REPORT OF THE
VIRGINIA STATE CRIME COMMISSION AND
DEPARTMENT OF CORRECTIONS ON

A Study of the Current and Future Needs for Programs Providing Substance Abuse Treatment for Inmates

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 54

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VIRGINIA STATE CRIME COMMISSION

General Assembly Building

FREDERICK L. RUSSELL
EXECUTIVE DIRECTOR

December 14, 1993

TO: The Honorable L. Douglas Wilder, Governor of Virginia, and Members of the General Assembly:

House Joint Resolution 676, agreed to by the 1993 General Assembly, directed the Virginia State Crime Commission and the Department of Corrections to study and evaluate current and future needs for drug and other substance abuse programs for inmates and the cost and funding of such programs and to submit its findings and recommendations to the Governor and the 1994 session of the General Assembly.

In fulfilling this directive, a study was conducted by the Virginia State Crime Commission in 1993. I have the honor of submitting herewith the study report and recommendations on substance abuse programs for inmates.

Respectfully submitted,

Robert B. Ball, Sr.
Chairman

RBB:sc

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Studying
The Current and Future Needs for Programs Providing Substance Abuse Treatment for Inmates
HJR 676

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TABLE OF CONTENTS

Authority for Study

House Joint Resolution 676

House Joint Resolution No. 676 directs that the Department of Corrections and the Virginia State Crime Commission study and evaluate the current and future needs for programs providing substance abuse treatment and similar rehabilitation for inmates and methods for providing such services. This study and evaluation is required to include, but is not limited to:

1. identification of current and future needs for such programs;
2. evaluation of available public and private sector programs and expertise, including the ability of such programs to reduce the direct and indirect costs to the Commonwealth of recidivism of individuals in need of substance abuse treatment;
3. costs of and funding mechanisms for such programs;
4. existing authority of the Department's current ability to utilize the expertise and services of other state agencies, public and private institutions of higher education, and nonprofit and other private organizations; and
5. the need for further legislative authority for such programs and related undertakings.

Executive Summary

There is a need for substance abuse treatment programs in prison. The Virginia Department of Corrections houses a significant number of inmates with problems associated with the distribution, use, abuse and dependency upon drugs. The number of persons psychologically dependent on cocaine and crack cocaine is increasing dramatically. According to the report Drugs in Virginia: A Criminal Justice Perspective, "cocaine related offenders are now the fastest growing offender group being imprisoned". The number of inmates with physical addiction to heroin is on the rise.

The 1992 Joint Legislative Audit and Review Commission report Substance Abuse and Sex Offender Treatment Services for Parole Eligible Inmates indicated that eighty-one (81%) percent of all state-responsible inmates "had a substance abuse problem when they were initially incarcerated". An updated analysis by the Department of Corrections (Dec. 1993 Appendix B) affirms this trend. The Department of Corrections has in the last four years, seen a three-fold increase in the number of inmates incarcerated for drug charges, to more than one in every five inmates.

Effective and efficient treatment programs are vitally important in correctional facilities. Delays in receiving treatment often mean that individuals return to drug usage, even after lengthy periods of enforced abstinence during incarceration. Recidivism rate studies on drug abusers indicate that treatment intervention during incarceration can have profound effects on maintenance of drug-free lifestyles and reduction of criminality when these persons are returned to the community. **According to the Commission on Prison and Jail Overcrowding study 80% of untreated substance abusing inmates return to prison within three years while less than 25% who received treatment will recidivate.**

Treatment works. Substance abuse treatment, when provided to incarcerated individuals in the appropriate setting, and at the appropriate time, can reduce the demand for inappropriate use of alcohol and other drugs. The motivation to enter into treatment, as well as to actively engage in treatment activities, can be increased as the inmate sees program participation directly effecting his/her opportunities for increased privileges and opportunities for release from incarceration. The earning of "good time" for example has been tied directly by the Department to the participation in substance abuse treatment programs. Numerous studies have shown that there is very little difference between the outcomes of voluntary and involuntary treatment, so long as the participant was maintained in the program long enough for issues of denial and resistance to be overcome.

Good treatment is good security. While often not intended as a direct outcome of treatment intervention, the supervision requirement during incarceration may be reduced when inmates are involved in substance abuse treatment programs. Participants in treatment programs tend to break prison rules less often than those not in treatment. They tend to destroy property less often than those not in treatment. They tend to require a lower level of management supervision, which can reduce overtime and injury-related absenteeisms costs. Finally, security supervision costs are reduced as the risk of drug importation is reduced.

Spending money to treat incarcerated persons may increase the benefits gained from incarceration. Incarcerated individuals have a reduced treatment cost per-diem as compared to non-incarcerated individuals in treatment. Providing treatment programs while abusers are incarcerated maximizes the opportunities for future cost avoidances in the community. Prisons, being residential centers already have the ancillary services such as food, shelter, health care, and education that are required in community residential substance abuse treatment programs. With these services already in place there is a relatively small additional cost necessary to provide for a substance abuse treatment program. In prison the abuser has more time to participate. And inmates often have a prison sentence which allows sufficient time to complete the intensive treatment necessary. Prison-based substance abuse treatment programs are better able to maintain full capacity utilization, as opposed to community-based programs which may experience peaks and valleys in admissions due to intake processing delays.

Treatment is not a one-time event. Drug addiction cannot be cured. Drug abuse can be brought into remission quickly and at a relatively low cost. To maintain remission, it is necessary to provide for access to needed services throughout the life of the substance abusing individual. For those who are able to place their abuse in remission, the costs of continuing services needed are very low. Community-based support services, such as the Alcoholics Anonymous (AA) and Narcotics Anonymous(NA) programs are available without cost to the community. Other self-help programs addressing other dysfunctional behaviors may be available in the community.

Improved access is needed for services to assist those who are in danger of relapsing, or who have relapsed. Short-term intervention services to prevent a complete relapse usually provide a better outcome, at a significantly lower cost, than services needed to "re-treat" an individual who, for lack of early intervention, has returned to full-blown drug abusing behavior.

Reduction in Recidivism. Criminals who abuse alcohol and other drugs tend to commit between three (3) and thirty (30) times as many crimes as non-substance abusing criminals. The variance between the levels of intensity of criminal behavior appears to be related directly to the intensity of drug use at the time of the criminal act. To illustrate - an individual addicted to smoking crack cocaine may commit as many as two and twelve criminal acts per day to support their crack cocaine addiction.

