as Drug Abuse units.
2. Drug Abuse units continue to be provided funds for Operational and Consultant needs. Operational money is not to be spent only for services which cannot be provided by staff of the institution.
3. Consultants will be used in conjunction with a unit staff member.
4. Consultants may be used for training staff in various counseling techniques and modalities when institution or Bureau resources are not available.
5. Alcohol units and the Chemical Abuse units be included in the funding provided out of the existing Cost Center 317 budget.
6. Drug and Narcotics Surveillance program and testing for Alcohol Abuse be funded and managed under Cost Center 319.
7. For a Drug Abuse unit of 100 or less, the minimum staffing pattern will be: 1 Unit Manager; 1 Case Manager; 2 Correctional Counselors; 1 Clerk/Typist; 1 Psychologist; Part-Time Educational Representative; Correctional Officers on all shifts.
8. Under the supervision of the Unit Manager, the Unit Psychologist will coordinate the consultant activity in the unit and provide a well rounded program.
9. Minimal standards for all program involvement by unit staff will be established. (Described in Full Report)
10. There will be three phases of program involvement. The standard must have:
 - A. An Introductory/Opting Out Phase
 - B. Intensive Program Phase
 - C. Pre-Release Phase
 (See Full Report)
11. Establish a definite standard before an inmate can be considered as having completed a program or can be certified as completing the program. (See Full Report)
12. A system of data collection be established. (See Full Report)
13. Research projects relating to Drug Abuse will be approved prior to funding by the Unit Management Administrator, Central Office and the Research Director of the Bureau. Both will be responsible for signing for authorization of Drug Abuse funds used in research projects.
14. The research should be useful to management at all levels and written in non-technical terms.
15. The Bureau Research Department be responsible for establishment of liaison to the field for disseminating and interpreting Drug Abuse Research Information and Reports.
16. The data available in the Inmate Information System be made retrievable to the units by establishment of a unit code designation.
17. The Unit Manager monitor his program on a regular basis, using the internal audit.
18. The Regional Unit Management Administrator and Regional Psychology Administrator will audit each Drug Abuse program annually.

19. Drug Abuse/Alcohol Unit Managers will develop a training plan reflecting the specific type of training needs for staff which are necessary for the Drug/Alcohol unit.

20. A minimum standard of one (1) specialized training program be provided for each staff member in a Drug Abuse unit.

21. All staff in a Drug Abuse unit will complete a course in drug education.

22. Regional Directors will review positions in Drug Abuse units to see if positions are being used fully and that maximum productivity of program and operational standards are being achieved. The Regional Unit Management Administrator will present plans for bringing institutions which do not meet the minimum standard up to an acceptable level. In fiscal year 1979 high priority will be given to relocating positions where there is a need to meet the standards.

23. All institutions establish a Drug Abuse Unit. Positions should first be sought locally; with Regional Directors attempting to assist through reallocation of positions.

24. Funding for existing units not now having an adequate financial base will be through existing funds.

25. New Drug Abuse units will be implemented and financial resources distributed in the regions only when it is certified that the unit meets the basic standards which are set forth for Drug Abuse units.

26. Experimentation with different combinations e.g., Chemical Abuse/Substance Abuse will be encouraged.

REPORT OF THE DRUG ABUSE TASK FORCE

CONCERNS AND RECOMMENDATIONS

The Drug Abuse Task Force met in the central office conference room on January 31, 1978 through February 1, 1978, to review drug abuse/alcohol/chemical abuse. The main responsibilities of the Task Force were outlined in operations memorandum 8500.8, dated January 3, 1978. Director Norman A. Carlson met with the Task Force and related his concerns regarding the effectiveness of drug abuse units, the setting of standards for drug abuse units, staffing of drug abuse units and funding of drug abuse units. At the present time there are 26 drug abuse units in 21 institutions; five alcohol abuse units, and two chemical abuse units. These units provide direct services to inmates. Approximately 30 percent of the inmates in Bureau of Prisons institutions indicate having had a history of drug abuse.

Recommendation:

1. For the purpose of this Task Force reports alcohol abuse units; chemical abuse units; and NARA/DAP units will be considered under the inclusive designation as drug abuse units.

Funding of Drug Abuse Programs/Units

Concern: The Task Force is concerned about the allocation of drug abuse money. At the present time the drug abuse money is allocated from the central office to the regions to the local institutions. At the central office level the responsibility for allocating drug abuse monies lies with the chief of unit management. However, at the present time \$100,000 is taken out of the drug abuse funds for research purposes. The Task Force questions the use of these monies.

The local institution is allocated money for operational and consultant budgets in drug abuse units. There is a double funding issue involved in the operational aspects of drug abuse programs. Money allocated for drug abuse programs should be used directly for program purposes rather than purchasing equipment and services which are already taken care of in the institutional budget. At the present time there is a wide disparity in the use of drug abuse funds, and in some cases are used for other programs. It was felt that basic operational needs should be funded through the institutional M & O budget while consultants, testing, and training and inmate program needs money will be available to the unit manager out of the 317 budget.

Alcohol treatment programs are being carried on in five separate units in the Bureau of Prisons and two chemical abuse programs combine both drug abuse programs and alcohol programs. Funding for these alcohol programs has been difficult to maintain. For some time these programs were funded out of the 316 budget (psychological services) but when alcohol programs were switched to unit management no provision was made for funding for these programs.

The Bureau is involved in a random selection narcotics surveillance program consisting of urine analysis in all its institutions. Over and above this 5 percent sampling, drug abuse units have a higher rate of urinalysis sometimes resulting in as much as 20 percent sampling of their unit populations. Concern was expressed as to whether this could be carried on under the present policy, and where funding for this program would be provided. At the present time cost center 319 has been established for the drug abuse surveillance program. Future policy which is in the draft stage will reflect reporting procedures for the 5 percent category and for specialized testing of drug abusers.

Recommendations:

2. The drug abuse units be provided money for operational and consultant needs. Operational money is not to be spent on major equipment, basic institutional needs, or services provided elsewhere in the institution. Consultant money will be spent only for services which cannot be provided by staff of the institution.

5. Alcohol units and the chemical abuse units be included in the funding provided out of the existing cost center 317.

6. Drug and narcotics surveillance program and testing for alcohol abuse be funded and managed under cost center 319.

Staffing Patterns of Drug Abuse Units

Concern: Staffing patterns of drug abuse units vary throughout the Bureau of Prisons. This is usually dependent upon the degree of staffing conversion that was or can be made in the local institution. In the beginning of the NARA unit positions were available to establish well-staffed units. However, in the most recent months staffing patterns in drug abuse/alcohol units have required a much larger ratio of inmates to staff because of our overcrowded institutions. There should be a higher level of staffing in specialized program units which is needed to provide intensive unit programs. The following staffing pattern will be considered necessary to maintaining a quality type program in specialized units.

7. For a drug abuse unit of 100 or less, the minimum staffing pattern will be: 1 unit manager; 1 case manager; 2 correctional counselors; 1 clerk/typist; 1 psychologist; part-time educational representative; correctional officers on all shifts.

Additional staff will be added as number of inmates and intensity of program develops at a ratio of 1 case manager per 75 inmates and 1 correctional counselor per 40 inmates. Assignments to these special units will take into consideration staff training and interest in intensive treatment programs.

Utilization of Community Resources

Concern: It is recognized that there are certain types of programs and service which cannot be provided by regular institution staff. These must come from community resources. The major community resource available to the specialized unit (drug abuse or alcohol) is the consultant. Consultants have too often been used to supplement programs that should be provided by unit staff, and in some cases have taken over the responsibility of programs in drug abuse units. In these cases staff have often reverted back to a basic general operational type of posture in the units relinquishing the program responsibilities to the consultants. This creates many problems for the institution and avoids responsibilities which should be accepted and taken on by the staff.

Recommendations:

3. Consultants will be used in conjunction with a unit staff member.

4. Consultants may be used for training staff in various counseling techniques and modalities, when institution or Bureau resources are not available.

8. Under the supervision of the unit manager, the unit psychologist will coordinate the consultant activity in the unit and provide a well-rounded program.

Staff Responsibilities

Concern: Drug abuse units have been developed around the premise that a major part of the utilization of staff resources will be devoted toward programs and activities which impact upon the dependency needs and problems of the inmate involved. Expectations of staff members of specialized units have often not been defined at the central office regional or institutional level. Therefore, in many cases, the drug abuse unit or alcohol treatment unit has been little different in design or program from the general type units developed throughout unit management. To maintain integrity in these areas it becomes very necessary to establish standards for utilization of institutional staff and resources.

Recommendation:

9. The following is set forth as a minimal involvement in program areas for staff in specialized units.

A. The unit manager has administrative responsibility for the entire unit, its program, and staff.

B. The psychologist will be responsible for development, evaluation, and coordination of unit therapeutic and training programs. The Psychologist must have a minimum of two groups a week.

C. Each case manager in addition to case management responsibilities will be expected to conduct at least one group per week.

D. Each correctional counselor will have a minimum of two groups per week and will provide on-going contact with all assigned inmates in accordance with policy statement 7300.125, correctional counseling program.

E. The education representative will spend a minimum of 8 hours in unit-related responsibilities, data and expertise in developing the inmate's educational/vocational training program. The education representative will be a regular voting member of the unit team.

Program Components of Drug Abuse Units

Concern: One of the areas which has caused frequent difficulties in drug abuse unit programming has been the determination of exactly what the program should consist of. There are wide variations through the Bureau of Prisons regarding these programs. At the present time each manager has the option of developing his particular program. There is often confusion on the part of the inmate in knowing just what is expected of him for completion of a drug abuse program and similar confusion on the part of the staff regarding the things that should be placed in a particular program. The recommendations given below will set standards for program components.

Recommendation:

10. Every Unit must have three phases of program involvement.

A. Introductory and Opting Out Phase

- (1) An intensive orientation program to the unit and the institution.
- (2) Evaluation by the unit staff.
- (3) A drug education class which devotes time to explaining the different types of drugs and their effects upon the human body and mind.
- (4) Exposure to the different program modalities which are offered by the unit.
- (5) At least one group counseling meeting weekly.
- (6) At least a half-day work assignment while awaiting classification.

