# CHAPTER 4: DESCRIPTION OF DRUG TREATMENT PROGRAMS AND SERVICES

This chapter describes the nature of the BOP's drug treatment programs and the changes that occurred since the inception of the TRIAD evaluation project. In addition, we provide a brief description of the post-release treatment services available for inmates released with conditions of supervision.

## Paths to Treatment Service

Inmates interested in drug treatment receive services through various means. Treatment services for BOP inmates are available at three different stages: while incarcerated, during a halfway house placement, and while under supervision by a Probation officer. Services can be offered during the latter two stages only if the individual received a halfway house placement or was released with a condition of supervision. Treatment services for study subjects ranged from none to services at all three stages. The treatment available while incarcerated consisted of the residential DAP in combination with non-residential outpatient services and self-help groups. Treatment provided during a halfway house stay is referred to as "transitional drug abuse treatment" and consists of outpatient counseling services. Transitional drug abuse treatment was required for all DAP graduates.

Treatment provided while an individual was under supervision is referred to as post-release treatment. This treatment consists of a wide range of services, including both outpatient and residential/inpatient services, with an emphasis on outpatient services. It also includes participation in self-help groups.

## Program Development by Location

The residential Drug Abuse Treatment Programs offered treatment for alcohol and other drug problems, and were implemented in two distinct categories: pilot programs and comprehensive programs. Later, all programs were referred to as residential Drug Abuse Treatment Programs. Pilot programs offered 1,000 hours of treatment over a 12-month period, with a staff-to-inmate ratio of 1:12. Comprehensive Drug Abuse Treatment Programs provided 500 hours of treatment over a 9-month period, with a staff-to-inmate ratio of 1:24.

The first eight programs were approved for activation in FY's 1989 and 1990.[1] During FY's 1989 and 1990, the BOP implemented its first three residential Drug Abuse Treatment Pilot Programs

[1] The Federal fiscal years run from October 1 through September 30.

at FMC Lexington, FCI Butner, and FCI Tallahassee.[2] By the end of FY 1996, 39 programs had been approved for implementation. Figure 3 shows when each DAP was approved for activation and indicates which of the programs were included in this study and which were eliminated as research sites during the study.[3] We note that between 1997 and 2000 another 17 programs have been activated and 9 programs were closed since 1996. At the beginning of 2000 there were 44 programs operational.

**Admission Criteria**

All admissions into the BOP's residential Drug Abuse Treatment Programs were voluntary. Initially, residential programs required inmates to have (1) a drug problem and to have completed the BOP's Drug Abuse Education Course; (2) no outstanding legal concerns to interfere with Community Corrections Center (CCC) placement; (3) no serious medical or mental health problems; (4) no violent behavior within the last 12 months; and (5) between 24 and 36 months remaining on their sentences. By the time the first policy was issued, however, a number of these criteria had changed.

Inmates could apply for program admission at any time, with priority given to those inmates with less time remaining on their sentences. All program participants had to have at least 15 months remaining until their release dates (18 months for pilot program participants). An inmate was accepted into a program if:

- the inmate had a history of moderate to severe drug abuse, as reflected in the psychological assessment score on the Inventory of Substance Use Patterns (ISUP) administered by Psychology Services (or as reflected in the presentence investigation report);
- the inmate had no history of violence or assaultive behavior during the current incarceration;
- the inmate was fluent in the English language;
- the inmate had no serious medical, psychiatric, or psychological problems that would interfere with full program participation;
- the inmate was not a State boarder;

[2]FMC refers to a Federal Medical Center, FCI to a Federal Correctional Institution, and FPC to a Federal Prison Camp (*see* Glossary of Terms).

[3] A comprehensive history of DAP development between 1988 and 1995 is contained in an unpublished report — "BOP Residential Drug Treatment Program Development: 1988 to 1995 " — available upon request. A narrative description summarizing the selection of the research sites is contained in Chapter 5 under the section entitled "A Chronological History of the Selection of Subjects."