The criminal activity of addicts is much greater than that of non-addict criminals. Even when the criminal abuse/use (purchase and possession) of drugs is eliminated from the count, the addicted criminal will still commit significantly more criminal acts than will a non-addicted criminal.

The Department of Corrections has developed two budget addendum packages addressing improvements in prison substance abuse treatment. The first provides for an overall enhancement of the inmate counseling services entitled "statewide counseling & treatment services" with a biennium cost of $16,238,909.

The second proposal requests additional funding to convert an entire prison, soon to be opened (Feb. 1994) into a single substance abuse treatment facility with a biennium cost of $3,373,560.

Finally, the prison inmates cannot be successfully treated without immediate and ongoing aftercare and follow up in the community upon release.

Study Design

A study of the current and future needs for programs providing substance abuse treatment and similar rehabilitation for inmates was conducted by staff of the Department of Corrections and the Virginia Crime Commission assisted by staff from the Governor's Institute on Alcohol and Other Drugs (VCU), the Department of Criminal Justice Services, and the Office of Substance Abuse Services, Department of Mental Health, Mental Retardation and Substance Abuse Services. A review was conducted of existing state and national publications and research on the benefit of correctional-based substance abuse treatment program designs, and of the cost-effectiveness of various treatment modalities. Additional reviews were made of state and federal projections for inmate population growth and crime trends relating to this population. Funding, cost, and data collection issues were explored to determine if data evaluation and cross-program comparisons were possible. A review was made of the legislative authority of the Department of Corrections to engage in or contract the substance abuse treatment for inmates, as well as the potential needs for further and specific legislative authority in these areas.

Study of the Current and Future Need for Programs Providing Substance Abuse Treatment for Inmates

I Prior Studies

Since 1989 a series of legislative studies and commission reports have supported the need for substance abuse treatment for Virginia's inmates. The final report of the Commission on Prison and Jail Overcrowding (COPJO) noted that between 1983 and 1989 the incarcerated population had grown at an average rate of nearly 9% annually. Much of this growth was attributed to the influx of drug related crime. Between 1985 and 1988, arrests for the sale or manufacture of opium, cocaine and cocaine derivatives increased over 300 percent. New commitments increased 37% during the period between 1983 and 1989, but new admissions for drug offenders increased over 195% during the same period. **The Commission concluded that given the numbers of offenders committing drug-related crimes, the Commonwealth must find ways to deal with large numbers of these offenders and their drug problems, to stop the revolving door of drugs, crime and incarceration.**

COPJO made specific recommendations regarding treatment programming for drug offenders:

- o inmate substance abuse treatment (19)
- o community treatment (26)
- o implement a statewide substance abuse program for inmates (47)
- o assess the feasibility of special purpose prisons for substance abuse (49)

Next, the 1990 Appropriations Act (Chapter 972, Item 472E) required the Department of Corrections and the Department of Mental Health, Mental Retardation and Substance Abuse Services to jointly assess the feasibility of establishing special purpose treatment facilities for substance abusers.

The assessment examined special-purpose substance abuse facilities operating nationally to determine success rates, client profiles, physical plant, staffing, costs, and program design. **The study found that for chronic, heavy substance abusers, the Therapeutic Community model of treatment has overwhelming success in the correctional setting.** Further, the study found that Therapeutic Community programs, which isolate participants from the general population for intensive treatment, can be effective operating as a part of a larger prison facility or as an entire special-purpose treatment facility.

In 1991 a study was conducted by the Department of Criminal Justice Services (DCJS) titled Drugs in Virginia: A Criminal Justice Perspective. This study further examined the drug problem in Virginia and echoed many of the findings in the COPJO report: **the need for available and accessible drug treatment programs for inmates, continuing and reliable evaluations of drug treatment efforts, and the allocation of financial and personnel resources to those drug treatment efforts that demonstrate effectiveness.**

The Joint Legislative Audit and Review Commission (JLARC) conducted a study in 1992 on Substance Abuse and Sex Offender Treatment Services for Parole Eligible Inmates and determined that 81% of incarcerated offenders were substance abusers. Further, this study noted that 25% of inmates with substance abuse problems did not receive any type of treatment before reaching their parole eligibility date. Another 55% only received a twelve-step support group (such as Alcoholics Anonymous or Narcotics Anonymous) as treatment. Only 1% of substance abusers were treated in the Therapeutic Community program model. **JLARC concluded that the Department should "develop a multi-tiered system of treatment that includes options for inmates with different levels of drug and alcohol abuse problems".**

In April 1992, the Governor's drug treatment summit was convened which was attended by 400 criminal justice and substance abuse specialists. One of the important recommendations was that **the Commonwealth should establish a single purpose prison fully dedicated to substance abuse treatment.** The same recommendation was prominent among recommendations made in a study contracted out by the Governor's office to Virginia Commonwealth University. The report, Substance Abuse Services in Virginia's Adult Correctional System: A Blue Print for the Future, urged that an institutional treatment program be tightly coordinated with follow-through programming in the community so there is no interruption of services as inmates are paroled.

Finally, as recently as June 22, 1993 the Governor's Commission on Violent Crime supported DOC budget proposals aimed at increasing the capacity of drug treatment available in institutions and particularly a single purpose substance abuse treatment such as the soon to be opened Indian Creek Correctional Center.

Current Services

In 1974, the Department began the House of Thought, a program modeled after the therapeutic community concept developed in the late 1960's at the Marion Federal Prison. In spite of promising results, this program was terminated in the early 1980's due to statewide agency

budget cuts.

The Department has progressively pursued the implementation of substance abuse treatment services. The most recent emphasis for treating drug dependent offenders began in fiscal year 1988-89, subsequent to the enactment of the federal Anti-Drug Abuse Act (ADAA) of 1988. The Department was successful in obtaining ADAA grant funding in 1989. Through this grant the DOC began developing an infrastructure for substance abuse treatment programming in prisons. With the use of the federal grant funds, the Department was able to establish three small therapeutic community programs and three substance abuse education programs at prison facilities. These programs were staffed by substance abuse therapists funded by the grant. In addition, the grant funded the central office position of Substance Abuse Program Coordinator and a trainer at the Department's Academy for Staff Development. A curriculum of basic substance abuse education was developed through the grant and is currently being provided to prison counselors. With the federal funding, the Department also began a program to extensively train selected prison counselors to become State Certified Substance Abuse Counselors. Currently 21 counselors participate in this initiative. In addition, Federal funds enabled the Department to develop substance abuse aftercare services in the Parole offices in concert with local Community Services Board.