B. Intensive Programming Phase

- (1) A contractual agreement spelling out the things which the inmate and the staff have agreed upon as being effective approaches to the inmates' problems of dependency on alcohol or drugs.
- (2) There will be an identifiable unit program modality. Each unit will provide at least one major modality with options and alternatives for those inmates who find that they cannot accept or participate in the primary modality.
- (3) Group and individual counseling.
- (4) Classes or groups in personal development.
- (5) Psychotherapy—group or individual.
- (6) A unit narcotics and/or alcohol surveillance program.
- (7) Social skills development program.

C. Pre-Release Phase. Each unit will have a pre-release or community readiness program to provide continuity between unit program and community support services.

- (1) Appropriate aftercare information will be disseminated to the individual inmate, including:
 - a. A list of community resources.
 - b. Expectation of parole performance.
 - c. Listing of support groups in the community.
- (2) Aftercare will be recommended for inmates who have drug dependency problems and follow-up services provide for inmates with alcohol problems. Urine analysis/breathalyzer tests should be included in the program. Counseling, emergency services, job counseling, housing assistance and other assistance to meet the inmate's needs should be included.

(3) The aftercare contractor of follow-up service in the community should be invited and encouraged to come to the institution and meet with the inmate.

(4) The pre-release program is outlined in the unit management manual policy statement 8000.1, and aftercare manual, policy statement 8500.1.

Expectations of Inmates in Drug Abuse Units

Concern: The inmates in drug abuse units need to know what is expected in consideration for completion (certification) of the program.

Recommendation:

11. Establish a definite standard before an inmate can be considered as having completed a program or can be certified as completing the program. Such a standard should include, but is not limited to:

- A. An orientation period of at least 40 hours which has both individual and group orientation, fully documented in the inmate file.
- B. A minimum of 100 hours in counseling and/or psychotherapy.
- C. A demonstrated knowledge of drug information and its various problems and effects on body.
- D. A demonstrated pattern of good work habits.
- E. Good institutional adjustment.
- F. A demonstrated pattern of clean urine analysis.
- G. Completion of at least 40 hours in a pre-release program set up by the unit.
- H. Preparation for aftercare in the community.
- I. Work assignments—minimal of a half day.
- J. Recreation and/or leisure program within unit.
- K. Communication type meetings.
- L. Community involvement if appropriate to the institution.
- M. Inmate progress assessment.

Evaluation and Research

Concern: There should be an ongoing evaluation program within the unit which will evaluate program and inmate participation. Local program evaluation should give the institutional executive staff adequate information to assess whether the program is really accomplishing what it should. It should help the local DAP/NARA/alcohol abuse unit manager to determine whether his staff are carrying through with their responsibilities in counseling, program development operations and "treatment" of the drug/alcohol dependent inmate.

Recommendations:

12. A system of data collection be established which will show the following:
 - A. The number of inmates and months of post release success as reflected by unit assignments.
 - B. The institutional adjustment of inmates by units.
 - C. Comparison of units within institutions, institutions within regions; and regional priorities.
13. Research projects relating to drug abuse will be approved prior to funding by the unit management administrator, central office and the research director of the Bureau. Both will be responsible for signing for authorization of drug abuse funds used in research projects.
14. The research should be useful to management at all levels and written in non-technical terms.
15. The Bureau research department be responsible for establishment of liaison to the field for disseminating and interpreting drug abuse research information and reports.
16. The data available in the inmate information system be made retrievable to the units by establishment of a unit code designation.
17. The unit manager monitor his program on a regular basis, using the internal audit.
18. The regional unit management administrator and regional psychology administrator will audit each drug abuse program annually.

Staff Training

Concern: In order to develop and maintain viable drug abuse programs in the Bureau of training of staff is a necessity. Intensive type programs require training of staff to assure quality performance. This training should be over and above that which is presently provided by the Bureau for all of its employees.

Recommendations:

19. Drug abuse/alcohol unit managers will develop a training plan reflecting the specific type of training needs for staff which are necessary for the drug/alcohol unit.

20. A minimum standard of one (1) specialized training program be provided for each staff member in a drug abuse unit.

21. It is expected that all staff who work in a drug abuse unit will complete a course in drug education.

Implementation of Recommendations

Concern: It is a concern that implementation of the recommendations be done in order to restore and create integrity in the Bureau drug abuse program. The following recommendations are made to achieve this goal.

Recommendations:

22. The regional directors with the assistance of their regional administrator review positions in drug abuse units to see if positions are being used fully and that maximum productivity of program and operational standards are being achieved. The regional unit management administrator will present plans for bringing institutions which do not meet the minimum standard up to an acceptable level. The regional directors will give high priority in fiscal year 1979 to relocating positions where there is a need to meet the standards which are set forth.

23. All institutions establish a drug abuse unit. Positions should first be sought locally; with regional directors attempting to assist through reallocation of positions.

24. Funding for existing units not now having an adequate financial base will be through existing funds.

25. New drug abuse units will be implemented and financial resources distributed in the regions only when it is certified that the unit meets the basic standards which are set forth for drug abuse units.

26. Experimentation with different combinations e.g., chemical abuse/substance abuse will be encouraged.

Conclusion: The goal is to meet the needs of Bureau of Prisons inmates through providing such units and to maintain integrity, high standards and accountability in the drug abuse programs.

Drug abuse programs should be available to all offenders in the Bureau of Prisons.

The program must meet established standards and be evaluated through Bureau.

Staffing patterns and staff expectations must be standardized through Bureau. Inmates must be advised of their program responsibilities.

Research and evaluation must occur on an ongoing basis.

Present funding is adequate to support drug abuse/alcohol units.

APPENDIX B

AUDIT OF SCHEDULE 2, 3, 4, AND 5 DRUGS—FCI, ALDERSON

Units		Beginning stock, July 1, 1975	Plus purchases	Dispensed to outpatients	Dispensed to inpatients	Destroyed	Remarks	Ending stock, June 30, 1978
	Schedule 2:							
30 mg tablets	Codeine sulfate	1,000	2,000	775	100			2,125
Do	AP Codeine	400	4,000	3,300	400			700
50 mg tablets	Demerol hydrochloride	650	0	100	75			475
50 mg tubex	Demerol, injection	10	200	0	40			170
100 ml tubex	Demerol	90	250	0	250			90
15 ml tubex	Morphine injection	0	30	0	0			30
100 mg capsules	Sodium Seconal	500	0	0	0			500
	Schedule 3:							
100 mg capsules	Pentobarbital	500	0	0	0			500
100 ml injections	Sodium pentobarbital	90	0	0	0			90
5 mg	Amobarbital	7	0	0	1			6
	Schedule 4:							
130 mg ampules	Sodium phenobarbital	100	0	0	0			100
30 mg/7.5 cc	Phenobarbital elixir ¹	5,166	0	4,973	64			132
100 mg tablets	Darvon-N	8,500	0	2,727	850			4,923
100 mg tablets	Darvocet	6,000	0	1,749	840			3,411
5 mg tablets	Valium (diazepam)	6,500	1,450	2,763	3,687			1,500
10 mg tablets	Valium	3,000	2,500	2,091	1,409			2,000
10 mg	Valium injection	15	250	154	27			84
10 mg capsules	Librium	3,500	1,500	2,750	250			2,000
100 mg tablets	Darvon with aspirin	2,500	1,040	502	115			2,923
2.5 mg tablets	Schedule 5: Lomotil	3,000	1,500	3,000	500			1,000

¹ Converted from gross liquid amounts to dosages by committee staff.

CONTINUATION OF DRUG AUDIT—FCI, ALDERSON

	Beginning stock, July 1, 1975	Plus purchases	Dispensed to outpatients	Dispensed to inpatients	Destroyed	Remarks	Ending stock, June 30, 1978
Schedule 2: Preludin.....	0.....	0.....	0.....	0.....	0.....	0.....	0.
Unscheduled:							
Thorazine, 2 ml vial/25 mg per milliliter, 50 mg dose (average).....	163 vials.....	100 vials.....	Doses (41) 41 vials.	Doses (98) 98 vials.	0.....	0.....	124 vials.
Solution concentrate: Thorazine, 30 mg per milliliter, 60 mg equals 1 dose (average) 120 ml bottles—60 doses per bottle.....	50 bottles.....	96 bottles.....	Doses (3,540) 59 bottles.	Doses (2,280) 38 bottles.	0.....	0.....	49 bottles.
Solution concentrate: Stelazine, 2 oz bottle, 10 mg per milliliter, 30 ml per ounce (60 ml per bottle) 5 mg average dose, 120 doses per bottle.....	12 bottles.....	12 bottles.....	Doses (720) 6 bottles.	Doses (2,160) 18 bottles.	0.....	0.....	0.
Tablets: Tofranil, 25 mg tablets.....	1,300.....	2,500.....	250.....	0.....	0.....	0.....	3,550.

AUDIT OF SCHEDULE 2, 3, 4, AND 5 DRUGS—FCI, TERMINAL ISLAND

Units	Beginning stock, July 1, 1975	Plus purchases	Dispensed to outpatients	Dispensed to inpatients	Destroyed	Remarks	Ending stock, June 30, 1978
Schedule 2:							
100 mg.....	50	0	0	0			50
1.5 gr capsules.....	3,302	0	270	631			2,401
1/16 gr tubex.....	0	100	0	100			0
3/4 gr.....	14	0	0	0	14	(1)	0
30 mg.....	110	0	0	110			0
50 mg tubex.....	150	2,200	0	1,793			557
50 mg tablets.....	626	0	79	112			435
1/4 gr tablets.....	360	0	0	360			0
1/4 gr tubex.....	4	200	0	150			54
01 mg.....	404	0	34	170			200
02 mg per cc.....	18	0	8	10			0
2.5 gr tablets.....	62	600	0	360			302
Tablets.....	6	0	0	0	6	(1)	0
Injection.....	2,459	0	0	0	2,459	(1)	0
0.1 mg per injection.....	12	0	0	12			0
Do.....	20	60	0	33			47
3/4 gr.....	6	0	0	0	6	(1)	0
Schedule 3:							
30 mg tablets.....	800	5,200	1,364	2,118			2,518
5 mg.....	4	0	0	0	4	Outdated	0
0.2 mg.....	3	0	0	0	3	Outdated	0
15 mg.....	7	25	0	12			20
Cubic centimeter.....	6,320	0	0	0			6,320
50 mg tablets.....	0	9,000	2,912	340			5,748
Schedule 4:							
100 mg tablets.....	0	9,000	2,650	137			6,213
400 mg tablets.....	700	8,800	7,036	175			2,289
500 mg capsules.....	13	2,000	383	298			1,332
5 mg capsules.....	0	3,000	2,642	126			232
10 mg capsules.....	0	2,500	1,969	31			500
25 mg capsules.....	0	3,000	1,948	52			1,000
30 mg per 7.5 cc.....	2,016	3,025	4,937	104			0
1/4 gr tablets.....	4,000	12,000	15,598	402			0
30 mg tablets.....	80	0	38	5			37
3/5 gr.....	0	24,000	1,260	24			22,716
2 mg tablet.....	0	2,000	1,290	105			605
10 mg tablet.....	0	17,500	17,112.5	384			3.5
15 mg.....	0	530	228	50			252
15 mg capsules.....	0	500	0	0			500
30 mg capsules.....	0	1,500	525	246			729

¹ Outdated.

