THE FEDERAL BUREAU OF PRISONS
ANNUAL REPORT ON SUBSTANCE ABUSE TREATMENT PROGRAMS FISCAL YEAR 2011

REPORT TO THE JUDICIARY COMMITTEE
UNITED STATES CONGRESS

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

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TABLE OF CONTENTS

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). As required by statute, 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, including: meeting the demand for treatment; providing an early release for appropriate offenders who successfully complete the residential drug abuse program; and the coordination of activities and research with the Department of Health and Human Services.

I. IDENTIFYING OFFENDER TREATMENT NEEDS

According to the National Institute of Justice (NIJ) on June 30, 2008, 2,310,984 prisoners were held in federal or state prisons or in local jails, and 1,540,805 sentenced prisoners were under state or federal jurisdiction. The Bureau of Justice Statistics (BJS) *Special Report on Drug Use and Dependence, State and Federal Prisoners, 2004*, revised in 2007, reports, 53 percent of state prisoners and 45 percent of federal prisoners met the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) diagnostic criteria for a drug use disorder.

According to the National Institute on Drug Abuse (NIDA), drug abuse is implicated in at least three types of drug-related offenses: (1) offenses defined by drug possession or sales, (2) offenses motivated by drug abuse (e.g., stealing to get money for drugs), and (3) offenses related to a lifestyle that predisposes the drug abuser to engage in illegal activity, for example, through association with other offenders or with illicit markets. Individuals who use illicit drugs are more likely than those who do not use illicit drugs, to commit crimes, and it is common for many offenses, including violent crimes, to be committed by individuals who had used drugs or alcohol prior to committing the crime, or who were using at the time of the offense[1]. Separating the needs of these inmates through perpetual assessment, a continuum of treatment approach and planning for a continuity of care upon reentry into the community is paramount in working with the incarcerated offender.

II. THE BUREAU OF PRISONS SUBSTANCE ABUSE TREATMENT POPULATION

The BOP has drug abuse education and substance abuse treatment available in each of its 117 institutions. Inmates identified with a history of drug use, a judicial recommendation for treatment, a violation of supervision related to drug use, or an instant offense related to drug use are required to

[1] National Institute on Drug Abuse (2007). *Principles of drug abuse treatment for criminal justice populations – a research based guide.* National Institute of Health, Publication No. O6-5316. Washington, DC.

take the BOP's drug abuse education course. Inmates who are found to have a drug use problem are also referred for nonresidential drug abuse treatment.

The BOP also has 63 intensive, residential drug abuse programs (RDAP) for inmates with a diagnosis of substance abuse or dependence based on the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (See Attachment I for DSM definitions). The residential drug abuse treatment program includes a program incentive of up to one year-off the inmate's sentence as allowed by the Violent Crime Control and Law Enforcement Act of 1994 (VCCLEA; 18 U.S.C. § 3621 (e)(2)). This program incentive dramatically increased the number of inmates who volunteer for the RDAP.

The BOP's drug abuse treatment strategy parallels community drug abuse treatment regimens differentiating between residential treatment (RDAP) and out-patient treatment (non-residential treatment). This approach allows the Bureau to provide the appropriate treatment intensity to its substance using, abusing, and dependent population.

To estimate future demand and determine the number of beds that will be required for the residential drug abuse treatment program in subsequent years, the BOP conducted a study of the prevalence of drug use disorders among an admission cohort of federal prisoners. The BOP reviewed over 2,500 presentence investigation reports to ascertain the frequency of inmates who had either a reference to a medical diagnosis of a drug use disorder or a 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 APA criteria for a substance use disorder. The report by the Bureau of Justice Statistics (BJS), noted above is consistent with the Bureau's data.

In 2011, the Office of National Drug Control Policy (ONDCP) added a new Action Item to the Drug Control Strategy -- to improve and advance substance abuse treatment in prisons. As the lead agency for this item, the BOP will work with the Bureau of Justice Assistance (BJA) and the National Institute of Corrections (NIC) to ensure evidence-based treatment services are provided to prisoners. BJA and the Substance Abuse, Mental Health Services Administration (SAMHSA) will provide training and technical assistance to state Residential Substance Abuse Treatment (RSAT) programs with the intent of maximizing the use of evidence-based substance abuse treatment and aftercare for inmates in need of such treatment. New training curricula, incorporating the latest evidence-based practices and aftercare research, will be available through a website. This will advance the field of residential substance abuse treatment for current grantees, as well as for directors, key correctional personnel, and treatment providers implementing or planning to implement residential treatment.

III. 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 offenders with a history of drug use to review the choices they have made and the consequences of their choices including their choice to use drugs. They must review how those choices have affected them physically, socially, and psychologically. Drug abuse education takes the offender through the cycle of drug use and crime and offers compelling evidence of how continued drug use can lead to a further criminality and related consequences. Drug abuse education is designed to motivate appropriate offenders to participate in nonresidential or residential drug abuse treatment, as needed.

