THE FEDERAL BUREAU OF PRISONS
ANNUAL REPORT ON SUBSTANCE ABUSE TREATMENT PROGRAMS
FISCAL YEAR 2007

REPORT TO THE CONGRESS

As Required by the Violent Crime Control and Law Enforcement Act of 1994

January 2008

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INTRODUCTION

The Federal Bureau of Prisons (BOP) has prepared this report for the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives as required by 18 U.S.C. § 3621(e)(3). This report provides the following:

- A description of the process of identifying offenders with drug abuse treatment needs;
- A description of substance abuse treatment programs in the BOP; and
- The BOP's compliance with the requirements of Subtitle T of Title III of the Violent Crime Control and Law Enforcement Act of 1994, Substance Abuse Treatment in Federal Prisons, in terms of
  - meeting the demand for treatment;
  - providing an early release for appropriate inmates who successfully complete the residential drug abuse treatment program; and
  - coordinating with the Department of Health and Human Services.

IDENTIFYING OFFENDER TREATMENT NEEDS

Consistent with the research and literature on drugs and crime, the BOP has identified two types of incarcerated drug offenders based on their respective treatment needs:

Drug defined offenders are individuals whose violation of the drug laws is based on a business venture – they tend to be motivated solely by financial gain. These individuals may or may not need drug abuse treatment, but may benefit from other types of intervention.

Drug related offenders are individuals who violate the law as a direct result of their drug use. Their illegal activity may be a drug offense (such as possession of illegal substances) or it may be an offense committed to support their continued drug use (such as stealing to get money to buy

illegal drugs). These individuals are likely to need and benefit from drug abuse treatment.

The BOP uses the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) to analyze the extent and nature of an inmate's drug use. (See Attachment I for DSM definitions.) Inmates who meet the DSM criteria for a drug use disorder (abuse or dependence) are referred to the BOP's intensive Residential Drug Abuse Treatment Program. Inmates who are found to have a drug "problem" are referred for Nonresidential Drug Abuse Treatment or for Drug Education. This parallels community drug abuse treatment regimens, that differentiate between residential treatment and out-patient treatment.

At the time of an inmate's admission to a BOP facility, a staff psychologist reviews the inmate's case for any history of drug use. If it is determined that the inmate could benefit from drug abuse treatment, the offender is referred to the institution's drug abuse treatment coordinator, who will further assess the inmate's need for treatment. If appropriate, the drug abuse treatment coordinator will refer the inmate for Residential Drug Abuse Treatment, Nonresidential Drug Abuse Treatment, or Drug Abuse Education.

To estimate the demand and determine the number of beds required for the Residential Drug Abuse Treatment Program each year, the BOP analyzed a portion of data that were collected as part of a study of the prevalence of mental health conditions in the inmate population. These data characterize samples of inmates from admissions cohorts during fiscal years 2002 and 2003. The BOP reviewed over 2,500 presentence investigation reports to ascertain the frequency of inmates with a drug use disorder (a reference to a medical diagnosis of a drug use disorder or an offender's self report of drug use that met the criteria for a drug use disorder). The findings extrapolated from these data indicate that approximately *40 percent of inmates entering BOP custody during fiscal years 2002 and 2003 met the criteria for a substance use disorder.*

DRUG ABUSE TREATMENT PROGRAMS IN THE BUREAU OF PRISONS

Drug Abuse Education

Drug Abuse Education is not drug abuse treatment. The purpose of Drug Abuse Education is to encourage inmates with a history of drug use to review the harmful consequences of their choice to use drugs and how those choices have effected them physically, socially, and psychologically. Drug Abuse Education is designed to inform inmates of the effects of drug use and to motivate them to participate in drug abuse treatment.

Overview and Admission Criteria

Upon entry into a BOP facility, staff assess an inmate's records to determine if an offender is suited for Drug Abuse Education using a set of specific criteria. The criteria used for this determination include a prolonged history of drug use, evidence in the presentence investigation report that alcohol or drug use contributed to the commission of the instant offense, a judicial recommendation for treatment, or a violation of community supervision as a result of alcohol or drug use.