² Converted from gross liquid amounts to dosages by committee staff.

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CONTINUATION OF DRUG AUDIT—FCI, TERMINAL ISLAND

	Beginning stock, July 1, 1975	Plus purchases	Dispensed to outpatients	Dispensed to inpatients	Destroyed	Remarks	Ending stock, June 30, 1978
Schedule 2: Preludin.....	0.....	0.....	0.....	0.....	0.....	0.....	0.
Unscheduled:							
Solution concentrate: Thorazine, 100 mg per 1 ml 8 oz bottles, 30 ml equals 1 oz, 240 ml equals 1 bottle, 75 mg average dose; 320 doses per bottle.	10 bottles.....	98 bottles.....	Doses (13,440) 42 bottles.	Doses (9,600) 30 bottles.	0.....	0.....	36 bottles.
Thorazine, 25 mg per milliliter, 10 ml vials, 250 mg per vial, 100 mg average dose, 2.5 doses per vial.	10 vials.....	139 vials.....	0.....	Doses (305) 122 vials.	0.....	0.....	27 vials.
Thorazine, 50 mg tablets	1,000.....	3,000.....	1,000.....	1,000.....	0.....	0.....	2,000.
Stelazine, 10 mg per milliliter, 60 ml bottles, 600 mg per bottle, 5 mg average dose, 120 doses per bottle.	12 bottles.....	72 bottles.....	Doses (4,320) 36 bottles.	Doses (1,080) 9.	0.....	0.....	39 bottles.
Tofranil, 25 mg tablets.....	100.....	500.....	200.....	200.....	0.....	0.....	200.

CONTINUED

1 OF 2

AUDIT OF SCHEDULE 2, 3, 4, AND 5 DRUGS—U.S. PENITENTIARY, LEAVENWORTH

Units	Beginning stock, July 1, 1975	Plus purchases	Dispensed to outpatients	Dispensed to inpatients	Destroyed	Remarks	Ending stock, June 30, 1978
Schedule 2:							
2.5 gr tablets	Cocaine HCL	460	0	0	260		200
0.5 gr tablets	Codeine sulfate, H.T	200	5,700	0	3,500		2,400
0.5 gr tablets	Codeine sulfate, oral	678	0	0	20		658
1.5cc liquid (7.5 mg)	Demerol ¹	4,000	800	0	3,200		1,600
.25 gr tablets	Morphine sulfate	1,500	0	0	260		1,240
3.75 gr ampules	Sodium Amytal	75	0	0	0		75
1.5 gr capsules	Sodium pentobarbital	1,000	2,600	0	1,600		2,000
Schedule 3:							
1 gr ampules	Sodium pentothal	27	0	0	1		26
50 mg tablets	Fiorinal	3,000	3,000	1,000	2,000		3,000
Schedule 4:							
500 mg per 5cc	Chloral hydrate ¹	2,112	18,528	0	20,160		480
500 mg capsules	do	0	11,100	0	9,100		2,000
10 mg capsules	Librium	5,500	0	1,500	0		4,000
25 mg capsules	do	5,500	0	900	100		4,500
30 mg per 7.5cc	Phenobarbital elixir ¹	4,096	25,600	23,040	5,120		1,536
2 gr ampules	Sodium phenobarbital	150	450	0	300		283
5 mg tablets	Vallium (diazepam)	15,000	36,000	33,000	8,300	17 (*)	10,000
10 mg tablets	do	33,500	93,000	102,500	20,500		3,500
10 mg ampules	do	210	600	0	590	80 (*)	140
7.5 mg tablets	Tranxene	0	1,302	0	1,000		302
22.5 mg tablets	do	0	700	0	264	416 (*)	20
100 mg tablets	Darvon-N	0	19,259	5,759	4,000		9,500
50 mg tablets	Darvocet-N	0	2,612	2,612	0		0
100 mg tablets	do	0	12,000	2,500	0		9,500
2.5 mg	Schedule 5: Lomotil	1,000	7,000	5,000	500		2,500

¹ Converted from gross liquid amounts to dosages by committee staff.
² See note bottom of table 45.

³ Outdated.

CONTINUATION OF DRUG AUDIT—USP; LEAVENWORTH

	Beginning stock, July 1, 1975	Plus purchases	Dispensed to outpatients	Dispensed to inpatients	Destroyed	Remarks	Ending stock, June 30, 1978
Schedule 2: Preludin.....	0	0	0	0	0	0	0
Unscheduled:							
Thorazine, 25 mg. per 1 milliliter, 50 mg. average dose, 5 doses per bottle, 10 ml. bottles.	30 bottles	144 bottles	Doses (30) 6 bottles.	Doses (555) 11 bottles.	10 bottles	Expired	47 bottles.
Solution concentrate: Thorazine, 100 mg per 1 milliliter, 8 oz bottles, 30 milliliter, equals 1 oz, 240 milliliter equal 1 bottle, 50 mg average dose, 480 doses per bottle.	42	296	Doses (91,200) 190	Doses (43,200) 90	3	Broken	55.
Stelazine 5 mg tablets.....	0	3,000	0	0	0	0	1,000.
Stelazine, 2 mg per milliliter, 10 milliliter bottle, 20 mg per bottle, 10 mg average dose, 2 doses per bottle.	29 bottles	120 bottles	Doses (40) 20 bottles.	Doses (120) 60 bottles.	0	0	69.
Solution concentrate: Stelazine, 10 mg per milliliter, 60 milliliter bottle equal 600 mg, 15 mg average dose, 40 doses per bottle.	40	564	Doses (14,400) 361	Doses (4,840) 121	1	Broken	121.
Stelazine, 2 mg tablets.....	0	3000	0	0	0	0	3,000.
Tofranil, 25 mg tablets.....	1,000	18,000	12,000	3,000	0	0	4,000.

AUDIT OF SCHEDULE 2, 3, 4, AND 5 DRUGS—FCI, EL RENO

[Note: It is local policy at the El Reno health facility to only dispense schedule 2 drugs to inpatients. If a patient requires a schedule 2 drug he is admitted as an inpatient.]

Units	Beginning stock July 1, 1975	Plus purchases	Dispensed to outpatients	Dispensed to inpatients	Destroyed	Remarks	Ending stock June 30, 1978
Schedule 2:							
2 cc ampules.....	Innovar.....	5	54	0	5		30
1.5 gr tablets.....	Amytal.....	500	0	0	0	(1)	0
4. gr ampules.....	do.....	3	0	0	500	(1)	0
15 gr ampules.....	do.....	1	0	0	3	(1)	0
3 gr capsules.....	do.....	150	0	0	0	(1)	0
30 mg tablets.....	Codeine.....	200	0	0	0	(1)	0
60 mg tablets.....	do.....	100	0	0	150	(1)	0
50 mg tablets.....	Demerol.....	269	0	0	12		200
50 mg ampules.....	do.....	150	400	0	85		88
75 mg ampules.....	do.....	100	100	0	475		184
100 mg ampules.....	do.....	100	100	0	175		75
100 mg tublex.....	do.....	20	300	0	275		25
50 mg cc vial.....	do.....	2	0	0	0		125
2 cc ampules.....	Sublimazo.....	7	5	0	3	(1)	0
1/2 gr tablets.....	Morphine.....	100	24	0	23		4
15 mg per cc syringe.....	do.....	9	0	0	0	(1)	0
100 mg capsules.....	Nembutal (pentobarbital).....	280	0	0	1	(1)	0
100 mg ampules.....	do.....	18	50	0	140		8
250 mg ampules.....	do.....	17	0	0	0	(1)	0
100 mg capsules.....	Seconal.....	107	0	0	0	(1)	50
Schedule 3:							
50 mg tablets.....	Florinal.....	0	5,000	2,225	50		2,725
0.5 gr tablets.....	APC with Codeine.....	1,728	6,000	1,420	486		3,250
50 mg capsules.....	Duragasic.....	140	0	11	0	(2)	128
500 mg vial.....	Penthotal.....	2	25	0	0	(1)	16
5 gr tablets.....	Wans suppositories.....	0	160	0	9	(1)	180
12.5 ml.....	Tylenol with Codeine.....	923	2,000	1,097	776		1,050
15 ml.....	Tylenol elixir.....	0	19	0	19		0
	Paregoric liquid.....	438	0	7	0		431

AUDIT OF SCHEDULE 2, 3, 4, AND 5 DRUGS—FCI, EL RENO—Continued

[Note: it is local policy at the El Reno health facility to only dispense schedule 2 drugs to inpatients. If a patient requires a schedule 2 drug he is admitted as an inpatient.]