Figure 3

Chronological History of DAP's and DAP Research Sites

| DAP Research Site | FY Approved for Activation | Date Selected as Research Site | Date Discontinued as Research Site |
|---|---|---|---|
| Butner FCI | 1990 | 03/90 | 06/96 |
| Fairton FCI | 1990 | 03/90 | 06/96 |
| Lexington FCI* | 1989 | 03/90 | 02/94 |
| Oxford FCI | 1990 | 03/90 | 06/96 |
| Rochester FCI | 1990 | 03/90 | 08/91 |
| Seagoville FCI | 1990 | 03/90 | 06/96[4] |
| Sheridan FCI | 1990 | 03/90 | 06/96 |
| Tallahassee FCI | 1990 | 03/90 | 06/96 |
| Danbury FCI | 1991 | 03/93 | 06/96 |
| Dublin FCI* | 1991 | 08/93 | 06/96 |
| El Reno FCI | 1991 | not selected | not selected |
| Englewood FCI | 1991 | not selected | not selected |
| Leavenworth USP | 1991 | not selected | not selected |
| Marianna FCI | 1991 | 02/92 | 06/96 |
| Phoenix FCI | 1991 | 03/93 | 08/93 |
| Bastrop FCI | 1992 | not selected | not selected |
| La Tuna FCI | 1992 | 03/93 | 02/93 |
| Bryan FPC* | 1992 | not selected | not selected |
| Atlanta USP | 1992 | not selected | not selected |
| Lompoc USP | 1992 | not selected | not selected |
| Lompoc FCI | 1992 | 03/93 | 06/96 |
| Allenwood FPC | 1992 | not selected | not selected |
| McKean FCI | 1992 | 03/93 | 06/96 |
| Alderson FPC* | 1992 | 03/93 | 06/96 |
| Morgantown FCI | 1992 | 03/93 | 06/96 |
| Yankton FPC | 1992 | 03/93 | 06/96 |
| Terminal Island FCI | 1992 | 03/93 | 06/96 |
| Terre Haute USP | 1992 | not selected | not selected |
| Three Rivers FCI | 1992 | 03/93 | 06/96 |
| Talladega FCI | 1992 | not selected | not selected |
| Fort Worth FCI | 1994 | not selected | not selected |
| Dublin FPC* | 1995 | not selected | not selected |
| Sheridan FPC | 1995 | not selected | not selected |
| Fort Dix FCI | 1995 | not selected | not selected |
| Cumberland FPC | 1996 | not selected | not selected |
| Talladega FPC | 1996 | not selected | not selected |
| Texarkana FPC | 1996 | not selected | not selected |
| Florence FCI | 1996 | not selected | not selected |
| Milan FCI | 1996 | not selected | not selected |

Notes: Sites having female inmates are denoted by an asterisk (*). Also, Tallahassee and Danbury converted to all-female institutions in 1995, and Lexington converted to all-male in 1994.

**!** the inmate did not have a State or Immigration and Naturalization Service (INS)

[4] As will be noted in Chapter 5, this site was dropped between 1991 and 1993.

detainer or pending charges, and the inmate qualified for Community Corrections Center placement where transitional drug abuse treatment would be provided;

- the inmate was willing to sign an agreement to participate in the residential Drug Abuse Treatment Program; and
- the inmate successfully completed the Drug Abuse Education Program (described below).[5]

After several programs had admitted cohorts of inmates to drug treatment, the admission criteria were reviewed and modified in a number of ways. Inmates with detainers, State boarders, and inmates ineligible for Community Corrections Center placement became eligible to participate in residential Drug Abuse Treatment Programs, as did inmates who spoke Spanish (as more bilingual staff became available).

In October 1993, new BOP policy dictated a further modification in the admission criteria. Individuals now had to meet Diagnostic and Statistical Manual of Mental Disorder (DSM-III-R — American Psychiatric Association, 1987) criteria for substance abuse or dependence.

After the passage of the 1994 Violent Crime Control and Law Enforcement Act (VCCLEA), drug program policy required a number of changes as the VCCLEA made demands on the BOP's residential Drug Abuse Treatment Programs. The VCCLEA provided the Bureau with an incentive for inmate participation: the BOP Director was allowed to provide up to a 1-year sentence reduction for non-violent inmates who successfully completed a residential Drug Abuse Treatment Program. In addition, the VCCLEA required that by the end of FY 1997 the Bureau provide residential drug abuse treatment for all inmates who were "eligible."

In May 1995, the BOP revised its policy in accordance with the VCCLEA. Additional admission criteria required inmates to have a *verifiable, documented*[6] drug abuse problem. This criterion was established to prevent inmates who did not have drug problems from volunteering for drug treatment solely to obtain early release from prison. In addition, while inmates were always taken into the program with priority placement given to those with the least amount of time to serve, the time frame was generally limited to 36 months before release to account for a potential 1-year reduction in custody.