Program Content

Participants in Drug Abuse Education review their individual drug use histories and are shown evidence of the nexus between drug use and crime. Participants also receive information on what distinguishes drug use, abuse, and addiction; and, when appropriate, are referred for Nonresidential Drug Abuse Treatment or to the Residential Drug Abuse Treatment Program.

This winter, the BOP will release a revised Drug Abuse Education protocol to further emphasize the relationship between drug use and criminal activity and how the participant has abused his or her interpersonal relationships through the use of drugs. Drug Abuse Education will be reduced from between 30 to 40 hours to between 15 to 20 hours. The course will be streamlined to focus on the essentials of education about drugs and drug abuse. This will allow Psychology Services personnel to spend more time providing treatment.

In fiscal year 2007, 23,596 inmates participated in Drug Abuse Education. (See Attachment II for a breakdown of participants by program and fiscal year.)

Nonresidential Drug Abuse Treatment

Nonresidential Drug Abuse Treatment is available in every BOP institution. Services are provided through the Psychology Services Department at each facility. Every BOP facility is staffed with a minimum of one Drug Abuse Program Psychologist and one Drug Abuse Treatment Specialist. Nonresidential Drug Abuse Treatment is designed with the flexibility necessary to meet the treatment needs of the inmates at the particular institution.

Overview and Admission Criteria

Specific populations targeted for Nonresidential Drug Abuse Treatment include:

- Inmates with a relatively minor or low-level substance abuse impairment,
- Inmates with a drug use disorder who do not have sufficient time to complete the intensive Residential Drug Abuse Treatment Program,
- Inmates with longer sentences who are in need of treatment and are awaiting placement in the residential program,
- Inmates identified with a drug use history who did not participate in the Residential Drug Abuse Treatment Program and are preparing for community transition, and
- Inmates who completed the unit-based component of the Residential Drug Abuse Treatment Program and are required to continue treatment upon their transfer to the general inmate population.

Recently, the BOP developed two new treatment protocols for Nonresidential Drug Abuse Treatment. The first protocol follows the cognitive behavioral therapy treatment model, which is the foundation of the Residential Drug Abuse Treatment Program. This treatment approach focuses on an inmate's criminal and cognitive thinking errors and works toward the development of positive attitudes, beliefs, and behaviors. (The success of the BOP's Residential Drug

Abuse Treatment Program is due in large part to its use of the cognitive behavioral therapy treatment model.)

Inmates participate in Nonresidential Drug Abuse Treatment for a minimum of 12 weeks and for a minimum of 4 hours per week. Treatment staff might increase these minimum requirements depending upon the needs of the inmate and the ability of the institution to provide services.

The second protocol is Follow-up Treatment, which is required for inmates who have completed the unit-based component of the Residential Drug Abuse Treatment Program and who have time remaining in BOP custody before their transfer to a residential reentry center.

Follow-up Treatment is conducted for a minimum of 12 months and a minimum of 1-1/2 hours per week. An inmate must remain in follow-up treatment for the full 12 months or until his/her transfer to a residential reentry center.

Follow-up treatment allows treatment staff to address each key topic of the residential program with an inmate, reviewing the entire continuum of treatment.

Program Content

Both protocols within Nonresidential Drug Abuse Treatment use the cognitive behavioral therapy treatment model. This treatment model is described in detail in the section on the Residential Drug Abuse Treatment Program.

A drug abuse treatment specialist, under the supervision of a psychologist, develops a treatment plan based on a psycho-social assessment of the inmate. Self-help groups, such as Alcoholics Anonymous and Narcotics Anonymous, are available to support the BOP's nonresidential treatment regimen.

In fiscal year 2007, 14,392 inmates participated in Nonresidential Drug Abuse Treatment, including the Follow-up Treatment component. (See Attachment II for a breakdown of participants by fiscal year.)