In 1992, based on recommendations made by JLARC, the Department developed a comprehensive treatment plan to provide, on an annual basis, substance abuse services for 20% of inmates in need of such treatment. Resources needed to implement this plan were presented to the 1992 and 1993 sessions of the General Assembly.

The 1993 General Assembly was able to partially fund the Department's substance abuse resource request by approving the partial cost assumption of several programs previously funded by the federal grant. In addition, four (4) clinical supervisors of the substance abuse program were approved. The Department continues to seek requests to support a 20% treatment goal.

Recently, the Department has been approved for additional federal grant funds administered through the Department of Criminal Justice Services, which will fund an expansion of the therapeutic community treatment program at Botetourt Correctional Unit and implement a 50 bed therapeutic community program at Pulaski Correctional Unit.

In July, 1993 the Department applied for a federal grant from the Center for Substance Abuse Treatment of the U. S. Department of Health and Human Services to operate an entire special purpose substance abuse treatment facility. In October 1993 the Department was informed by

the Center for Substance Abuse Treatment that it's application was approved but not funded. The Department has requested funding for this project from the 1994 General Assembly.

II Current Needs

Prison Needs

In spite of the initiatives to date by the Department, **the need for treatment among Virginia inmates far exceeds the Department's ability to provide them.** For intensive programming, including the program under development at Pulaski Correctional Unit, the Department will have four small, modified therapeutic community programs operating in its prison facilities. However, the capacity of each program is less than 60 beds, with a total statewide capacity of only 216 beds. This translates into therapeutic community treatment for only 1.5% of the 81% substance abusing population in need of treatment. The Department studies suggest that at least 10% of the population in need of treatment will require therapeutic community services.

The Department also has formed intensive education/group counseling programs at three other facilities, each with a capacity of 80 inmates per year, for a statewide yearly total of 240 treatment slots. This is only an additional 1.7% of the population in need of treatment. The Department anticipates that 40% of this population will require both substance abuse education and group counseling services, and another 30% will require substance abuse education services alone.

In conclusion, since approximately 80% of the confined prison population has abused substances, a portion of this group may benefit from substance abuse treatment and educational and counseling services. However, since many inmates have very lengthy sentences left to serve, it is neither necessary nor feasible to provide treatment to the total (ie 80%) group at one time. After analysis of several factors including the severity of abuse, the time left to serve, the treatment time necessary to complete the program as well as the availability of space and the post treatment deterioration/contamination factor, it was decided that only 20% of the inmates in need of treatment would require and benefit from services each year.

Hence, the following table depicts the estimated number of inmates requiring treatment slots in each year for the next four years. As an example for the fiscal year ending in June 1994, 13639 inmates would have substance abuse histories. Applying the Department's 20% treatment goal only 2727 inmates would receive treatment. Unfortunately, today only approximately 456 treatment slots are available annually. As the inmate population continues to grow, the treatment gap will only grow larger.

Prison Substance Abuse Treatment Need

Fiscal Year	Prison Population	80% Need Substance Abuse Treatment	20% to be Treated Annually	Current Treatment Shortfall
1993	17049	13639	2728	2272
1994	19949	15959	3192	2736
1995	21149	16919	3384	2928
1996	22216	17773	3555	3099
1997	23648	18918	3784	3328

Table II

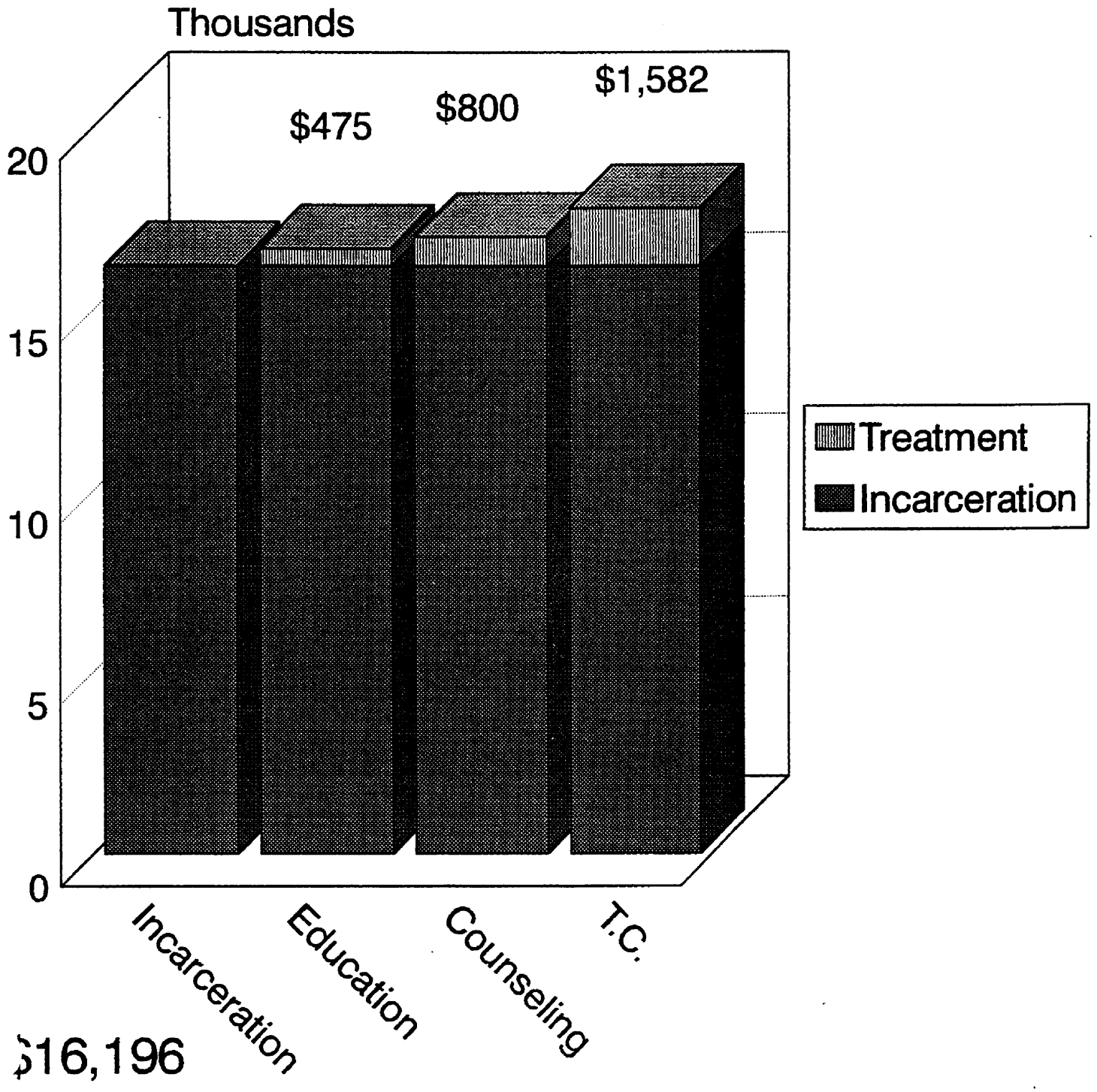
Services Delivered by Community Services Boards
FY 1992