The policy statement issued in May 1995 also implemented more specific criteria for program expulsion. While in the residential Drug Abuse Treatment Program, an inmate could be expelled if he or she was found to have used or possessed alcohol or drugs, exhibited violence or threatened violence against staff or another inmate, committed a serious rule infraction, or exhibited disruptive behavior related to the program. Much of the greater specificity in discharge criteria —

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[5] Bureau of Prisons, Operations Memorandum 132-90 (5330), September 20, 1990. Inmate Drug Abuse Program.

[6] Self-reported drug use does not qualify as a verifiable, documented problem.

especially those related to disruptive behavior in the program — was the direct result of VCCLEA. Drug abuse treatment coordinators believed it necessary to define clearly expulsion criteria because program expulsion was accompanied by loss of eligibility for an early release.

It should be noted that some institution residential Drug Abuse Treatment Coordinators did not always apply the admission criteria as dictated by policy. Clinical judgment used as one of the selection filters into treatment is a process that must be acknowledged by researchers. This process, which we referred to in the literature review as the administrative selection process, can affect the profile of individuals being admitted to the treatment program. The question is, "to what extent do clinicians reject individuals who meet the admission criteria?" Although there were no systematic data available to shed definitive light on this process, some information was available from the field notes of researchers located at six of the initial research sites. While there were some programs with twice as many applicants as admitted individuals, the primary reasons for rejection were that staff had made referrals for inmates who id not volunteer or that the inmates did not meet the admission criteria. However, there was evidence that staff occasionally would reject an applicant due to a lack of motivation, because the inmate was disliked by staff, or because the individual was considered a management problem.

**Incentives for Program Participation**

At the earliest implementation, there were no incentives for DAP participation. However, initially low numbers of DAP volunteers despite increased funding and scrutiny by external agencies and Congress led the BOP Executive Staff to approve residential Drug Abuse Treatment Program incentives in October 1991.

Financial achievement awards[7] were approved as a means of overcoming the "disincentive" of pay losses incurred by inmates who, by participating in treatment, were no longer able to work full-time. Achievement awards were dispensed quarterly and were based on program performance — no unexcused absences from program activities, a 95-percent promptness rate for all scheduled program activities, no guilty findings for disciplinary infractions, and successful completion of all program assignments (including readings, homework, and self-evaluations).

The second incentive approved by the Executive Staff was consideration for a full 6 months in a Community Corrections Center for all successful residential Drug Abuse Treatment Program graduates.

The third incentive involved tangible and intangible benefits granted to treatment participants by local institution staff. Wardens received the latitude to offer such items as shirts, caps, and pens

[7] We note that financial incentives can also be viewed as having imposed a contingency management situation into the treatment process. The effect of this particular aspect of the treatment process cannot be disentangled from other aspects of the treatment process.

with program logos to program participants in good standing. Other local incentives included the assignment of participants to preferred living quarters and to units with washer/dryer access, special recreation privileges, and special dining privileges.

The incentives for drug treatment changed with the passage of the Violent Crime Control and Law Enforcement Act. This law allowed eligible inmates who successfully completed the Bureau's residential Drug Abuse Treatment Program to earn as much as a 1-year reduction from their statutory release dates (the qualification for early release was limited to inmates who had not committed a "crime of violence").[8] Successful completion of drug treatment was defined as completion of all phases of the drug treatment program — the residential program, the institutional aftercare program (when applicable), and the transitional drug abuse treatment component received while housed in a Community Corrections facility (described below).

A final change in DAP incentives came in 1995, with the discontinuation of tangible incentives for residential Drug Abuse Treatment Program participants. This was modified as part of an overall BOP policy to reduce the quantity of inmates' personal belongings.

## Program Design and Content

### *In-Prison Residential Drug Abuse Treatment Program (DAP)*

All residential DAP's are unit-based; that is, all residential Drug Abuse Treatment Program participants live together — separate from the general population — for the purpose of building a treatment community. Each unit has a capacity of approximately 100 inmates, based on a staff-to-inmate ratio of 1:12 or 1:24. Ordinarily, treatment is conducted on the unit for a half-day in two 2-hour sessions. During the other half day, inmates participate in typical institution activities (*e.g.*, work or school). During these times, as well as during meals, treatment participants interact with general population inmates.