Residential Drug Abuse Treatment

The Residential Drug Abuse Treatment Program (RDAP) was developed based on a review of drug abuse treatment at the time of the program's implementation in 1995 and the incorporation of the elements that were shown to be effective in drug abuse treatment at that time. The BOP has enhanced the program over the years, incorporating several treatment approaches under a foundation based on the cognitive behavioral therapy treatment model. At present, 58 BOP institutions operate an RDAP. (See Attachment III for program locations.)

Overview

The RDAP provides intensive drug abuse treatment to inmates diagnosed with a drug use disorder (based on the DSM criteria mentioned above). The programs are staffed by a doctoral-level psychologist (the Drug Program Coordinator) who supervises the treatment staff. The average ratio of drug abuse treatment staff to inmates is 1 to 24.

Inmates in the residential program are housed together in a treatment unit that is set apart from the general population. Treatment is provided for a minimum of 500 hours over 9 months; however, in accordance with findings in the literature on drug abuse treatment, residential treatment might last as long as 12 months.

Admission Criteria

Prior to acceptance into an RDAP, inmates are interviewed and assessed to determine if they meet the diagnostic criteria for a substance use disorder set forth in the DSM.

Inmates must enter residential treatment voluntarily and must sign an agreement to participate in RDAP. The agreement stipulates the behaviors that are expected and the behaviors that will not be tolerated both within and outside the treatment unit. Participants are informed of how the BOP measures treatment success and what behaviors will lead to the inmate's completion of the RDAP. Treatment staff make sure inmates know that the primary purpose of the program is to treat inmates for drug abuse, not to provide an early release from BOP custody.

Inmates typically enter the program as they near their release date to ensure that all eligible inmates who are diagnosed with a drug use disorder and volunteer for residential treatment: (1) receive such treatment before they are released from custody, and (2) continued treatment as they transfer to a residential reentry center.

Inmates must have enough time left to serve to complete the unit-based component and the community transition drug abuse treatment phase of the program. Follow-up Treatment, as described above, is provided to inmates after they complete the unit-based residential treatment and before they transfer to a residential reentry center.

Program Content

The BOP's RDAP adheres to a cognitive behavior therapy treatment model. This treatment model targets the major criminal/ drug-using risk factors, especially anti-social and pro-criminal attitudes, values, beliefs, and behaviors. Using evidence-based practices, the BOP targets these behaviors by reducing anti-social peer associations; promoting positive relationships; increasing self-control, self-management, and problem solving skills; ending drug use; and replacing lying and aggression with pro-social alternatives. Treatment includes the development of a specific transition plan.

The BOP revised its treatment protocol in 2005 to ensure it included all recent treatment practices that have been proven to be effective with a population in custody. A review of treatment programs for female inmates was a part of this revised protocol.

All treatment staff follow the RDAP treatment protocol within the context of program policy. This ensures consistency in program fidelity which allows inmates to meet the objectives of the program and to ensure specific behavioral values are placed on inmates both within and outside the treatment unit.

To date, the RDAP modules have been requested by all 50 States and 7 foreign countries, as well as a number of local correctional agencies and community-based treatment providers. The *RDAP Facilitator's Guide* is available through the National Institute of Corrections Information Center to assist treatment providers in the

use of the BOP's residential drug abuse treatment modules.

In fiscal year 2007, 17,549 inmates participated in residential drug abuse treatment programs. (See Attachment II for a breakdown of participants by fiscal year.)

Treatment Evaluation

In coordination with the National Institute on Drug Abuse, the BOP conducted a rigorous 3-year outcome study of the residential drug abuse treatment program beginning in 1991. The results were published in 2000 within reports on the study known as *Treating Inmates Addiction to Drugs (TRIAD)*. The evaluation was superior to any drug abuse treatment assessment to that point because of the size of the treatment population assessed, the opportunity to evaluate the effect of treatment on both male and female inmates (1,842 men and 473 women), and a methodology developed to address the problem of selection bias found in other evaluations.