Units	Beginning stock July 1, 1975	Plus purchases	Dispensed to outpatients	Dispensed to inpatients	Destroyed	Remarks	Ending stock June 30, 1978
Schedule 4:							
2 mg tablets.....	Valium.....	500	0	0	0		500
5 mg tablets.....	do.....	550	2,500	1,750	200		1,100
10 mg tablets.....	do.....	400	3,000	2,875	25		500
10 mg capsules.....	do.....	30	20	1	18	23 (1)	8
5 mg per cubic centimeter.....	do.....	2	0	0	2		0
5 mg capsules.....	Librium.....	122	0	0	122		0
10 mg capsules.....	do.....	817	0	0	0		817
25 mg capsules.....	do.....	900	0	130	112		65
500 mg liquid.....	Chloralhydrate.....	0	800	8	50		742
30 mg per 7.5 cubic centimeter.....	Phenobarbital elixir ¹	512	2,506	1,376	64		1,632
5 gr ampules.....	Phenobarbital.....	18	0	0	0	18 (2)	0
2 gr ampules.....	do.....	1	0	0	0		1
15 mg tablets.....	do.....	1,400	0	0	0		1,400
30 mg tablets.....	do.....	12,620	1,500	10	0	12,620 (2)	1,490
Grain.....	Phenobarbital powder.....	29.5	0	0	29.5		0
1 gr.....	Phenobarbital unit dose liquid.....	200	0	110	0		90
Tablets.....	Phenobarbital and Belladonna.....	2,500	0	0	0	2,500 (2)	0
100 mg capsules.....	Eskabarb.....	100	0	0	0		100
7.5 mg capsules.....	Tranxene.....	0	2,000	1,348	0		652
400 mg tablets.....	Meprobamate.....	150	1,000	89	0		1,061
Milliliter.....	Codeine antitussive elixir.....	1,500	0	0	0		1,500
32 mg capsules.....	Darvon.....	272	0	0	0	272 (2)	0
65 mg capsules.....	do.....	390	0	0	0	390 (2)	0
65 mg capsules.....	Darvon compound.....	111	0	0	20	91 (2)	0
100 mg tablets.....	Darvon-N.....	694	1,500	690	29		1,475
100 mg tablets.....	Darvon-N with aspirin.....	433	0	55	0	378 (2)	0
5 gr vials.....	Brevital.....	1	0	0	0	1 (2)	0
Schedule 5:							
Tablets.....	Bismuth, Pectin, and Paregoric.....	0	200	0	0		200
5 mg tablets.....	Lomotil.....	500	1,000	226	24		1,250

¹ Outdated.

² Destroyed, Outdated—1,000 trns. to Lompoc; 1,000 trns. to Texarkana.

³ Converted from gross liquid amounts to dosages by committee staff.

CONTINUATION OF DRUG AUDIT—FCI, EL RENO

	Beginning stock, July 1, 1975	Plus purchases	Dispensed to outpatients	Dispensed to inpatients	Destroyed	Remarks	Ending stock, June 30, 1978
Schedule 2: Preludin.....	0	0	0	0	0	0	0
Unscheduled:							
Thorazine, 50 mg tablets.....	1,000	4,500	3,375	1,125	0	0	1,000
Spansule: Thorazine, 150 mg spansules.....	273	0	30	68	0	0	175
Thorazine, 2 ml vial, 25 mg per milliliter, 50 mg average dose.....	75 vials	100 vials	25 vials	60 vials	0	0	90 vials
Stelazine, 1 mg tablets.....	500	0	0	0	0	0	500
Stelazine, 2 mg tablets.....	500	0	244	82	0	0	174
Tefranil, 25 mg tablets.....	273	100	135	38	0	0	200

AUDIT OF SCHEDULE 2, 3, 4, and 5 DRUGS—FCI, LEXINGTON

Units	Beginning stock, July 1, 1975	Plus purchases	Dispensed to outpatients	Dispensed to inpatients	Destroyed	Remarks	Ending stock, June 30, 1978
Schedule 2:							
30 mg 5 cc.....	Codeine phosphate elixir.....	6,000	13,000	15,715	2,825		1,000
30 mg per dose.....	Codeine, injection.....	240	70	0	310		0
10 mg capsules.....	Dextroamphetamine.....	0	650	550	0		100
0.1 mg.....	Fentanyl, injection.....	84	250	0	294		40
2 mg.....	Hydromorphone, injection.....	0	180	0	70		110
4 mg tablets.....	Hydromorphone.....	13	600	438	25		150
50 mg.....	Moperidine, injection.....	448	500	0	848		10
75 mg.....	do.....	290	300	0	400		190
100 mg.....	do.....	218	100	0	230		88
5 mg per 5 cc.....	Methadone elixir.....	4,250	0	1,050	500		2,700
10 mg per 5 cc.....	do.....	13,500	0	1,050	300		12,200
8mg.....	Morphine, injection.....	420	120	0	490		50
10 mg.....	do.....	370	1,700	0	1,950		120
15 mg.....	do.....	190	140	0	230		100
100 mg per 5 cc.....	Pentobarbital Elixir.....	2,075	0	0	50		2,025
Schedule 3:							
500 mg.....	Thiopental, injection.....	0	400	0	375		25
5 mg per 5 cc.....	Paregoric.....	480	100	20	60		500
Schedule 4:							
500 mg per 10 cc.....	Chloral hydrate.....	860	400	350	420		490
10 mg capsules.....	Chlordiazepoxide.....	1,410	12,000	6,582	840		5,988
25 mg capsules.....	do.....	1,350	1,000	1,428	60		862
10 mg injection.....	Valium (diazepam).....	88	170	0	242		16
2 mg tablets.....	do.....	975	500	983	125		367
5 mg tablets.....	do.....	2,375	38,000	22,303	7,025		11,047
10 mg tablets.....	do.....	125	29,000	17,210	4,000		7,915
400 mg tablets.....	Meprobamate.....	2,109	8,000	4,592	800		4,717
20 mg per 5 cc.....	Phenobarbital elixir.....	3,080	27,400	22,660	2,480		5,340
16 mg tablets.....	Phenobarbital.....	1,227	0	934	0		293
32 mg tablets.....	do.....	1,545	0	597	0		948
100 mg tablets.....	do.....	53	2,330	1,738	150		495
100 mg tablets.....	Propoxyphene.....	6,787	18,000	13,585	2,825		3,377
2.5 mg tablets.....	Schedule 5: Diphenoxylate with atropine.....	1,230	4,600	2,999	200		2,631

CONTINUATION OF DRUG AUDIT—FBI, LEXINGTON

	Beginning stock July 1, 1975	Plus purchases	Dispensed to outpatients	Dispensed to inpatients	Destroyed	Remarks	Ending stock, June 30, 1978
Schedule 2: Preludin.....	0.....	0.....	0.....	0.....	0.....	0.....	0.
Unscheduled:							
Inj. capsule: Thorazine, 50 mg ampule.....	290.....	0.....	0.....	75.....	0.....	0.....	215.
Solution concentrate: Thorazine, 100 mg per milliliter, 240 ml equals 1 bottle (8 oz) 5 ml equals 1 dose (50 mg) 480 doses per bottle.	89 bottle.....	0.....	Doses (16,800) 35 bottles.	Doses (2,400) 5 bottles.	0.....	0.....	49.
Tablets: Thorazine:							
25 mg.....	740.....	0.....	45.....	0.....	0.....	0.....	695.
50 mg.....	890.....	0.....	50.....	0.....	0.....	0.....	840.
100 mg.....	175.....	0.....	25.....	0.....	0.....	0.....	150.
200 mg.....	100.....	0.....	0.....	0.....	0.....	0.....	100.
Solution: Stelazine, 10 mg per milliliter, 60 ml equals 1 bottle, 4 mg average dose, 600 mg per bottle, 150 doses per bottle.	4.....	4.....	Doses (900) 6.....	Doses (300) 2.....	0.....	0.....	0.
Tablets: Stelazine, 2 mg tablets.....	230.....	0.....	80.....	0.....	0.....	0.....	150.
Tablets: Tofranil, 25 mg tablets.....	1,000.....	5,000.....	4,000.....	1,000.....	0.....	0.....	1,000.

APPENDIX C

Fluphenazine (Prolixin) is a major tranquilizer of the phenothiazine class of which Stelazine is probably the best known. It has the highest milligram potency of the group, with 2 mg of the oral form being therapeutically equivalent to 100 mg of Thorazine.

Given intramuscularly or subcutaneously to adults under age 50, the typical dose would be 12.5 mg initially and 25 mg every 2 weeks thereafter. Close supervision and individualization of dosage is mandatory when the drug is administered in this form. In its oral form Prolixin is initially given in 2.5 mg to 10 mg doses with the amount reduced gradually to 1 mg to 5 mg daily; however, doses in excess of 3 mg are rarely necessary.

The drug is used in the management of outpatient schizophrenics with a history of poor medical cooperation or frequent relapses. Like all drugs of its class, Prolixin may cause side effects which are difficult to control and for which the patient must be carefully monitored.

Fluphenazine (Prolixin) was dispensed by the five institutions in the following strengths:

TABLE C-1.—FLUPHENAZINE (PROLIXIN)

Institution	Dosage strength					
	2.5 mg (tablet)	2.5 mg (injection)	5 mg (tablet)	15 mg (injection)	25 mg (injection)	35 mg (injection)
FCI Alderson.....						
FCI Terminal Island.....	0	X				
USP Leavenworth.....			0	X		X
FCI El Reno.....					0	
FCI Lexington.....					0	

Note: A dosage strength which is circled (O) indicates the most frequently prescribed strength at a particular institution.

The standard dosage units selected for fluphenazine (Prolixin) are 3 mg in the tablet or oral form, and 25 mg for injections.

As indicated in table C-2, the utilization of Prolixin varied significantly between the five institutions. The average number of actual dosages dispensed per inmate per year by the five institutions ranged from a low of no utilization (FCI Alderson) to a high of 1.32 dosages (USP Leavenworth). The remaining three institutions dispensed this drug as follows: 0.13 dosages (FCI Terminal Island), 0.05 (FCI Lexington), and 0.03 (FCI El Reno).

TABLE C-2.—BUREAU OF PRISONS: DISTRIBUTION OF ACTUAL DOSAGES OF FLUPHENAZINE (PROLIXIN) AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—						Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients		Total dispensed		
	Number	Percent	Number	Percent	Number	Percent	
FCI Alderson.....	0		0		0		0
FCI Terminal Island.....	406	100.0	0	0	406	100	.13
USP Leavenworth.....	4,085	50.4	4,022	49.6	8,107	100	1.32
FCI El Reno.....	10	9.6	94	90.4	104	100	.03
FCI Lexington.....	100	71.4	40	28.6	140	100	.05

In terms of standard dosage units dispensed per inmate per year, the average number of dosages ranged from a low of no utilization (FCI Alderson) to a high of 1.91 dosages (USP Leavenworth). The remaining three institutions dispensed fluphenazine (Prolixin) as follows: 0.11 dosages (FCI Terminal Island), 0.05 dosages (FCI Lexington), and 0.03 dosages (FCI El Reno). This data is illustrated in table C-3.