Admission Criteria

Upon entry into a BOP facility, unit staff assesses the offender's records to determine if the offender meets the criteria for drug abuse education (see criteria, Attachment I). If the criteria for admission are met, the offender is required to participate.

Program Content

Drug abuse education is offered at every BOP institution. 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. Appropriate participants are referred for nonresidential drug abuse treatment or residential drug abuse treatment.

The new BOP drug abuse education protocol implemented in 2009 is fully operational. The streamlined protocol improves offender engagement and allows Psychology Services personnel to spend more time providing drug abuse treatment to inmates. In fiscal year 2011, 41,243 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 through the Psychology Services Department, which is staffed with at least one Drug Abuse Program Psychologist and one Drug Abuse Treatment Specialist. Nonresidential drug abuse treatment is a flexible program designed to meet the specific individualized treatment needs of the inmate.

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 remaining on their sentence 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; and

- Inmates who completed the unit- based component of the Residential Drug Abuse Treatment Program and are required to continue with "aftercare" treatment upon their transfer back to the general inmate population.

Program Content

The BOP's treatment of substance abuse includes a variety of clinical activities organized to treat complex psychological and behavioral problems. The activities are unified through the use of Cognitive Behavioral Therapy (CBT), which was selected as the theoretical model because of its proven effectiveness with the inmate population.

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

Inmates participate in nonresidential drug abuse treatment for a minimum of 12 weeks and a minimum of four hours per week. Treatment staff may increase these minimum requirements depending upon the needs of the inmate and the ability of the institution to provide services.

Nonresidential drug abuse treatment in the form of aftercare is also required for inmates who have completed the unit-based component of the RDAP and who are not immediately transferred to a Residential Reentry Center (RRC). This aftercare treatment is conducted for a minimum of 1-1/2 hours per month for 12 months or until his/her transfer to an RRC.

In fiscal year 2011, 15,211 inmates participated in Nonresidential Drug Abuse Treatment. (See Attachment II for a breakdown of participants by fiscal year).

Residential Drug Abuse Treatment

The Residential Drug Abuse Treatment Program (RDAP) was originally developed in 1989 based on the correctional drug abuse treatment research and literature of that time. Since 1989, the BOP has enhanced the program, incorporating treatment approaches that are based on the CBT model of treatment. At present**,** 62 BOP institutions and one contract facility, Rivers Correctional Institution, North Carolina, operate an RDAP (See Attachment III for program locations). Two of these institutions, the Federal Medical Center (FMC) at Carswell, Texas (for women) and FMC Lexington, Kentucky, (for men) also provide specialized treatment services for the inmate with co-occurring substance abuse and mental illness and/or medical problems. One facility, the United States Medical Center for Federal Prisoners (USMCFP) Springfield, Missouri, treats inmates with specific medical problems (e.g., kidney disease requiring dialysis provided at the USMCFP).

Overview

The RDAP provides intensive drug abuse treatment to inmates diagnosed with a drug use disorder as defined by the APA. Programs are staffed by a doctoral-level psychologist (the Drug

Program Coordinator) who supervises the treatment staff. The 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. Consistent with drug abuse treatment research on program effectiveness, treatment is provided for a minimum of 500 hours over 9 to 12 months.

Admission Criteria

Prior to acceptance into an RDAP, inmates are screened and assessed by the RDAP clinical staff to determine if they meet the diagnostic criteria for a substance use disorder.

Inmates must enter residential treatment voluntarily and must sign an agreement to participate in the RDAP and abide by the rules regarding the behavior that is expected within and outside the treatment unit. Participants are informed of how the BOP measures treatment success and what behaviors are required to successfully complete the RDAP. Treatment staff emphasize that the primary purpose of the program is to treat inmates for drug abuse, not to provide an early release from BOP custody.

Qualified inmates, as defined within the VCCLEA, are admitted into the RDAP based on their nearness to release. This system ensures all eligible inmates who volunteer for the RDAP receive treatment before they are released from custody, and are able to continue treatment with a community-based treatment provider when transferred to an RRC while still in Bureau custody.

Program Content

As noted above, the BOP's theoretical model of change is CBT, which targets behaviors that reduce anti-social peer associations; promote positive relationships; increase self-control, self-management, and problem solving skills; end drug use; and replace lying and aggression with pro-social alternatives. The residential treatment unit is operated as a modified therapeutic community. A therapeutic community is a society in miniature where attitudes and behaviors, thoughts and feelings, connectedness and alienation are viewed as if under a magnifying glass. The therapeutic community is designed to enable individual members to view themselves from other perspectives, and in roles different from the ones they have carved out for themselves. Each person is everyone else's mirror, reflecting the positive and negative back to one another in a supportive and caring way. The BOP's therapeutic community is a modified form of traditional therapeutic community models, in that we do not allow inmates to have authority over one another.

To date, the Bureau's residential drug abuse treatment protocol has been requested by all 50 States and 9 foreign countries. In addition, a number of local correctional agencies, contract correctional agencies and community-based treatment providers have ordered the BOP's

treatment protocol. The BOP facilitator's protocol is available through the National Institute of Corrections (NIC) Information Center.