According to the analysis, male participants are 16 percent less likely to recidivate and 15 percent less likely to relapse than similarly-situated inmates who did not participate in residential drug abuse treatment for up to 3 years after release. The analysis also found that female inmates are 18 percent less likely to recidivate than inmates who did not participate in treatment. In addition, female inmates had higher rates of success than male inmates in maintaining work, acquiring educational degrees, and caring for children.

This study demonstrates that the BOP's Residential Drug Abuse Treatment Program makes a positive difference in the lives of inmates and improves public safety following the inmates' release from custody.

Community Transition Drug Abuse Treatment

Community Transition Drug Abuse Treatment has been a component of the BOP's drug abuse treatment strategy since 1991. All inmates who participate in the RDAP are required to participate in the Community Transition Drug Abuse Treatment component to successfully

complete the RDAP.

Upon completion of the unit-based portion of the RDAP, the BOP ensures that inmates receive a continuum of treatment and supervision when the inmate is transferred to a residential reentry center. Research has shown that with the continuum of supervision and treatment, the chances of relapse or other behavioral problems decrease dramatically, reducing the likelihood of an offender's return to custody. Co-occurring disorder, such as mental illness, also continue to be treated during this period of transition.

The BOP uses residential reentry centers to place inmates in the community prior to their release from custody in order to help them adjust to life in the community and find suitable post-release employment. These centers provide a structured, supervised environment and support in job placement, counseling, and other services.

It is within the structure of the residential reentry center that inmates continue their regimen of drug abuse treatment, with a community-based treatment provider with whom the BOP contracts for service. The inmate must continue to participate in transition drug abuse treatment or he or she will be returned to custody and will lose any of the residential program's incentives (e.g., early release).

Inmates who have not participated in drug abuse treatment in an institution, but who are found to have a drug use disorder as they near release or during their placement in a residential reentry center, could be required to participate in community-based drug abuse treatment as part of their program plan. The BOP terms this provision of drug abuse treatment an "enhanced treatment service" and applies this service to ensure that all inmates in need of drug abuse treatment have the opportunity to participate in treatment while in BOP custody.

An important component of Community Transition Drug Abuse Treatment is the transfer of information from institution treatment staff to the BOP's regional transition teams. Institution drug abuse treatment specialists provide regional

transition teams with a treatment summary that includes information on the inmate and his or her program involvement while in BOP custody. The regional transition team forwards these reports to the contract drug abuse treatment provider and the United States Probation Office.

To further the continuum of treatment, participants in Community Drug Abuse Treatment often continue drug abuse treatment during their period of supervised release while under the supervision of the United States Probation Office. These inmates frequently remain with the same treatment provider, ensuring continuity in treatment and accountability during this period of community reentry and supervision.

In fiscal year 2007, 15,432 inmates participated in Community Transition Drug Abuse Treatment. (See Attachment II for a breakdown of participants by fiscal year.)

COMPLIANCE WITH THE REQUIREMENTS OF THE VIOLENT CRIME CONTROL AND LAW ENFORCEMENT ACT OF 1994

Meeting the Demand for Treatment

Subtitle T of Title III of the Violent Crime Control and Law Enforcement Act of 1994 requires the BOP (subject to the availability of funds) to provide residential substance abuse treatment to all eligible inmates.

In fiscal year 2007, the BOP provided residential drug abuse treatment to 80 percent of eligible inmates before their release from custody. In fiscal year 2007, 17,549 inmates participated in the RDAP.

To treat all eligible inmates, before their release from custody, the Bureau projected 22,000 inmates would require treatment in FY 2007. Without receiving additional funding, the Bureau will continue to be unable to meet the VCCLEA mandate. The last RDAP expansion was in 2003. At that time the RDAP waiting list averaged 6,000 inmates. Today the RDAP waiting list is more than 7,600 inmates.