TABLE C-3.—BUREAU OF PRISONS: DISTRIBUTION OF STANDARD DOSAGES OF FLUPHENAZINE (PROLIXIN) AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Dispensed to—				Total dispensed		Average actual dosages dispensed per inmate per year
	Inpatients		Outpatients		Number	Percent	
	Number	Percent	Number	Percent			
FCI Alderson.....	0		0		0		0
FCI Terminal Island.....	334	100.0	0	0	100	100	.11
USP Leavenworth.....	5,182	44.3	6,528	55.7	11,710	100	1.91
FCI El Reno.....	10	9.6	94	90.4	104	100	.03
FCI Lexington.....	100	71.4	40	28.6	140	100	.05

The conversion from actual dosages dispensed to standard dosage units dispensed resulted in a decrease in dosages dispensed at FCI Terminal Island (-15.4 percent) and an increase at USP Leavenworth (+44.7 percent). This indicates that FCI Terminal Island utilized Prolixin in dosage strengths below the selected standard dosage unit while USP Leavenworth relied on dosage strengths in excess of the standard dosage unit. No change in the level of dosages occurred at FCI El Reno or FCI Lexington, indicating that these institutions relied on the standard dosage unit. FCI Alderson did not dispense Prolixin during the 3-year period. This data is reflected in table C-4.

TABLE C-4.—BUREAU OF PRISONS: PERCENT CHANGE IN DOSAGES OF FLUPHENAZINE (PROLIXIN) DISPENSED PER INMATE PER YEAR BY CONVERSION FROM ACTUAL DOSAGES TO STANDARD DOSAGE UNITS AT 5 INSTITUTIONS, JULY 1, 1975, THROUGH JUNE 30, 1978

Institution	Average dosages dispensed per inmate per year		Percent change
	Actual	Standard	
FCI Alderson.....	0	0	0
FCI Terminal Island.....	.13	.11	-15.4
USP Leavenworth.....	1.32	1.91	+44.7
FCI El Reno.....	.03	.03	0
FCI Lexington.....	.05	.05	0

The percentage distribution of fluphenazine (Prolixin) between inpatients and outpatients varied among for four institutions reporting utilization of this drug. In terms of actual dosages dispensed, FCI El Reno dispensed the most to outpatients (90.4 percent) while FCI Terminal Island dispensed all fluphenazine (Prolixin) to inpatients. USP Leavenworth dispensed this drug almost equally between inpatients and outpatients while outpatients received 28.6 percent at FCI Lexington (see table C-2). In terms of standard dosage units no change occurred in the distribution between inpatients and outpatients except in the case of USP Leavenworth. The conversion resulted in outpatients receiving 55.7 percent of all fluphenazine (Prolixin), representing an increase of 6.1 percent at USP Leavenworth (see table C-3).

The following data was supplied by the Bureau of Prisons relative to the utilization of fluphenazine (Prolixin) at the five institutions during the 3-year period covered in this study:

DRUG AUDIT CONTINUATION—SPECIAL REPORT ON UTILIZATION OF PROLIXIN (FLUPHENAZINE), UNSCHEDULED

Units	Beginning stock, July 1, 1978	Plus purchases	Dispensed to outpatients	Dispensed to inpatients	Destroyed	Remarks	Ending stock, Mar. 2, 1979
FCI, ALDERSON							
Prolixin 1 milliliter (ml) cartridge (25 mg per milliliter)	10 cartridges (250 mg)	0	0	0	0	In stock as of July 1978.	10 cartridges (250 mg)
Prolixin Elixir 473 ml bottles 1/2 mg per milliliter = 236.5 mg per bottle.	6 bottles (1,419 mg)	0	0	0	0	do.	6 bottles (1,419 mg)
Tablets 2.5 mg in 500 sized bottles	2 bottles	0	0	0	0	do.	2 bottles (1,000 tablets)
Tablets 5 mg in 500 sized bottles	2 bottles (1,000 tablets)	0	0	0	0	do.	Do.
Vials 10 ml 25 mg per vial	5 vials (125 mg)	0	0	0	5 vials (125 mg)	Outdated. Received with a short expiration date from the supply source.	0.
FCI, EL RENO							
Standard 25 mg dose syringe administered on the average of 1 every 3 weeks.	7 syringes (175 mg)	100 syringes (2,500 mg)	94 syringes (2,350 mg)	10 syringes (250 mg)	0	Average dose 25 every 3 weeks via syringe.	3 syringes (75 mg)
USP, LEAVENWORTH							
Injection, 5 ml bottles, 25 mg per milliliter, 1 bottle equals 125 mg.	27 bottles (3,375 mg)	430 bottles (53,750 mg)	184 bottles (23,000 mg) or 657 doses (average dose 35 mg)	183 bottles (22,875 mg) or 1,525 doses (average dose 15 mg)	20 bottles (2,500 mg)	Outdated. Note: Injections given on average of 1 for 2 weeks.	70 bottles (8,700 mg)
Oral liquid pint bottle 473 ml, 1/2 mg per milliliter equals 237 mg per bottle.	6 bottles (1,422 mg)	130 bottles (30,810 mg)	71 bottles (16,827 mg) (average dose 5 mg) 3,365 doses.	54 bottles (12,798 mg) (average dose 5 mg) 2,560 doses.	0		11 bottles (2,607 mg)
FCI, LEXINGTON							
Injection, 5 ml vial, 25 mg per milliliter equals 125 mg per vial.	20 vials (2,500 mg)	30 vials (3,750 mg)	8 vials (1,000 mg) (average dose 25 mg) 40 doses.	20 vials (2,500 mg) (average dose 25 mg) 100 doses.	15 vials (1,875 mg)	Outdated. Average doses given at 1 injection per week (25 mg).	7 (875 mg)
FCI, TERMINAL ISLAND							
Injection, 30 ml vial, 215 mg equals 1 ml, 750 mg per vial.	4 vials (3,000 mg)	0	0	0; 6 injections of 2.5 mg (6 doses).	All existing vials	Stock reached expiration date. Received with a short expiration date from supplier.	0.
Tablets, 2.5 mg per tablet. 500 tablets per bottle.	4 bottles (2,000 tablets)	0	0	400 tablets (1,000 mg)	0		1,000 tablets.
Liquid concentrate 120 ml per bottle, 2.5 mg per 5 ml.	4 bottles (96 mg)	0	0	0	0		4 bottles (96 mg)

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APPENDIX D

This appendix consists of communications from Federal prisoners incarcerated at USP Leavenworth concerning the alleged abuse of psychotropic substances and other drugs by personnel at that institution.¹

APRIL 27, 1979

DEAR SIR: We, the undersigned, are writing this letter in an attempt to end the continual forced drugging with Prolixin and other psychotropic drugs being administered to us. We've each submitted individual affidavits to the National Prison Project concerning this practice. We hope that you . . . can do something to end this prolonged physiological and psychological torture.

The Leavenworth prison authorities utilize widespread forced drugging for completely inappropriate reasons; it could be fairly viewed as a preventive detention measure utilizing chemical strait jackets. Many of us haven't *done* anything contrary to their rules and regulations, but they seem to feel we *might* disobey orders (emphasis in original). It was used on at least one of us—in lieu of proper medical treatment—when he complained of an ear infection and asked to be excused from work.

Some of us have tried to physically resist the injections—believing it inherently unjust to be given dangerous medication for certified psychotics when we're not psychotic—only to be assaulted by their "goon squad," beaten, held down, injected with Prolixin and confined in the neuropsychiatric ward. Some are resigned to our fate and regard it as futile to resist this mad technototalitarianism. We merely acquiesce to their demands and take our periodic injections quietly.

Some of the effects of these injections are persistent restlessness, characterized by the need to keep moving continuously (even to shuffling back and forth from one foot to the other); inability to concentrate; insomnia; torpor; inability to read; blurred vision; constipation; nightmares; depression; anxiety; and a bleak despairing outlook for one's future. It is indeed a persistent torture difficult to describe.

Since legal remedies through the courts in this area are usually perfunctorily dismissed or take years to be processed, we appeal to you as a "Court of Last Resort" to please help us stop this chemical violation of our rights.

Very truly yours,

[Signed and endorsed by 14 prisoners]

APRIL 24, 1979.

GREETINGS Mr. ———: I am a Federal prisoner at Leavenworth, Ks. serving a 12 year sentence. I have been in prison 4 years and at Leavenworth for 3 years. In this time, I have observed numerous cases of Federal prisoners being subjected to illegal and unethical practices by Federal authorities, with the ultimate control measure being "Chemotherapy," namely Thorazine and Prolixin.

While it is true that the most common form of controlling "unruly prisoners" is the use of the "Strip Cell", the more insidious and dangerous is the forced and coerced drugging of prisoners, most notably at Springfield Medical Facility in Missouri and at the Leavenworth Penitentiary at Kansas.

If you think I am overstating the case, then I challenge you or any progressive and aggressive reporter to try to inspect the Mental Health section of this prison and try to interview the psychiatrist or a few prisoners. You will find it nearly impossible. When a public institution is closed to the public and the light of the press is shut out, the greater the danger of atrocity being carried out in the name of public welfare.

¹ These communications, originals or copies of which are in the possession of the Select Committee, were either addressed to the Committee or brought to the attention of the Committee by third parties. To insure the confidentiality of these communications the names of the writer, addressee, and other persons referred to in the text have been omitted.

At other Federal institutions, the threat of confinement in segregation (some aspects of which resemble the conditions of the strip cell), is the greatest means of controlling prisoners. If this is not sufficient, one will be transferred to a more "secure" prison, such as Marion, Ill., where the infamous "Long Term Control Unit" was first unveiled. This Control Unit has been the subject of court suits since 1973. In that time, other Federal institutions have opened similar units, where the prisoners are held in isolation for 23½ hours a day. Some people may not see this as being barbaric but that's probably because they've never been subjected to it. Animals in a zoo are treated more humanely.

It is in the realm of "drug therapy" that the Bureau of Prisons outdoes itself, in my opinion. I don't know if you're familiar with the drugs Thorazine and Prolixin, but here's a little information: they are called "antipsychotic" drugs, and are two of the most popular tranquilizers used here to control behavior and have the heaviest effects. Thorazine is usually given orally once, twice or even thrice a day. It causes one to lose coherent thinking, physical sluggishness, loss of appetite, weight gain; in short causing a zombie-like condition. There are other effects, including a form of brain damage called "tardive dyskinesia" (late occurring abnormal muscle movements) with prolonged use.

At Leavenworth, these drugs and others are given to prisoners by force and through coercion, under a program in the prison hospital. These prisoners are, for the most part, released to the general population under the control of these drugs, (although they are periodically taken out of the population for "check-ups" in the mental ward AKA "behind the green door").

As far as we can ascertain, Leavenworth is the only prison in the Federal system that has such a program on this scale and it is highly unusual to find so many people on these unsafe and largely experimental drugs within the general population. The usual place for prisoners with alleged "mental disorders" is the Springfield facility. Leavenworth seems to have its own version, unofficially.