SERVICE	Number Treated	# UNITS	STATIC SLOTS
Outpatient Counseling	39867	683,146 hours	39,876/year
Case Management	13748	118,534 hours	13,748/year
Day Treatment	2308	50,263DOS*	366
Therapeutic Community	1305	98,932 beds	316 beds
Group Home	280	17,822 beds	63.4 beds

* = Days of Service

Illustration I

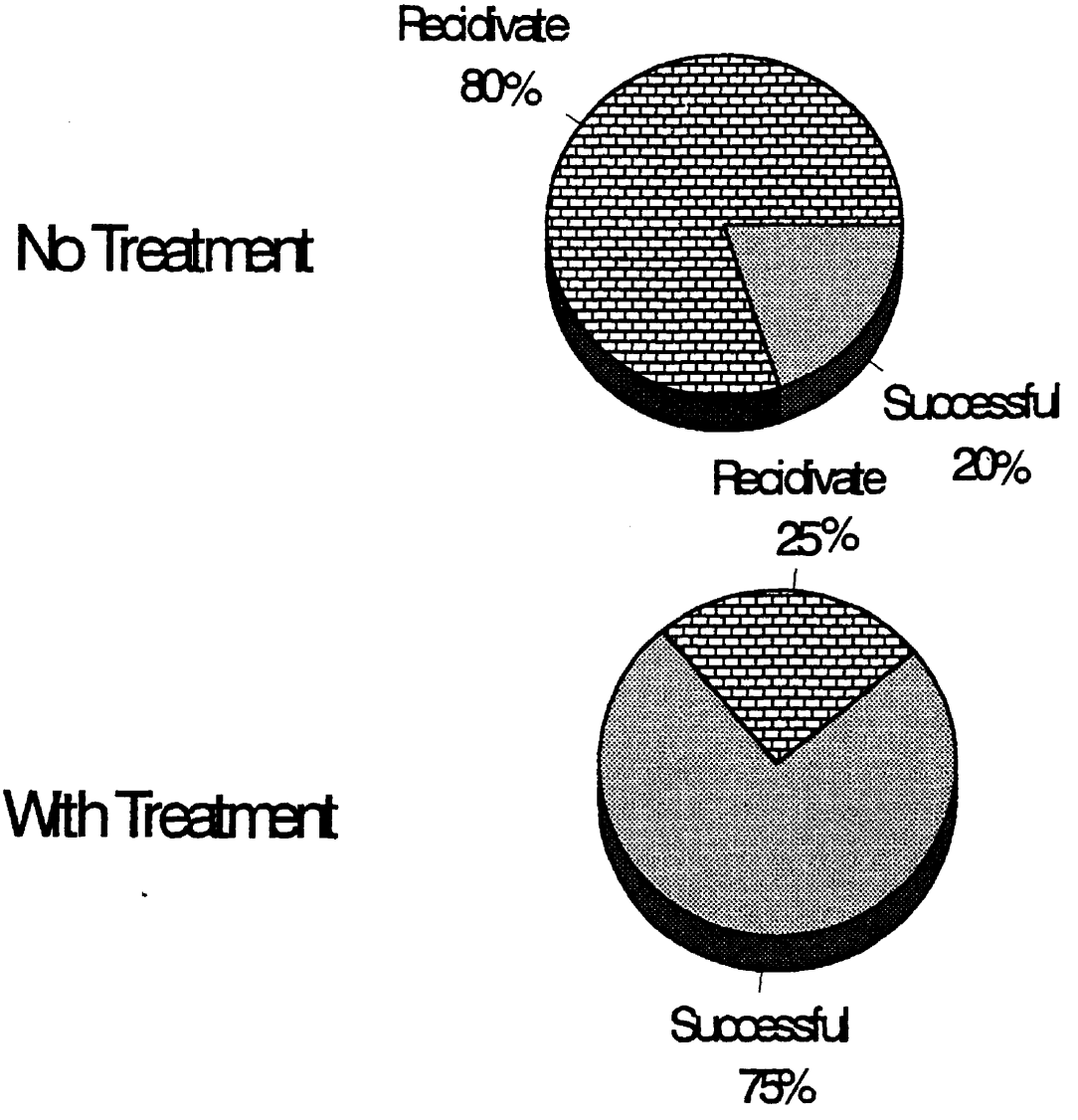
Annual Costs of Substance Abuse Treatment Programs in Prison



Source: Virginia Statewide Substance Abuse Program: FY 93-94

Illustration II

Comparison of Substance Abuse Treatment vs. No Treatment: High-Risk Substance Abusers



Source: Commission on Prison & Jail Overcrowding, pg. 59

Table III
Projection of Additional Population to be Served by Community Services Boards by Fiscal Year and Type of Service