Program specifications originally were geared toward the 9-month residential Drug Abuse Treatment Programs, with the 12-month programs following the same guidelines but adding increased flexibility in terms of hours not devoted to required program content. At the outset, the 9-month programs were to include 40 hours of comprehensive assessment and treatment-plan development, 280 hours of group/individual counseling, 100 hours of wellness lifestyle training, and 40 hours of study devoted to transitional-living issues. The individual/group therapy focused

[8] This early release provision presents issues of disparity for Bureau inmates. The disparity arises when, for example, two inmates convicted of the same offense receive different prison terms because the inmate who has been diagnosed with a substance abuse problem receives a 1-year reduction in his or her sentence and the inmate without a substance abuse problem serves the entire sentence. In effect, many perceive this 1-year reduction as a reward for drug-abusing behavior.

primarily on behavioral-skill building, cognitive-skills development, family issues, vocational/educational issues, criminal-thinking confrontation, pro-social values development, and relapse prevention. The program also provided support groups and elective self-help groups.

Individualized treatment plans were required, based on assessments of the subjects' needs. Full-team reviews were scheduled every 90 days, with a treatment plan review every 30 days.[9] Urinalyses were to be conducted more frequently than was the case with the general population.

In July 1991, residential Drug Abuse Treatment Program content became standardized. All residential Drug Abuse Treatment Coordinators were brought together, and they agreed that residential Drug Abuse Treatment Programs would include specific core components, including screening and assessment, treatment orientation, criminal-thinking confrontation, cognitive skill building, relapse prevention, interpersonal skill building, wellness, and transitional programming.

Together, these components accounted for 350 hours of programming, both in didactic and process groups. The remaining program hours were to be divided at the discretion of the individual coordinators.

In FY 1993, a workgroup chaired by the BOP national clinical coordinator developed the residential "Drug Abuse Treatment Program Handbook," standardizing 450 hours of the required 500 hours of treatment. These manuals were distributed during staff training conducted in the summer of 1994. As a result of this handbook — and modifications required by VCCLEA — the BOP policy, issued in May 1995, required post-testing of each module covered in the handbook.

Finally, due to the changing admission criteria, and because not all inmates were released to Community Corrections Centers or from custody shortly after completing the program,[10] an institutional transition program was established in 1992. The program originally required 25 hours of "refresher" treatment in the last 4 months prior to an inmate's release from the institution. However, in 1995 that policy changed and required each successful residential Drug Abuse Treatment Program graduate to receive no less than one hour of individual or group counseling per month for the first 12 months out of the residential unit or until transfer to a Community Corrections Center or release, whichever came first.

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[9] Full-team reviews include all members of the unit team (unit manager, case manager, and case counselor), as well as representatives from Education and Psychology Services. During these meetings, the following items are discussed: custody and security classification, work assignment and performance, leisure time activities, overall institutional adjustment, education and other program activities, plans for release, and Financial Responsibility Program involvement.

[10] Although priority was placed on admitting individuals near release from custody, individuals with time left to serve after program completion were initially admitted in order to fill the DAP treatment beds.

### *Non-Residential Drug Abuse Treatment Services/Self-Help Groups*

Although a few non-residential programs existed from the start, these programs were not defined clearly in drug treatment program policies. By June 1992, non-residential programs were better defined and it became mandatory to make these programs available in every BOP institution. This level of programming now provides individual and group counseling to inmates with substance abuse histories. Non-residential programs provide alcohol and other drug abuse treatment services to inmates who are not eligible or not interested in residential Drug Abuse Treatment Programs or who may have overriding mental health problems that preclude the inmate's full residential Drug Abuse Treatment Program participation. Non-residential drug abuse treatment also provides inmates with institutional transitional services. Self-help groups are available in all types of drug abuse treatment in the BOP, but they are most often associated with non-residential drug abuse treatment. However, self-help groups alone do not constitute non-residential drug abuse treatment as defined in BOP policy.

### *Drug Education Course*

Drug Abuse Education is the only drug abuse program service that is mandated by BOP policy. Inmates are required to participate in this program if they meet any of the following criteria:

- there is evidence in the presentence investigation report (PSI) that alcohol or other drug use contributed to the commission of the offense for which the inmate is currently incarcerated;
- alcohol or other drug use was a reason for a violation of supervised release — including parole — or BOP community status (CCC placement) for which the inmate is currently incarcerated; or
- the inmate was recommended by the sentencing judge for drug programming during the current incarceration.

Participants in the 40-hour drug abuse education course receive information about alcohol and drugs, as well as the physical, social, and psychological impact of these substances. Participants must complete an assessment of their lives, including an accounting of the costs that their drug use has had on their health, on the lives of their families, and on the community.

Inmates required to take the Drug Abuse Education course who refuse, or who fail to complete the course successfully are remanded to the lowest pay-grade for the remainder of their incarceration and are ineligible for community programs. It should be noted, however, that inmates may also volunteer for this course.