The forced and coerced druggings are for the most part punitive rather than therapeutic treatment. When a prisoner is targeted for drug therapy, he will be visited by the psychiatrist and given a choice: stay in segregation or the mental ward or "voluntarily" accept the drugs. That there is intimidation and coercion as essential elements of this program can be seen in the statements of the prisoners themselves and in the process by which drugs are administered. Within one week's time, jailhouse lawyers gathered affidavits from a dozen prisoners who are on the drugs against their will and want to help to be taken off. There are more who want off but fear the retribution too much to sign statements unless they see some support or help from outside the walls. These affidavits have been forwarded to an attorney for the National Prison Project . . . but I'd like to share some excerpts from them with you.

" . . . When I first came here, I went to see [the] psychiatrist [name omitted]. I explained to him my problem of being afraid to be confined within the walls . . . he locked me up in the hospital strip cell. There I was confined for nine weeks, naked, with only a mattress and blanket. After nine weeks, [a doctor] talked to me; he diagnosed my problem and recommended Prolixin. Two hours later, an MTA came to give me some Prolixin; I refused to take it. He summoned reinforcements. Two guards and another MTA arrived. They held me down while the MTA shot me . . . Presently, I've been on Prolixin since Nov., 1976 . . . it makes me feel lousy, jittery, and want to lay down but not sleeping. My weight has increased 45 lbs. . . .

" . . . the [psychiatrist] put me on Prolixin and had me locked in the hospital, in a strip cell for fifteen days and in the hospital ward for thirty days. [The psychiatrist] said I had to take Prolixin for one year. He stated that if I didn't he would not allow me to go to population, that I would be kept in the hospital until I agreed to take Prolixin. I have to take [this drug]—50 milligrams—once every two weeks . . .

" . . . At the present time I have been on Prolixin for 1½ years. The affects it has on me is like being on a cliff, on the edge, and feel like I'm going to fall . . . No matter how cold it is, I'm always perspiring . . . I hope that by me doing this affidavit won't make things worse for me. I want to help get off this stuff, but I don't want these people to hurt me more.

" . . . I was taken to the hospital and placed into the strip cell. Immediately I was given some drugs, Thorazine, by the MTA. . . I was confined to the strip cell for two weeks, each day I was given a dose of Thorazine. On the last day, I was seen by [the psychiatrist]. He told me that I [had] schizophrenia and gave me a dose of Prolixin before he released me to the population (50 milligrams was the

dosage he gave me). He told me that I would receive an injection once every two weeks for a year . . .

" . . . I receive 25 milligrams of Prolixin, injected by a syringe every two weeks. The side effects give me muscle spasms, cause my eyes and nose [to run], loss of appetite, and loss of sleep . . . I was placed in the prison hospital for six months because of the side effects, causing me to vomit and [my] stomach to swell. I want to get off, please help me!"

These prisoners are not "mental patients" they are prisoners in a penal institution and they are crying out for help. It is little understood by the general public how much and how easily those behind bars are abused and experimented on. I write this letter in the hope that you will not abandon your effort to write your story; I implore you to do what you can to bring some light into the dungeons.

Sincerely,

[name omitted]

AFFIDAVIT

COUNTY OF LEAVENWORTH,
State of Kansas.

During the fall of 1978 (perhaps in September), here in Leavenworth Federal prison, I was given Valium and some other unknown drug for a nervous condition. About three weeks later, while I was working in the shoe factory, I asked to check into the hospital for a short rest. I was tired of the monotony of the factory routine. [The psychiatrist] said I needed Prolixin. I didn't know what it was, so I said okay. After a few shots, I found out it made me much more nervous, sometimes I couldn't sleep all night, I had to keep constantly moving, I started to get fat, and it was a terrible experience. I told [the psychiatrist] in a reasonable manner what it was doing to me and I stated that I didn't want any more of it. He said that I didn't know what I was talking about and I would get it regardless. He then had me locked in the neuropsychiatric ward where four guards held me down while he injected me with Prolixin. After about a month I got out, but I'm still forced to take Prolixin.

[The psychiatrist] asked me at one of his interviews if I heard voices. I said no, since I don't hear imaginary voices. But, for some reason, he wrote in his record that I did hear voices. Or at least, he told me that he did this.

I've never been in a mental hospital; I function satisfactorily in the prison environment; I'm not psychotic, yet I'm forced to take this psychotropic drug.

I hereby certify under penalty of perjury that the above is true and correct.
Executed on this 19th day of February, 1979.

STATEMENT

I, [name omitted], a member of the Oglala, Sioux Tribe, am incarcerated here at U.S.P. Leavenworth, Kansas serving a term for 4th degree burglary, and am being heavily drugged.

The drug is called "Prolixin". Along with the drug, Prolixin, I am, also, given Valium. The effect of these drugs on my physical body has caused me to lose vision in my eyes. My speech is slow, sluggish and slurred. I have it hard pressed to think in a clear intelligent manner. My skin, facial and scalp, has broken out in large bumps, similar to pimples. I sleep when I don't want to sleep and awake when I want to sleep. I go to school, but can't concentrate or focus on my studies. It is bad for me. All of these are effects of the drugs.

The drugs are not what I want. The drugs are harmful to me. I am afraid of lasting effects of the drugs. I have tried repeatedly to be taken off the drugs, but no use. They (the administration) have not even given me any reason whatsoever for condoning the use of drugs upon me. I am not here for a violent crime. I haven't even committed one infraction of institutional rules to merit such treatment. My record is clear, yet, they treat me such.

I have tried through institutional remedies to be taken off the drugs with negative results. They have me on the drugs for 6 months now. I am afraid with prolonged use of these drugs I'll develop a drug habit and other permanent side effects. If I just refuse to take the drugs they lock me up in solitary and use physical force in administering the drugs. Totally against my will.

So I come to you for your support and more importantly your "Help" in getting off these drugs. The help comes in the form of letter writing to the Warden of this institution, to make him aware that you are aware of whats happening to me. Gather together petitions to the Warden giving your support in helping me get off the drugs, and last, my friend, a letter of word of encouragement to me. Pray for me.

You can write the Warden at the same address, just title the letter "Warden".
In Spirit

Date: January 17, 1979.

[S] _____

AFFIDAVIT

COUNTY OF LEAVENWORTH,
State of Kansas.

May 26, 1978, after having spent 9 wks at the Farm Camp and working in the slaughter house, I was sent back into the prison. May 26 was a Fri and I had been being treated for an ear infection since the preceeding Mon. Dispite the infection I worked—up until Fri, a day the slaughter house did not operate.

Shortly after the noon meal on Fri, my name was called over the P.A. system to report to the desk. I did, and was told to report to the ball field for a work assignment. I told the officer I was sick, had an ear infection and headache and had had only 12-15 hours sleep all wk and requested to be excused from the work detail. The officer told me to report to [my case worker]. I reported to him and explained my complaint. [The case worker] said I'd have to talk with [the] Superintendent of the Farm Camp.

Presently I was confronted by [the Superintendent] and explained to him I was sick. He asked for any medical report and it was produced. He said there was nothing on my medical report preventing me from working. I said that it did say on my medical report that I have been being treated for an ear infection since Mon and that the report even showed that I had been treated even that morning. [The Superintendent] told me that I would do as told. I said I did not feel compelled to work when I was sick because every sick person has the inherent human right to convalesce and, therefore, I claimed that right for myself. He repeated that I'd do as told. I said okay, I will work but if you're forcing me to work I intend to take whatever legal remedy I have. As a response he said that I was trying to intimidate him. I answered, quite the contrary, that I was the one being intimidated.

He told me to pack up my belongings, that I was being sent back inside the prison. I asked him what the beef was. He said none, that I was being sent to the hospital. I was brought inside to the psychiatric ward and was granted an immediate interview with [the psychiatrist]. He started asking me asinine questions which I answered in the negative. He asked if I heard voices, if I had delusion or feeling of persecution or paranoia. I told him what had happened, that I was presently sick and in pain, that I'd had little sleep all wk, and that I was in fact very tired and exhausted. Not saying one word about my genuine medical disposition, he commenced telling me I need medication for my nerves. I reiterated my previous remarks and said that I was against taking any psychiatric medication on moral and intellectual grounds and maintained the certainty that I did not need them anyway and ended begging to only be left alone.

[The psychiatrist] insisted on making me take psychotropic drugs. And I flatly refused to take them. Finally he said I'd either take them or else. I told him that he did not intend forcing them on me. He answered in the affirmative.

This alarmed me a great deal but I knew I was helpless and was caught tight in the vise of a serious conspiracy. I know there was no way out, that I had to cooperate—or else.

I immediately wrote a 4-page letter to [the Chief Medical Examiner]. I wrote to my family. I begged them to help me. They came from Michigan to visit me and to talk with the Warden and the doctors, and as a result my medication was reduced by two-thirds. I spent 90 days in the psychiatric ward, during which time I was forced to take Valdol and Cogentor and another 'so-called' mood elevator. The medication made me terribly sick and I begged, argued, protested, implored, and reasoned in my efforts to have it stopped. I contended with this humiliation and abject degradation for 3 mos and was finally released to the prison population and assigned to the kitchen with the provision that I was to continue taking the medicine for 6 mos. I agreed, but immediately stopped

taking it. I wrote a letter to the Warden explaining why I refused the medication. He referred the letter to [my case worker]. [The case worker] advised me to continue not taking it and said he'd talk to [the psychiatrist] for me.

Shortly I had an interview with [the psychiatrist] and he had the temerity to say that he didn't force people to take medicine. I did not argue, For the time being I was satisfied that I survived the ordeal.

I fail to see how any reasonable person can fail to see how I was conspired against and victimized. I held up under a tremendous amount of pressure and consider myself one of the lucky ones. I was almost driven to violent and desperate protest or self destruction.

If you people are really interested in my case, I will gladly provide you all the details and give you my total cooperation. This is only a general outline and many important particulars are purposely omitted.

I certify under penalty of perjury that the foregoing is true and correct.
JANUARY 8, 1979.

(Signed) _____

APPENDIX E

During the preparation of this staff study committee staff consulted frequently with BOP Washington staff, particularly concerning the data tabulations for U.S.P. Leavenworth. As a result of these discussions the Bureau of Prisons undertook an examination of the prescribing practices at that institution. The following is the communication sent by the Bureau of Prisons upon completion of that investigation:

U.S. DEPARTMENT OF JUSTICE,
FEDERAL PRISON SYSTEM,
Washington, D.C., February 1, 1979.