FY	A	B	C
1994	1596	1277	958
1995	1692	1354	1015
1996	1777	1422	1066
1997	1891	1513	1135

A: Population completing Therapeutic Community model treatment - will need community-based residential care

B: Population completing substance abuse education and outpatient group counseling - will need community-based outpatient and support services

C: Population completing substance abuse education only - will need community-based support (AA/NA) services and may require community-based outpatient counseling

III Enabling Authority for the Delivery of Substance Abuse Programs in Prison

Department of Corrections

Legal Authority for Department of Corrections to Operate Inmate Drug Treatment Programs is derived from Section 53.1-10.3 of the Code of Virginia of 1950, as amended, empowers the Director of the Department of Corrections "[T]o employ such personnel and develop and implement such programs as may be necessary....". and from Section 53.1-32 "The Director may establish... a comprehensive substance treatment program..." The legal authority to receive and expend funds in support of these activities is obtained through the Appropriations Act and other legislation regarding the general fiduciary operation of the Department of Corrections. While not defined in 53.1-10.3, later at 53.1-261 et seq. "programs" are defined to include 'counseling, special treatment programs, or other programs for special needs.' Both federal and state legislation has identified substance abusers in a number of ways as being a special category of individuals due consideration and privileges based on their condition. The treatment of this population would appear to be within the scope of the authority granted to the Director of the Department in order to carry out the provisions of Title 53 of the Code of Virginia of 1950, as amended.

Authority of DOC Contract for Services

Another discussion of "legal authority" assumes the issue is whether or not the Department of Corrections has the authority to contract for private drug rehabilitation programs for both inmates and releasees in need of drug rehabilitation. It assumes that expenditure of funds for privately operated programs are already authorized through other mechanisms (separately funded Pre- and Post Incarceration Services funds [PAPIS, administered by the Department of Criminal Justice Services] and budget line item expenditures [e.g., Va. Cares]) and that funds for state-run/DOC in-facility programs are clearly available.

Pursuant to the Corrections Private Management Act (Section 53.1-261 et seq.), the Director of Corrections is authorized to enter into contracts with "prison contractors" for the operation of "prison facilities." Prison contractors are defined as entities who provide "correctional services" to inmates "under the custody of the Commonwealth." "Correctional services" include, when provided in a prison or otherwise, "counseling, special treatment programs, or other programs for special needs."

This would seem to grant the Director full authority to contract for such services for inmates whether in a prison facility or otherwise. The question, then, is whether such services are authorized for "non-inmates" (parolees).

Inasmuch as parolees are considered "within the custody" of the Commonwealth for purposes of habeas corpus petitions, it would seem that the Director may fund a private contract for the drug rehabilitation of a parolee as well as an inmate.

Likewise, general authority exists in the Code for the expenditure of Corrections monies for contacts with private service provides. For example, Section 53.1-10 (4) authorizes the Director "[t]o make and enter into all contracts and agreements necessary or incidental to the performance of the Department's duties and the execution of its powers under this title, including, but not limited to, contracts with the United States, other states, and agencies and governmental subdivisions of this Commonwealth, consistent with applicable standards and goals of the Board..."

Additionally, the Director is authorized in Section 53.1-181 to expend funds for the purchase of Community Diversion Incentives Program services from "private, non-profit agencies."

Thus, the Code is replete with references to general and specific instances of Department of Corrections authority for the purchase of privately provided correctional services.

Authority of Department of Mental Health, Mental Retardation and Substance Abuse Services

Independent of the Department of Corrections, the Department of Mental Health, Mental Retardation and Substance Abuse Services has the responsibility to provide substance abuse services as follows:

> "The Department shall provide for the treatment and rehabilitation of persons addicted to or involved in substance abuse." Section 37.1-208.
>
> "The Commissioner (of the Department) shall contract for and/or establish such hospital and clinic facilities as are necessary to care properly for persons involved in substance abuse." Section 37.1-209.

Regarding the Department of Mental Health, Mental Retardation and Substance Abuse Services, the legal authority for the operation of their substance abuse treatment programs through the Community Services Boards is Section 37.1-208 and Section 37.1-209, Code of Virginia of 1950, as amended.

IV Evaluating Treatment in Prisons: Parallel Studies

The proposed commitment of substantial resources to substance abuse treatment should, if possible, be justified and guided by evidence of what has proven effective in such programs already operating and evaluated. Preferable would be evaluations of substance abuse programs in Virginia correctional settings, but there have not yet been any fully

committed treatment institutions for substance abusers in Virginia, and the partial therapeutic community (TC) programs in three of Virginia prisons have not yet been systematically evaluated. (Note: The Department has recently employed a full time employee to conduct Substance Abuse Program Evaluations) This leaves the most useful approach to be a study of treatment outcomes for appropriately similar programs elsewhere.

Accordingly, there is summarized here a review of reports on TC programs in correctional institutions or closely similar settings, especially those which are similar to the program design which the Department of Corrections proposed to incorporate at Indian Creek Correctional Center. In general, the findings have been of a positive nature, tending strongly to encourage combined institutional and community programming.

Evaluation of the outcomes of substance abuse treatment programs always is hampered by the high cost of following the post-treatment careers of former clients, and the necessity of relying heavily on subjective self-reported experienced when these clients are found and questioned. Nevertheless, there are numerous evaluative studies available for review, and the reported results are sufficiently consistent to make them usefully reliable. Below are summarized comments on several of the specific programs in correctional settings.

The Cornerstone program in Oregon is a modified TC program accepting prisoners who are between six and eighteen months from parole date, and who agree to remain in the follow-through portion of the program for six months after release. In evaluating this program the Oregon researchers looked at the graduates who had been aboard for an average of 11 months and found that in the three years after their release, 37% had not had any arrests; 74% had served no more prison time. Though the findings offer no comparison of these figures with the records of similar prisoners who received no treatment, the researchers assert that "[T]he Cornerstone program continues to demonstrate a positive effect on decreasing the criminal activity of program participants."

The Stay'n Out program is a TC operating since 1977 at Arthur Kill Correctional Institution on Staten Island, N.Y., and is one of the more carefully evaluated of such programs. It offers the advantage that comparisons can be made between clients receiving different levels of treatment intensity, including even a group of inmates who received no treatment. The latter were inmates who had applied for admission to the TC but reached their discharge dates before being accepted for treatment. In between were two treatment levels, one with clients in a "milieu therapy" category in which they were given individual and group counseling but at a less intensive level than in a TC; the remaining group was given short term help consisting only of weekly group counseling.