Providing an Early Release

The law allows the BOP to grant a non-violent inmate up to 1 year off his or her term of imprisonment for successful completion of the residential drug abuse treatment program (Title 18 U.S.C. § 3621(e)(2)).

In fiscal year 2007, 4,934 inmates received a reduction in their term of imprisonment. Since the implementation of this provision in June 1995, a total of 27,818 inmates have received such a reduction.

In fiscal year 2007, eligible offenders received an average reduction in their term of imprisonment of 7.7 months. Inmates are receiving less than 12 months due to the growing RDAP waiting list.

Coordinating with the Department of Health and Human Services

In fiscal year 2007, the BOP continued to work closely with the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute on Drug Abuse (NIDA), and the Office of Justice Programs in the development of protocols to facilitate treatment for the substance-abusing offenders during their movement through each component of the criminal justice system, from arrest to parole. The *Federal Consortium to Address the Substance Abusing Offender* was established and funded by the Bureau of Justice Assistance (BJA) as the mechanism to facilitate this process. The consortium includes representatives from many parts of the Federal criminal justice system, as well as representatives from the Department of Health and Human Services, the Department of Housing and Urban Development, the Department of Education, the National Highway Traffic Safety Administration, and the Centers for Disease Control and Prevention. The consortium works to develop information for State and local officials to assist with effective treatment protocols, communication and reporting strategies, data collection, and research.

The BOP continues to work closely with NIDA's Criminal Justice-Drug Abuse Treatments (CJ-DATS) and now in CJ-DATS II, as grantees continue in their assessments of drug abuse treatment

programs. The eight University-based CJ-DATS grantees conduct their research in institutions and community correction's sites across the United States. The BOP has been working with the Texas Christian University's Institute for Behavioral Research for the last 6 years in the testing of a program participant assessment protocol that provides drug abuse treatment staff with information on an inmate's progress in the RDAP. The instrument (known as the Criminal Justice - Client Evaluation of Self and Treatment) is designed to monitor individual inmate treatment improvements, program quality, and staff training needs.

In fiscal year 2007, the BOP continued its work with other CJ-DAT S grantees, including the University of Kentucky and the National Drug Research Institute. These grantees view the BOP as having developed a model reentry program, that includes drug abuse treatment as a component of reentry.

The BOP coordinates with NIDA, BJA, and SAMHSA to develop programs to improve the management and treatment of offenders with substance abuse and mental health disorders, to continue the development of gender-specific treatment protocols, to improve clinical case management systems in the reentry process, to enhance quality assurance measures and methods, and to foster the use of technologies that facilitate communication among the various criminal justice agencies involved.

Due to the high rates of co-occurrence of a sex offenders with a drug use disorder and as a result of the enactment of the Adam Walsh Child Protection and Safety Act of 2006, which calls for the civil commitment of dangerous sex offenders, the BOP has begun to coordinate with other Federal agencies and non-profit organizations to assess the development of a residential treatment program for individuals committed to the BOP under this civil commitment statute. The agency believes that intervening and treating both disorders at the same time will provide some beneficial results for drug-disordered sex offenders committed to BOP custody.

Attachment I

DEFINITION OF DRUG USE DISORDERS: DEPENDENCE AND ABUSE

CRITERIA FOR SUBSTANCE DEPENDENCE: A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period.

(1) tolerance, as defined by either of the following:

(a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect or

(b) markedly diminished effect with continued use of the same amount of substance.

(2) withdrawal, as manifested by either of the following:

(a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for withdrawal from the specific substance), or

(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

(3) the substance is often taken in larger amounts or over a longer period than was intended.

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use.

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.

(6) important social, occupational, or recreational activities are given up or reduced because of substance use.

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

CRITERIA FOR SUBSTANCE ABUSE: A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring at any time in the same 12-month period.

(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).

(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).

(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).

(4) continued substance use despite having persistent or recurrent social or inter-personal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

Taken from the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV. Fourth Edition. American Psychiatric Association, 1994.