HON. LESTER L. WOLFF,
Chairman, House Select Committee on Narcotics Abuse and Control,
Washington, D.C.

DEAR CHAIRMAN WOLFF: Enclosed is a copy of a report I received from our Medical Director, Dr. Robert L. Brutsche, concerning a recent team visit to the United States Penitentiary, Leavenworth, relative to questions you have raised concerning the use of certain prescription drugs.

I want to share this information with you and other members of your Committee on Narcotics Abuse and Control. As you can see from the report, it is our opinion that these pharmaceuticals are being utilized within the parameters of acceptable medical practice.

Please let me know if we may be of further assistance.
Sincerely,

NORMAN A. CARLSON,
Director.

Enclosure.

U.S. GOVERNMENT MEMORANDUM

Date: February 1, 1979.

Reply to: Robert L. Brutsche, M.D., Assistant Director.

Subject: Visit to USP, Leavenworth, December 19 and 20, 1978.

To: Norman A. Carlson, Director.

Pursuant to information that the U.S. House of Representatives Select Committee on Narcotics Abuse and Control was using information supplied by the Bureau of Prisons concerning controlled substances and several major tranquilizers to formulate a chart showing utilization of these substances, an "on site" review of the utilization of specific medications was conducted at the Leavenworth hospital during December 19 and 20, 1978.

The trip evolved out of discussions between the Bureau's medical staff and the Committee's staff over the amounts of the drugs being utilized. The Central Office team consisted of myself; Mr. Jim Meeker, Office of Professional Responsibility; Mr. John Kutch, Assistant for Health Care Plans and Operations, and Dr. Jack Eardly, Chief of Psychiatry at the Medical Center for Federal Prisoners, and BOP National Consultant for Psychiatry Services.

During the visit Leavenworth staff contacted included the Chief of Health Programs; the Chief of Psychiatry Services; the Chief of Pharmacy; the Chief of Health Records; the Hospital Supply Supervisor, and the Hospital Administrative Officer.

A general tour of the hospital was conducted and two (2) visits were made to the 14-bed psychiatric unit at different times on different days.

The findings of this visit are as follows:

1. USP, Leavenworth operates within their hospital, a 14-bed psychiatric unit. In general, most of the individuals are released back to the institution general population after a short stay in the unit.

The Chief of Psychiatry (Dr. Aristomenis Karagas), has his office physically located within the unit so that he is available to the patients at any given moment during his regular work day.

In addition to the Chief of Psychiatry having his office within the unit, the Chief of Health Programs (Dr. Charles Jarvis, a career Public Health Service Officer with the rank of Medical Director), exercises daily supervision over the unit and is knowledgeable of each case.

In summary, this psychiatric unit is providing many more services than other institutions in our system where patients are only held in an intermediary stage prior to transfer to the MCFP. This reason can explain higher amounts of utilization at USP, Leavenworth, if Leavenworth is compared to other institutions on the basis of specific drug utilization.

2. The main objective of the visit was to review health records as to the specific use of medications.

As a result of the review, the health records revealed that there were currently eight (8) individuals receiving Thorazine (Chlorpromazine), with appropriate amounts prescribed, and eight (8) individuals currently receiving Stelazine (Trifluoperazine), also within the appropriate range.

In addition, nineteen (19) individuals were currently receiving Prolixin (Fluphenazine)—a drug that the team added to the review because it falls into the same category with Stelazine and Thorazine. (Reference: *Medical Diagnosis and Treatment*, Chapter 17, "Psychiatric Disorders," see attached).

3. All of the health records reviewed contained evidence of careful documentation concerning diagnosis for psychiatric conditions, treatment plans, prescription of medications, and medical surveillance and follow-up of medication reactions.

In addition, we looked carefully for indications that certain medications might be used on an ad hoc basis solely for the purpose of controlling behavior, and found that in no instance were medications used in that manner.

4. Pharmacy records and storage areas as well as warehouse supply records and storage areas for medications were found to be satisfactory.

5. It was most apparent that when considering the current number of patients that were being treated on the days of our visit, and realizing that this current case load reflects the substantial decline in the institution's population, the medication utilization statistics were consistent with data submitted to the House Committee for the three year period requested (July 1975 to June 1978). Also, taking the modus operandi of the Leavenworth psychiatric service into consideration, the level of medication usage was in accord with the size of the psychiatric case load.

6. Focusing on the drug Valium (Diazepam) with sixty-three (63) patients receiving this medication out of the Leavenworth population of 1,418, 4.4 percent of the population were receiving Valium.

In the general population (non-prison), for the same age group the utilization rate is approximately 8 percent.

In certain cases, Valium was used in combination with other psychopharmacological medications for diagnosed and clearly supervised psychotic cases.

7. All cases in the psychiatric unit and all patients receiving significant therapy with controlled or noncontrolled psychopharmacologic medications are being, and have been, professionally managed by a psychiatrist assigned full-time to the Leavenworth hospital psychiatric unit, and closely monitored by the Chief of Health Programs.

8. I suggest that we invite the members of the House Committee to visit the hospital at Leavenworth so that they may see the day-to-day operations. Their visit need not be scheduled in advance, but can be arranged anytime they feel would be appropriate.

ROBERT L. BRUTSCHE, M.D.,
Assistant Surgeon General, USPHS,
Medical Director.

APPENDIX F

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, D.C., December 7, 1979.

MR. NORMAN A. CARLSON,
Director, Bureau of Prisons,
Washington, D.C.

DEAR DIRECTOR CARLSON: As you may recall, the Select Committee on Narcotics Abuse and Control has undertaken a staff study on the level of prescription drugs dispensed at five of the Bureau's facilities.

In order to more completely analyze the data previously supplied by your office the Committee has identified the need for additional information. Attached to this letter is a series of questions in this regard.

Your prompt response in providing the Committee with the requested information is appreciated. Should you or your staff have any questions concerning this request please contact Rick Carro of the Committee legal staff at (202) 225-1753. With personal regards.

Sincerely,

LESTER L. WOLFF, *Chairman.*

1. If an inmate is determined to require psychiatric care prior to assignment to a specific institution, is that inmate likely to be assigned to any particular institutions(s)?
2. For each institution identified in response to question No. 1 please supply the following information for the period July 1, 1975 through June 30, 1978:
 - a. average number of physicians assigned to the institution
 - b. average number of psychiatrists assigned to the institution
 - c. the average number of psychiatrists who were not board eligible
 - d. the average number of psychiatrists who were board eligible
 - e. the average number of psychiatrists who were board certified
 - f. the average capacity of the institution medical facility (non-psychiatric unit beds)
 - g. the average capacity of the institution medical facility (psychiatric unit beds)
3. If an inmate is discovered to require psychiatric care subsequent to assignment to a specific institution, is that inmate likely to be transferred to another institution for appropriate care? If so, which institution(s)?
4. For each institution identified in response to question No. 3 please supply the information requested under question No. 2 for the period July 1, 1975 through June 30, 1978.
5. With respect to Bureau facilities at FCI Alderson, FCI El Reno, FCI Terminal Island, FCI Lexington, and USP Leavenworth, please supply the following information for the period July 1, 1975 through June 30, 1978:
 - a. average number of physicians assigned to the institution
 - b. average number of psychiatrists assigned to the institution
 - c. the average number of psychiatrists who were not board eligible
 - d. the average number of psychiatrists who were board eligible
 - e. the average number of psychiatrists who were board certified
 - f. the average capacity of the institution medical facility (non-psychiatric unit beds)
 - g. the average capacity of the institution medical facility (psychiatric unit beds).
 - h. a precise definition of the security classification(s) assigned to the institution.

i. the number and nature of training or other informational sessions for psychiatrists and physicians concerning the dispensing of psychoactive drugs in the context of the prison setting.

j. the policy of the institution with regard to the criteria for dispensing psychotropic medications on an involuntary basis. Is a psychiatrist required to be present in each instance when a psychotropic medication is involuntarily administered to an inmate?

FEDERAL PRISON SYSTEM,
Washington, D.C., January 7, 1980.

HON. LESTER L. WOLFF,
Chairman, Select Committee on Narcotics Abuse and Control,
House of Representatives, Washington, D.C.

DEAR CHAIRMAN WOLFF: I am writing in reply to your letter of December 7, 1979.

The following information is furnished in response to the categorical questions in your referenced letter:

1. Inmates who were determined to require psychiatric care prior to assignment to a specific Federal Prison System institution were most likely to be assigned to one of the following institutions during the period July 1, 1975 through June 30, 1978:

- a. Medical Center for Federal Prisoners, Springfield, Missouri (an all male institution).
- b. Federal Correctional Institution, Butner, North Carolina (an all male institution).
- c. Federal Correctional Institution, Lexington, Kentucky (a co-correctional institution—both male and female).
- d. Federal Correctional Institution, Alderson, West Virginia (an all female institution).
- e. Federal Correctional Institution, Terminal Island, California (an all male institution—co-correctional prior to Nov. 1977).

Determinations on all inmates designations depend on the exact circumstances and background of each case. Assignment of an inmate to one of the above institutions is made after careful evaluation and review of various factors including care needed.

2. The following chart covers the quantitative information asked for in question No. 2 c^f your letter for the period July 1, 1978 through June 20, 1978:

	MCFP Springfield	FCI Butner	FCI Lexington	FCI Alderson	FCI Terminal Island
a. Average number of non-psychiatrist physicians assigned to the institution.....	7	10	4	1	2
b. Average number of psychiatrists assigned to an institution.....	5	10	1	1	2
c. Average number of psychiatrists who were not board eligible.....	0	10	0	0	0
d. Average number of psychiatrists who were board eligible.....	4	10	0	0	0
e. Average number of psychiatrists who were board certified.....	1	10	1	1	2
f. The average capacity of the institution medical facility (non-psychiatric unit beds).....	300	8	50	25	18
g. The average capacity of the institution medical facility (psychiatric beds).....	300	100	0	0	28

¹ No full-time nonpsychiatric physician or psychiatrists employed; consultant physicians and psychiatrists from nearby universities were used on a contract basis.

3. Inmates who are determined to require psychiatric care subsequent to assignment to a specific institution are most likely to be transferred to one of the institutions mentioned in No. 2 above, if transfer is considered appropriate for care.