The Arthur Kill facility utilizes a network of community resources to which clients can be referred for prompt and

intensive help upon discharge, though this aftercare help is not designed as an integral part of the treatment plan. Outcome evaluation has been a matter of statistical recording of arrest rates for the different treatment levels. The last published account of this evaluation, covering the experience for the years 1977 to 1984, shows clearly that the Intensive TC group has the least arrests and the others have more arrests in relation to lesser levels of treatment. For instance: 26.9% of the TC graduates were arrested while the arrests for the succeeding levels of less treatment were 34.6%, 39.8%, and 40.9%. A concluding comment by the evaluators is that "the TC was effective in reducing recidivism, and this positive effect increased as TIP (time in program) increased, but is tapered off after 12 months."

The experience of The Stay'n Out program has useful significance for the planning of a single-purpose facility program in its support of the concept of the intensive TC, but especially showing the need for a strong follow-through aftercare service to reinforce and protect the gains made in the institution component.

Daytop, in New York state, is one of the older, better know organizations in substance abuse treatment, and it has been included in a general review of such programs done some years ago. In this case the outcome evaluation was conducted by interviewers who sought the graduates of the Daytop program and evaluated their status just through personal questioning. This has usefulness but also possibilities for distortion, as mentioned above. In 1974 they located 64% of the graduates in the target study group, and assessed 84% of them as drug free and not re-arrested at an average time of one year after release. At the same time they located many of the clients who had entered treatment but had been early drop-outs and found that 46% of these remained drug free.

Phoenix House, another noted New York program, is included in the same evaluative report as Daytop, above. In one effort which located 35 Phoenix House residents graduated in 1974, they found only one case classed as failure. This study notes the significant fact that a high proportion of the successful graduates are found to be working in the field of addiction treatment, serving as counselors of various types.

The Veterans Administration, which has operated a variety of treatment programs including TCs, conducted a broad scale study of its graduates in 1973-74 and was able to locate 85% of them, about one third of whom had been in TCs. Their experience is reported in general terms as showing that "participation in treatment was associated with a large decrease in heroin use, moderate decreases in the use of several other drugs, a small increase in the use of alcohol, moderate lessening of involvement in the drug culture, a moderate increase in psychological well-being, small increases in economic independence."

Federal probation and parole, as reported from the northern district of California, shows that even a limited but resolute follow-through surveillance program can be effective. In that district the parole services have focused on their clients who have drug abuse histories, offering them various counseling helps, particularly with the requirement that they submit to regular urine screening. Without detailing the phases and variations adapted to individual cases, the plan is to require every parolee to submit to a schedule of combined routine and random urine tests, up to ten per month. It was found that as the program developed and as more of the clients learned of the certainty of testing and its consequences, drug usage declined. In 1984 the testing found up to 21% of the tests positive for illicit drugs. In 1990 the percentage had dropped to 6.6%. While this gives us no comment on the usefulness of institutional TC programs, it tells us that when aggressive aftercare measures by themselves can be rewarding to this extent, it has particularly encouraging implications for the Virginia planning of a strong treatment program in the institution combined with this level of aftercare.

As a general comment, all of the research reports are consistent in certain points -- the TC types of programs show the best results; length of time in program is directly related to outcome success, with clients performing much better as they stay longer in the programs (up to a year) before release; clients who enter the programs and then drop out without completing the full time still do better afterward than untreated people, but never as well as those who stay full time. "Dropout is highest within the first 15 days of admission and declines sharply thereafter in such a way that the likelihood of dropout decreases with length of stay itself." (NIDA, Monograph 51)

One encouraging finding is the consistent experience that treatment can be effective in a coercive setting. Although there is merit in the view that a person is not likely to be helped unless he himself recognizes his need and wants to get the help. It is being found that substance abuse clients rarely seek help voluntarily, but when in prison their interest in help can be effectively captured by a dynamic TC. "Research has determined that those who enter treatment under some form of coercion are likely to do at least as well as - sometimes better than - those who enter voluntarily." This comment comes from a federal report which goes on to give specific improvement rates for some of the graduates of prison-based treatment programs. The report comments on these findings with the observation that "those under legal pressure to undergo treatment ... do better, in part because legal pressure keeps an addict in treatment for a longer period of time, and virtually all studies agree that the longer time an addict receives treatment the better are his chances for long-term success." (Understanding Drug Treatment, 1990)

The National Association of State Alcohol and Drug Abuse Directors summarizes its view of treatment efforts with such comments as the following: "Drug abuse treatment

significantly reduces the transmission of AIDS among IV drug users," and "The potential for reducing criminal behavior is one of the most compelling reasons in favor of alcohol and other drug abuse treatment ... three to five years after leaving treatment, the proportion of clients who were involved in predatory crimes was one-third to one-half of the pre-treatment proportion in each of the modalities." (These and many more such observations by the Association are in most cases quoted from reports by the National Institute on Drug Abuse, March 1990.)

Any consideration of the nature of the conventional prison culture points up the enormous handicap under which correctional staffs operate in trying to help drug addicts in prison, or under which the clients themselves suffer frustration in case they have any desire to change. One of the research reports is eloquent on the point. "It is difficult to imagine an environment that is less therapeutic than a correctional institution .... The majority of inmates belong to disadvantaged minority groups and have earned few of the necessary educational and vocational achievements in order to realize the fruits of society." (Wexler and Williams, 1986) Such observations point up the importance of making a radical change of approach if drug addicted prisoners are to get effective help; they also point up the impressive potency of the TC when it can be effective in such a naturally hostile environment.

V Contractual Resources

Correctional agencies, with the limitations which hamper them in accomplishing desirable levels of treatment programming, will consider it sensible to look for private services that may supplement their programs under contract. The availability of such services is growing rapidly, but is most difficult to characterize briefly. These services differ in philosophical approach or method, and they vary from one-person businesses to large and extensively staffed organizations. Fees also vary greatly. Privately organized TCs often include on their staffs numbers of reclaimed ex-drug addicts, which is commendable, but the necessity for such agencies to be rooted in some geographical spot, tends to reduce their availability to many prospective clients. In some cases the private entrepreneurs have brought their operations into prisons under contract, and with good effect, though few such services exist in relation to the potential market.