Attachment II

INMATE PARTICIPATION IN DRUG ABUSE TREATMENT PROGRAMS
FISCAL YEARS 1990 - 2007

PROGRAM	1990	1991	1992	1993	1994	1995	1996	1997	1998
Drug Abuse Education	5,446	7,644	12,500	12,646	11,592*	11,681	12,460	12,960	12,002
Non-Residential Drug Abuse Treatment			654	1,320	1,974	2,136	3,552	4,733	5,038
Residential Drug Abuse Treatment	441	1,236	1,135	3,650	3,755	4,839	5,445	7,895	10,006
Community Transition Drug Abuse Treatment			123	480	800	3,176	4,083	5,315	6,951

PROGRAM	1999	2000	2001	2002	2003	2004	2005	2006	2007	TOTAL
Drug Abuse Education	12,202	15,649	17,216	17,924	20,930	22,105	22,776	23,006	23,596	274,335
Non-Residential Drug Abuse Treatment	6,535	7,931	10,827	11,506	12,023	13,014	14,224	13,697	14,392	123,556
Residential Drug Abuse Treatment	10,816	12,541	15,441	16,243	17,578	18,278	18,027	17,442	17,549	182,317
Community Transition Drug Abuse Treatment	7,386	8,450	11,319	13,107	15,006	16,517	16,603	16,503	15,432	141,251

*** In fiscal year 1994, the drug abuse education policy changed to allow for a waiver if an inmate volunteered for and entered the residential drug abuse treatment program. In addition, data for community transition drug abuse treatment was tabulated by average daily population.**

Attachment III

RESIDENTIAL DRUG ABUSE TREATMENT PROGRAM LOCATIONS

NORTHEAST REGION

FCI Danbury (CT)✳
FCI Elkton (OH)
FCI Fairton (NJ)
FCI Fort Dix (NJ)
FPC Lewisburg (PA)
FPC McKean (PA)

MID-ATLANTIC REGION

FPC Alderson (WV)✳
FPC Beckley (WV)
FCI Beckley (WV)
FCI Butner (NC)
FPC Cumberland (MD)
FCI Cumberland (MD)
FMC Lexington (KY)★
FCI Morgantown (WV)
FCI Petersburg (VA)

KEY

FCI = Federal Correctional Institution
FMC = Federal Medical Center
FPC = Federal Prison Camp
FSL = Federal Satellite (Low Security)
✳Female Facility
★Co-occurring Disorder Program

NORTH CENTRAL REGION

FCI Englewood (CO)
FPC Florence (CO)
FCI Florence (CO)
FPC Greenville (IL)✳
FPC Leavenworth (KS)
FCI Leavenworth (KS)
FCI Milan (MI)
FCI Oxford (WI)
FCI Sandstone (MN)
FCI Waseca (MN)
FPC Yankton (SC)

SOUTH CENTRAL REGION

FCI Bastrop (TX)
FPC Beaumont (TX)
FCI Beaumont (TX)
FPC Bryan (TX)✳
FMC Carswell (TX)✳★
FSL El Paso (TX)
FCI El Reno (OK)
FCI Fort Worth (TX)
FPC Forrest City (AR)
FCI Forrest City (AR)
FCI La Tuna (TX)
FCI Seagoville (TX)
FPC Texarkana (TX)

SOUTHEAST REGION

FCI Coleman (FL)
FPC Edgefield (SC)
FCI Jesup (GA)
FCI Marianna (FL)
FPC Miami (FL)
FPC Montgomery (AL)
FPC Pensacola (FL)
FPC Talladega (AL)
FCI Tallahassee (FL)✳
FCI Yazoo City (MS)

WESTERN REGION

FCI Dublin (CA)✳
FPC Dublin (CA)✳
FCI Lompoc (CA)
FPC Lompoc (CA)
FPC Phoenix (AZ)✳
FCI Phoenix (AZ)
FCI Sheridan (OR)
FPC Sheridan (OR)
FCI Terminal Island (CA)