4. Information concerning the institutions that inmates are most likely to be transferred to after discovery of psychiatric care needs is the same as that presented in answer to No. 2 in chart above.

5. The following chart covers the quantitative information asked for in question No. 5 of your letter for the period July 1, 1975 through June 30, 1978:

	FCI Alderson	FCI El Reno	FCI Terminal Island	FCI Lexington	USP Leavenworth
a. Average number of nonpsychiatrist physicians assigned to the institution	1	1	2	4	2
b. Average number of psychiatrists assigned to the institution	1	0	2	1	1
c. Average number of psychiatrists who were not board eligible	0	0	0	0	0
d. The average number of psychiatrists who were board eligible	0	0	0	0	1
e. The average number of psychiatrists who were board certified	1	0	2	1	0
f. The average capacity of the institution medical facility (nonpsychiatric unit beds)	25	28	18	50	66
g. The average capacity of the institution medical facility (psychiatric unit beds)	0	0	28	0	1

6. In accordance with paragraph 5h of your letter, the following information is furnished concerning security classification(s) of the institutions mentioned in No. 5 above:

A. *FCI, Alderson* (all female facility)—Alderson is designated as an "Administrative Facility" and has the capability of receiving inmates needing any level of security (i.e., 1 to 6 minimum to maximum).

B. *FCI, El Reno* (all male facility)—El Reno is designated as a Security Level "4" institution. "Four" level institutions are double fenced or have one fence or another type of barrier. Guard towers are manned; there is an external patrol of the institution; detection devices are utilized; housing areas are secure; cells are both single and multiple, with some dorms, and the level of supervision per population size is low to medium.

C. *FCI, Terminal Island* (all male facility, prior to Nov. 1977 was co-correctional)—Terminal Island is designated as a Security Level "2" institution. "Two" level institutions have one fence or building facade. These institutions may have towers, but the towers are manned less than 24 hours per day; there is no external patrol; no detection devices; the housing areas are open to medium; cells are both single and multiple, with some dorms, and the level of supervision per population size is low.

D. *FCI, Lexington* (co-correctional facility)—Lexington is designated as a Security Level "1" institution. "One" level institutions do not have fences. These institutions either do not have towers, or the towers are not manned; there is no external patrol; no detection devices; housing is open; cells are both single and double with some dorms, and the level of supervision per population size is low.

E. *USP, Leavenworth* (all male facility)—Leavenworth is designated as a Security Level "5" institution. "Five" level institutions are double fenced or walled. These institutions have towers that are manned 24 hours a day; there is an external patrol; detection devices are utilized; housing is secure; cells are single and multiple with some dorms, and the level of supervision per population size ranges from low to high.

7. Concerning the number and nature of training or other informational sessions for psychiatrists and physicians in the area of dispensing psychoactive drugs in the prison setting (paragraph 5i):

Both psychiatrists and physicians undergo two (2) separate informational and training sessions that address the subject of prescribing psychoactive drugs. The first session is a part of the orientation to the individual institution hospital. The second is at the annual Medical Officers Orientation (both psychiatrists and physicians attend) held at the Medical Center for Federal Prisoners, Springfield, Missouri. Medico-legal considerations in the context of the prison setting are presented and discussed, to include the subject of psychoactive drugs, at both of these informational sessions.

8. All institutions are required to follow Chapter 37405 of the Federal Prison System *Medical Manual* concerning "Refusal of Treatment." The basic criteria for administering any medications involuntarily to an inmate are: (1) in medical or psychiatric conditions where the patient may not be physically or mentally able to give consent, and the medical staff determines the treatment to be necessary

as an emergency measure; (2) when treatment is refused by an inmate, but subsequently ordered by a Court. It is the policy of the institutions asked in question 5j to not require a psychiatrist to be present in each instance when a psychotropic medication is involuntarily administered to an inmate.

If we can be of any further assistance, or provide you with additional information, please let us know.

Sincerely,

NORMAN A. CARLSON, *Director.*

APPENDIX G

U.S. DEPARTMENT OF JUSTICE,
FEDERAL PRISON SYSTEM,
Washington, D.C., June 13, 1980.

Mr. PATRICK L. CARPENTIER,
Chief Counsel, Select Committee on Narcotics Abuse and Control, House of
Representatives, Washington, D.C.

DEAR MR. CARPENTIER: I am writing in reply to Mr. Richard S. Carro's letter of February 1, 1980. I was happy to learn that our letter of January 7, 1980, provided the necessary information requested by the Select Committee.

Pursuant to Mr. Carro's letter, we can now provide you with information concerning our last twelve (12) month period. We understand that you desire this information for the purpose of comparison with our letter of January 7, 1980.

The following information, for the last twelve month period (May 31, 1979-May 31, 1980), is furnished:

1. Inmates who were determined to require psychiatric care prior to assignment to a specific Federal Prison System Institution were most likely to be assigned to one of the following institutions during the last twelve month period.

- a. Medical Center for Federal Prisoners, Springfield, Missouri (an all male institution).
- b. Federal Correctional Institution, Butner, North Carolina (an all male institution).
- c. Federal Correctional Institution, Lexington, Kentucky (a co-correctional institution—both male and female).
- d. Federal Correctional Institution, Terminal Island, California (an all male institution).

2. For each of the institutions identified in paragraph No. 1 above, the following chart provides a "break-down" of quantitative information that relates to each institution since May 1979.

	MCFP Springfield	FCI Butner	FCI Lexington	FCI Terminal Island
a. Average number of nonpsychiatrist physicians assigned to the institution.....	8	10	4	2
b. Average number of psychiatrists assigned to an institution.....	5	3	2	1
c. Average number of psychiatrists who were not board eligible.....	0	0	0	0
d. Average number of psychiatrists who were board eligible.....	4	3	2	0
e. Average number of psychiatrists who were board certified.....	1	0	0	1
f. The average capacity of the institution medical facility (non-psychiatric unit beds).....	350	7	100	23
g. The average capacity of the institution medical facility (psychiatric beds).....	300	100	28	18

¹ No full-time nonpsychiatric physicians employed; consultant physicians from nearby universities were used on a contract basis.

3. Inmates who are determined to require psychiatric care subsequent to assignment to a specific institution are most likely to be transferred to one of the four (4) institutions mentioned above, those being MCFP, Springfield; FCI, Butner; FCI, Lexington; or FCI, Terminal Island. Inmates are transferred when it is considered appropriate for their psychiatric and/or medical care.

4. Information concerning the institution that inmates are most likely to be transferred to after the discovery of psychiatric care needs is the same information furnished in the paragraph No. 2 chart above.

5. The following chart covers quantitative information concerning FCI, Alderson; FCI, El Reno; FCI, Terminal Island; FCI, Lexington; and USP, Leavenworth, for the last twelve month (May 31, 1979 to May 31, 1980) period.

	FCI Alderson	FCI El Reno	FCI Terminal Island	FCI Lexington	USP Leaven- worth
a. Average number of nonpsychiatrist physicians assigned to the institution.....	2	1	2	4	2
b. Average number of psychiatrists assigned to the institution.....	0	0	1	2	0
c. Average number of psychiatrists who were not board eligible.....	0	0	0	0	0
d. The average number of psychiatrists who were board eligible.....	0	0	0	2	1
e. The average number of psychiatrists who were board certified.....	0	0	1	0	0
f. The average capacity of the institution medical facility (nonpsychiatric unit beds).....	25	28	23	100	42
g. The average capacity of the institution medical facility (psychiatric beds).....	0	0	18	28	101

6. Security classification for the above mentioned institutions are as follows:

a. *FCI, Alderson* (an all female institution)—Alderson is designated as an "Administrative Facility" and has the capacity of receiving inmates needing any level security (i.e., 1 to 6 minimum to maximum).

b. *FCI, El Reno* (an all male institution)—El Reno is designated as a Security Level "4" institution. "Four" level institutions are double fenced or have one fence or another type of barrier. Guard towers are manned; there is an external patrol of the institution; detection devices are utilized; housing areas are secure; cells are both single and multiple, with some dorms, and the level of supervision per population size is low to medium.

c. *FCI, Terminal Island* (an all male institution)—Terminal Island is designated as a Security Level "2" institution. "Two" level institutions have one fence or building facade. These institutions may have towers, but the towers are manned less than 24 hours per day; there is no external patrol; no detection devices; the housing areas are open to medium; cells are both single and multiple with some dorms, and the level of supervision per population size is low.

d. *FCI, Lexington* (a co-correctional institution—both male and female)—Lexington is designated as a Security Level "1" institution. "One" level institutions do not have fences. These institutions either do not have towers, or the towers are not manned; there is no external patrol; no detection devices; housing is open; cells are both single and double with some dorms, and the level of supervision per population size is low.

e. *USP, Leavenworth* (an all male institution)—Leavenworth is designated as a Security Level "5" institution. "Five" level institutions are double fenced or walled. These institutions have towers that are manned 24 hours a day; there is an external patrol; detection devices are utilized; housing is secure; cells are single and multiple with some dorms, and the level of supervision per population size ranges from low to high.

7. The number and nature of training or other informational sessions for psychiatrists and physicians on the subject of dispensing psychoactive drugs in the prison setting are covered by having both psychiatrists and physicians attend two (2) separate informational and training sessions that address the subject of prescribing psychoactive drugs. The first session is a component part of the employee orientation to the individual institution hospital of employment. The second is at the annual Medical Officer's Orientation (both psychiatrists and physicians attend), held at the Medical Center for Federal Prisoners, Springfield, Missouri. Medico-legal considerations in the framework of the prison setting are presented and discussed, to include the subject of psychoactive drugs, at both of these informational sessions.

8. All institutions are required to follow Chapter 37405, "Refusal of Treatment", contained in the Federal Prison System *Medical Manual*. The basic criteria for administering medications "involuntarily" to an inmate are:

- a. In medical or psychiatric conditions where the patient may not be physically or mentally able to give consent, and the medical staff determines, through professional judgment, the treatment to be necessary as an emergency measure.

b. When treatment is refused by an inmate, but subsequently ordered by a court.

Policy at FCI, Alderson; FCI, El Reno; FCI, Terminal Island; FCI, Lexington, and USP, Leavenworth does not require a psychiatrist to be present in each instance when a psychotropic medication is involuntarily administered to an inmate.

If we can be of any further assistance, or provide you with additional information, please let us know.

Sincerely,

ROBERT L. BRUTSCHE, M.D.
(For Norman A. Carlson, Director).

END