The use of a privately operated residential TC is, of course much more expensive than out-patient counseling, but studies tend to show that the extra cost is worth it. According to one research report, "residential treatment costs three times as much as outpatient drug-free treatment: $18.50 per day compared to $6.00 per day." But in reckoning the results, the same study showed the treatment episode cost $3000 and yielded a reduction of $6000 in the costs to law-abiding citizens .... The ratio of benefits, i.e., reduction in costs, to the

expense of providing the treatment, is strong for residential treatment."

The previously quoted federal report cautions that a program's effectiveness is not necessarily related to the size of its fees. "Data from studies of private treatment programs reveal that those charging $12,000 a month are usually no more successful at stopping drug addiction than those charging half that amount." But the same report states that "therapeutic communities seem especially good for those with a history of criminal behavior or social pathology -- people unaccustomed to rules and responsibilities. Overall, TCs have a good record of success, with as many as 4 out of 5 patients who complete the program drug-free several years out of treatment." (Understanding Drug Treatment, 1990)

VI Findings

Current capabilities and capacity of public & private sector programs:

The Department of Corrections currently has the yearly capacity to provide therapeutic community treatment services for 216 and for 240 in counseling and education services. Out of a projected need for treatment of 2,727 inmates this figure is far short of the 20% goal. As the population grows larger each year this gap in services well good even larger.

The Department has increased the number of treatment slots available each year for the past 5 years. This increase has been limited by constraints such as space availability, lack of funding for programs, trained staff, time limitations, and inmate and staff scheduling conflicts. The Department has addressed many of these issues in its statewide counseling and treatment services budget proposal to the General Assembly.

The capability and capacity of the public community sector to provide substance abuse treatment services to inmate populations is severely restricted, due to the overwhelming demand for services from the non-incarcerated population. Waiting lists for residential treatment programs are often over one year long, and a three-month wait to enter outpatient counseling is not that uncommon. With budget reductions that have taken place over the past several years, it has become more and more difficult for Community Services Boards to absorb the expenses of providing even the most rudimentary services to jails and prisons.

Also, given that the overwhelming majority of the substance abusing population associated with the criminal justice system does not have private health insurance, access to private sector treatment services is limited. Recent changes in the private health care system, to "managed care" regimes, has reduced access both in duration of treatment and type of treatment available. Most managed care systems do not recognize "conduct disorders" - the mental health diagnosis most commonly given the criminal population - as being covered

for treatment services. Thus, even if a parolee/probationer had health insurance, his/her ability to receive substance abuse treatment paid for by the health insurance would be limited or doubtful.

Projected Capabilities and Capacity of Public & Private Sector Programs:

As the prison population grows, without an increase in the substance abuse programs it will be more and more difficult for the Department of Corrections to approach the goal of providing substance abuse services to at least 20% a year of those in need of services. Yearly increases in staff and programming capacity are needed to keep pace with the growth of the inmate population.

Community-based substance abuse treatment faces many of the same issues as the prison system. The Community Services Boards may experience a continuing decline in their ability to provide appropriate services for persons being released from incarceration. As prison-based substance abuse treatment programs improve, the need grows for new services in the community. For instance, an inmate completing a year-long therapeutic community treatment program will not be appropriately served by drug education programs or group counseling programs designed to overcome denial and resistance to cessation of drug use. The TC graduate is in need of community reintegration and job-finding services. Supervised apartment living arrangements are available in only a very few localities in the Commonwealth. Often, residency requirements prevent parolees from entering these programs.

Unit Costs of Treatment in Prisons

The additional costs of providing substance abuse treatment to inmates in prison is relatively small in comparison to the other costs already incurred. Illustration I depicts the average annual costs per prisoner in Virginia for FY 93 was $16,196. To add a Drug Education Component the cost increases the base by $475. A drug counseling service is estimated at approximately $800, whereas the most intensive form of treatment the therapeutic community adds $1,582 annually. Clearly in comparison for example, in a community substance abuse treatment center a **monthly** costs for residential treatment can easily be four to six times that of the added **yearly** cost of providing the same service in prison.

Cost Effectiveness Analysis

Perhaps the time has come to redefine the analysis of costs associated with substance abuse treatment. Historically, costs have been analyzed by reviewing its benefit: **cost benefit analysis - the ratio of the number of dollars worth of benefit created per dollar of program cost.** When considering all of the issues related to substance abuse, an additional measure ought to be considered - **cost effectiveness analysis - having an additional benefit worth the additional dollar spent**

on treatment.

Consider the cost benefit for persons receiving treatment against those receiving no treatment. The untreated substance abuser results in more long-term, chronic costs to society. This is especially true of offenders who have high recidivism rates. If their life problems, including substance abuse, are not addressed while they are under correctional supervision, there is little chance they will be corrected at all. The costs of treatment pale in comparison, with the cost of the most expensive form of treatment being just over one tenth (1/10th) of not treating them but locking them up. Cost benefit analysis also indicates that for every $1 invested in treatment programs, taxpayers enjoy a $4 return in the reduction of drug-related costs including:

- Decrease in drug-related crime
- Reduced criminal justice system costs
- reduction in insurance premiums and out-of-pocket expenses related to crime

Outpatient treatment of a substance abuser while incarcerated adds less than one twentieth (1/20th) of the cost of incarceration alone. Nationally, it has been reported that for every dollar spent for substance abuse treatment, $11.54 is saved in social costs. This type of analysis also reveals that although a majority of heroin and cocaine users have initiated criminality prior to their use of drugs, their crime rates increase from relatively few felonies (under 50 annually) to many crimes (about 200 non-drug crimes and over 300 drug sales crimes annually) during periods of daily and multiple daily use. The logical extension of this analysis is that additional treatment dollars results in benefits that reduce crime rates.