**Community Corrections Centers**

Ordinarily, inmates are transferred to a Community Correction Center (*i.e.*, a "CCC," or halfway house) prior to their release to the community or release to supervision. CCC placements provide inmates with structured environments in which to find a job, reunite with their families, and receive vocational and behavioral counseling.

Approximately 9 months before an inmate's probable release date, BOP staff determine an inmate's eligibility for CCC placement. A recommendation for CCC placement is based on the inmate's needs for services, the consideration of public safety, and the proper management of the BOP inmate population as a whole. An inmate may be referred to a CCC for as many as 6 months, but the average length of stay for all inmates is approximately 4 ½ months.

An inmate will most likely be determined *ineligible* for a CCC placement if he or she meets any of the following conditions:

- is a deportable alien;
- is serving a sentence of less than 6 months;
- has pending charges or detainers;
- requires psychological or psychiatric treatment or inpatient care;
- refuses to participate in the Inmate Financial Responsibility Program;[11]
- is deemed an aggressive sex offender; or
- poses a significant threat to the community.

Home confinement is another community option available to the BOP. In cooperation with the Federal Corrections and Supervision Division (probation services) of the Administrative Office of the U.S. Courts (AO), some inmates may be allowed to be placed at home while remaining under BOP custody. Home confinement provides inmates with increasing responsibility while remaining under supervision. Inmates on home confinement status are allowed to work, but are required to stay at home during non-work hours of the day. Where available, electronic monitoring equipment is used to ensure compliance with these conditions. The length of home confinement placement is limited to the last 10 percent of an inmate's sentence or 6 months — whichever is less. Individuals receiving a CCC placement may spend some of their time in home confinement.

When an individual is arrested for a new offense or is found guilty of a serious disciplinary infraction, he or she may be sanctioned and transferred to a local jail or to a Federal correctional facility and thus not successfully complete his or her CCC placement.

[11] This program involves a system of deductions from an inmate's pay in order to meet the requirements of court-ordered fines (e.g., child support, restitution).

### *Transitional Drug Abuse Treatment During Halfway House Placement*

At the outset of program planning in 1989, transitional drug abuse treatment was to consist of two phases. The first phase, pre-release services, would include 6 months in a CCC, with specialized programming provided either by a contractor or directly by BOP staff. The second phase — aftercare services — would consist of 6 months during which community services would be coordinated jointly by the BOP and the requisite U.S. Probation or Parole office, or provided directly by CCC staff if community resources were unavailable.

This initial plan was not implemented. Rather, in working closely with the AO's Federal Corrections and Supervision Division, in July 1992, a Memorandum of Understanding (MOU) was signed between the BOP and the AO concerning the provision of transitional drug abuse treatment. The agreement specified that for individuals with CCC placements, a planning conference involving CCC contract staff, a community-based drug counselor, and the inmate would be held within the first week of the inmate's arrival at the CCC. Because most Probation offices had community-based treatment contracts for offenders under Federal supervision, the MOU allowed the BOP to use the same contractors — in other words, to "piggyback" on the probation services agreements. This "piggyback" effort ensured that inmates would continue to receive treatment services from the same providers as they moved from BOP custody to Probation supervision.

Transitional drug abuse treatment generally includes community-based treatment with philosophies similar to those of institution-based treatments.[12] Initially, the intensity of transitional drug abuse treatment services was to be standardized, with each individual receiving 4 hours of services per week during his or her stay at the Community Corrections Center. However, soon after implementation, the community-based treatment provider began to direct the individual's course of treatment and, typically, now inmates receive, on average, 2 hours of Transitional Drug Abuse Treatment Services each week.

At the outset, transitional drug abuse treatment services were granted only to graduates of the DAP. In early 1993, the range of inmates who could receive transitional services during CCC placement was expanded to include any inmate in a CCC who was identified as needing drug treatment, even if he or she had not participated in an in-prison residential drug treatment program. This expansion resulted, in part, from recruitment problems in the early residential Drug Abuse Treatment Programs, which left funding available for an expanded community-based treatment population.

Although some transitional drug abuse treatment participants who had not been DAP participants received these services voluntarily, most did not. Most of these latter transitional drug abuse treatment participants became involved as a result either of community corrections staff

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[12] The Transitional Drug Abuse Treatment treatment would thus build upon the core components of the residential in-prison treatment program and provide continuity of care.

recommending treatment as a condition of the CCC placement or of two new community corrections programs initiatives implemented in 1994. The first initiative provided for the creation of Comprehensive Sanction Centers (CSC's), which were CCC's designed to offer more gradual and structured release experiences to individuals who might not be appropriate for the traditional CCC experience. All CSC residents were required to be screened for drug treatment needs and then referred, if appropriate, to Transitional Drug Abuse Treatment Services. CSC's had been fully implemented at 12 different sites in the country by January 1994, and they housed 4 percent of all the Transitional Drug Abuse Treatment Services participants.

The second initiative was called the Enhanced Transitional Drug Abuse Treatment Services (ETS) project. Within each of the six BOP regions, at least one CCC facility (not already designated as a CSC) was selected as an ETS site. ETS sites were similar to CCC's but contained special provisions for transitional drug abuse treatment services. ETS individuals were required to participate in community-based treatment *(i.e.*, transitional drug abuse treatment) if they were identified by a BOP community corrections manager as having a substance abuse problem and were determined by a community-based treatment provider to need treatment. Four ETS programs were implemented between January and March 1994, and another four began between April and August 1994. In the beginning of 1994, 26 percent of all the Transitional Drug Abuse Services participants were in ETS programs.

As of the end of 1996, with the implementation of the VCCLEA initiative, 62 percent of BOP inmates receiving transitional drug abuse treatment during their CCC placement were residential Drug Abuse Treatment Program graduates.

**Supervised Release**

Approximately 86 percent of the TRIAD research subjects were released from BOP custody with provisions for supervision by a U.S. Probation officer. The system of selecting individuals who were to receive treatment services as part of post-release supervision varied among each of the 94 judicial districts. Individuals with an identified history of drug abuse may have been required to receive treatment services while under supervision. Individuals under the supervision of a U.S. Probation officer may have undergone urinalysis tests and have had drug treatment services provided under the "Contract Services Program Plan" when the services were required as a condition of supervision.[13] However, urine testing was required of most individuals flagged as having a drug problem.

Urine testing involved a combination of regularly scheduled collections (fixed-interval testing) and unscheduled collections (random testing). Many, but not all, of the Probation offices follow a three phase urine testing program:

[13] In the event that the necessary services were not offered by one of the contract agencies, these services may have been provided by a non-contract agency or the Probation officer.

- Phase I — This phase involved six urinalysis (UA) collections monthly with at least two unscheduled collections. During this phase, the treatment contractor, when requested, should have provided four 30-minute counseling (or alternative treatment) sessions each month. This phase usually lasted 6 months.
- Phase II — When an individual completed 6 months of Phase I satisfactorily, he or she moved on to Phase II, where the urine collections were reduced to four per month, with at least two of these unscheduled. During this phase, if treatment services were required, there were three counseling sessions of at least 30 minutes each month. This phase generally lasted 3 months.
- Phase III — This phase reduced the monthly urine collections to two unscheduled urine tests. Counseling sessions were reduced to two sessions of at least 30 minutes each month. Usually, the type of treatment provided by a contractor consisted of either individual or group counseling. However, when necessary, intensive outpatient counseling, detoxification services, and residential services were provided.

Individuals who have positive urinalyses or violate other conditions of supervision, including being arrested for a new offense, may be revoked and transferred to a Federal prison or other correctional facility. Revocations are made at the discretion of the Probation officer and the judicial official presiding over a revocation hearing. Thus, in some districts an individual will be revoked for one positive urinalysis whereas in other districts an individual may have several positive urinalyses before being revoked. There are however, a few acts, such as possession of a firearm and possession of a controlled substance, that call for mandatory revocation.

**Summary**

In summary, it is clear that throughout the TRIAD drug treatment evaluation effort various components of the BOP's drug treatment programs underwent changes. The number of programs grew from 8 in fiscal years 1989 and 1990 to 39 in fiscal year 1996. The incentives for program participation changed from financial incentives to offset the loss of pay resulting from program participation to a 1-year reduction in sentence for successful program completion. Admission criteria became more stringent, eventually requiring an official DSM diagnosis of drug abuse or dependence that was verifiable and documented. Program content became more standardized over time.

Transitional drug abuse treatment provided during a CCC placement was initially limited to individuals who had completed the in-prison residential drug treatment program. Later these services became available to other drug-abusing individuals. Furthermore, several new community corrections initiatives mandated such services for individuals with histories of drug use.

Some of the program changes did not affect the research design for the TRIAD evaluation. However, the rapid growth in programs did notably affect the research design. Chapter 5 provides a description of the research design and how it was affected by the program changes.