VII Conclusion and Recommendations

This study indicates that substance abuse treatment works in prison settings but there is a large shortfall of treatment services for substance abusers. Approximately 80% of the incarcerated population had substance abuse problems when they were initially incarcerated. Previous studies conducted on the issue of substance abuse treatment have determined that therapeutic community design programs are the most effective treatment model for prison-based treatment programs. The DOC's goal of treating 20% of the substance abusers can provide significant benefits to the State in reducing crime, recidivism and hence costs. Treating the substance abusing group would represent a significant portion of those offenders being returned each year to their home communities. Resources, including personnel, materials, and treatment program space, should be made available to the Department of Corrections to meet this goal.

The Department of Corrections has prepared budget addendum packages which address a major portion of it's treatment goal

for substance abusers. The first, entitled "Statewide Counseling and Treatment Services" would add treatment program staff necessary for the DOC to treat 20% of the offenders in need. The biennium costs of this addendum is estimated at $16,238,909. The second addendum would provide for a substance abuse program as a dedicated, single purpose therapeutic community with 825 new beds. The estimated cost of this effort would be $3,373,560 for two years.

The Office of Substance Abuse Services, Department of Mental Health, Mental Retardation and Substance Abuse Services should seek the personnel, materials, and treatment program space necessary to reduce waiting lists for basic substance abuse education and group psychotherapy treatment services for criminal justice populations. Additionally, the Office of Substance Abuse Services should, in coordination with the Community Services Boards, develop, establish and implement additional treatment services necessary to support the transitional needs of substance abusers released from incarceration.

VIII Acknowledgments/Resources

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APPENDIX A

Appendix A

GENERAL ASSEMBLY OF VIRGINIA--1993 SESSION

HOUSE JOINT RESOLUTION NO. 676

Requesting the Department of Corrections and the Virginia State Crime Commission to study and evaluate current and future needs for drug and other substance abuse programs for inmates and the cost and funding of such programs.

Agreed to by the House of Delegates, February 7, 1993
Agreed to by the Senate, February 23, 1993

WHEREAS, the devastation of drugs and other substance abuse jeopardizes the safety of all citizens of Virginia; and

WHEREAS, repeat offender crimes and the dramatic growth of drug-related offenses threaten the public at large and impose rapidly increasing costs and operational problems for the Department of Corrections; and

WHEREAS, to better equip prisoners with the skills necessary to lead successful, law-abiding lives after incarceration, the Commonwealth must provide adequate training and treatment programs, including treatment for substance abuse; and

WHEREAS, it is imperative that state agencies play an integral part in the provision of these services based upon the Commonwealth's responsibility to protect the public and to reduce the rising costs of incarceration and increased recidivism among inmates with drug-related and other substance abuse problems; and

WHEREAS, it is the responsibility of the Commonwealth in the rehabilitation of prisoners to take advantage of all available expertise and knowledge, including the expertise and knowledge of the Department of Corrections, the Virginia State Crime Commission and other state agencies, state and private institutions of higher education and nonprofit and other private organizations; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Corrections and the Virginia State Crime Commission study and evaluate the current and future needs for programs providing substance abuse treatment and similar rehabilitation for inmates and methods for providing such services.

The study and evaluation shall consider, but not be limited to, (i) identification of current and future needs for such programs, (ii) evaluation of available public and private sector programs and expertise, including the ability of such programs to reduce the direct and indirect costs to the Commonwealth of recidivism of individuals in need of substance abuse treatment, (iii) costs of and funding mechanisms for such programs, (iv) existing authority of the Department of Corrections to provide such programs and their funding, and the Department's current ability to utilize the expertise and services of other state agencies, public and private institutions of higher education, and nonprofit and other private organizations, and (v) the need for further legislative authority for such programs and related undertakings.

All agencies of the Commonwealth shall, upon request, assist the Department of Corrections and the Crime Commission in the conduct of their study and evaluation.

The Department of Corrections and the Virginia State Crime Commission shall recommend such programs that can be implemented without legislation which are consistent with the purposes of this resolution. The Department and the Commission shall complete their work in time to submit their report to the Governor and the 1994 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

APPENDIX B

TABLE 1: INMATES CONFINED IN DOC ON 12/06/93
SUBSTANCE ABUSE STATUS AT TIME OF INTAKE*

SUBSTANCE ABUSE STATUS	FREQUENCY	PERCENT	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
ALCOHOL	1797	10.7	1797	10.7
BOTH DRUGS & ALCOHOL	5719	34.2	7516	44.9
DRUGS	5515	33.0	13031	77.9
NONE	3703	22.1	16734	100.0

TABLE 1:

As of December 6, 1993, 77.9% of the currently confined inmates were identified as abusing either alcohol, drugs, or both alcohol and drugs. (Alcohol abusers were counted only if they were identified as moderate or heavy users.)

TABLE 2:*

Table 2 represents the breakdown of drug use status (either yes or no) by the level of alcohol use. For example, of the 4131 inmates identified as **heavy** alcohol users, 78.7% were also identified as drug users.

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* Drug use status includes the use of the following drugs: heroin, opium, cocaine, synthetic drugs, marijuana, amphetamines, barbiturates, and hallucinogens.

TABLE 2: INMATES CONFINED IN DOC ON 12/06/93
DRUG AND ALCOHOL USE STATUS AT TIME OF INTAKE*

LEVEL OF ALCOHOL USE	FREQUENCY / PERCENT / ROW PCT / COL PCT	DRUG USE STATUS: NO	DRUG USE STATUS: YES	TOTAL
NA- EXTENT UNKNOWN		13	72	85
		0.08	0.43	0.51
		15.29	84.71	
		0.24	0.64	
NONE		1749	1653	3402
		10.46	9.88	20.34
		51.41	48.59	
		31.83	14.72	
HEAVY		880	3251	4131
		5.26	19.44	24.70
		21.30	78.70	
		16.01	28.95	
MODERATE		917	2468	3385
		5.48	14.76	20.24
		27.09	72.91	
		16.69	21.98	
OCCASIONAL		1769	3409	5178
		10.58	20.38	30.96
		34.16	65.84	
		32.19	30.36	
EXTENT UNKNOWN		167	377	544
		1.00	2.25	3.25
		30.70	69.30	
		3.04	3.36	
TOTAL		5495	11230	16725
		32.86	67.14	100.00

FREQUENCY MISSING = 9

* Data Source: Offender Based State Correctional Information System (OBSCIS), Felony Analysis & Simulation Tracking System (FAST) database, Virginia Department of Corrections.