In fiscal year 2011, 18,527 inmates participated in the RDAP. (See Attachment II for a breakdown of participants by fiscal year).

Challenge Program Locations

Northeast Region –
USP Allenwood (PA)
USP Caanan (PA)

MidAtlantic Region –
USP Big Sandy (KY)
USP Hazelton (WV)
USP Lee (VA)
USP McCreary (KY)

Southeast Region –
USP Coleman I (FLA)
USP Coleman II (FLA)

North Central Region –
USP Florence (CO)
USP Terre Haute (IN)

South Central Region –
USP Beaumont (TX)
USP Pollock (LA)

Western Region –
USP Atwater (CA)
USP Tucson (AZ)
USP Victorville (CA)

RDAP Treatment Evaluation

Beginning in 1991, in coordination with the National Institute on Drug Abuse, the BOP conducted a rigorous 3-year outcome study of the RDAP. 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 do not participate in residential drug abuse treatment for up to 3 years after release. The analysis also found that female inmates who participate in RDAP are 18 percent less likely to recidivate than similarly situated female inmates who do not participate in treatment. This study demonstrates that the BOP's RDAP makes a positive difference in the lives of inmates and improves public safety.

The Challenge Program

The Challenge Program is a unit-based, residential program developed for inmates in penitentiary settings. The Challenge Program provides treatment to inmates with substance abuse problems and/or mental illness.

Overview

Located in 15 United States Penitentiaries (USPs), the Challenge Program also offers CBT treatment programming wrapped within the therapeutic community model. Inmates may participate in the program at any point during their sentence; however, they must have at least 18 months remaining on their sentence. The duration of the program varies, based on inmate need, with a minimum duration of nine months. The staff to inmate ratio in the Challenge Program is 1-to-20.

Admission Criteria

An inmate must meet one of the following criteria to be admitted into the Challenge Program:

- A history of drug abuse as evidenced by self-report, Presentence Investigation Report (PSI) documentation, or incident reports for use of alcohol or drugs.
- A major mental illness as evidenced by a current diagnosis of a psychotic disorder, mood disorder, anxiety disorder, or personality disorder.

Program Content

The Challenge Program content is similar to the RDAP with three exceptions. First, the protocol was developed specifically for high security inmates and includes treatment activities geared to this high risk population, including a component focusing on violence prevention. Second, there is a separate protocol for those inmates with severe mental illness who require day-to-day self-management skills, medication management and basic daily living skills, and third the "program completion awards" are discrete. The Challenge Program does not afford an inmate an early release. However, if an inmate successfully completes the Challenge Program, his security point level may drop sufficiently to enable him to transfer to a medium security institution where he may (if he meets the RDAP qualification) be admitted to an RDAP.

Community Transition Drug Abuse Treatment

Community Transition Drug Abuse Treatment (Transition Treatment) has been a component of the BOP's drug abuse treatment strategy since 1991. Research has repeatedly demonstrated that continued supervision (as afforded in the RRC) combined with treatment, decreases the risk of relapse and other behavioral problems, thereby reducing the likelihood of an offender's return to custody. Thus, all inmates who participate in the RDAP are required to continue participation in the Community Treatment component to successfully complete the RDAP, including earning any "program completion award" for which they may be eligible (e.g., an early release). The opportunity to continue treatment in the community is also available to Challenge Program participants.

Upon completion of the unit-based portion of the RDAP, the BOP ensures that inmates receive continued treatment while remaining in Bureau custody through placement in an RRC. These centers provide a structured, supervised environment and support in job placement, treatment, and other services.

To further the continuum of treatment, participants in Community Transition Drug Abuse Treatment often continue drug abuse treatment during their period of supervised release under the auspices 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 FY 2011, the BOP continued to provide treatment for offenders with co-occurring disorders (e.g., substance abuse and mental illness) during this period of transition. Inmates with other behavioral disorders who also have substance disorders may also receive transition treatment.

Inmates who did not volunteer for drug abuse treatment in an institution, may request drug abuse treatment upon transfer to an RRC may volunteer for or may be required to participate in community-based drug abuse treatment as part of their program plan.

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/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.

In fiscal year 2011, 16,973 inmates participated in transition treatment. (See Attachment II for a breakdown of participants by fiscal year).

COMPLIANCE WITH THE REQUIREMENTS OF THE VCCLEA OF 1994

Meeting the Demand for Treatment

Subtitle T of Title III of VCCLEA requires the BOP (subject to the availability of funds) to provide residential substance abuse treatment to *all* eligible inmates (18 U.S.C. § 3621 (e)(2)(B)). In FY 2011, the BOP met the requirement to treat 100 percent of the eligible inmate population, with 18,527 inmates participating in the RDAP.

Providing an Early Release

Federal law allows the BOP to grant a non-violent offender up to 1 year off his/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 2011, 4,829 inmates received a reduction in their term of imprisonment based on this law (average reduction was 8.6 months).

In order to continue to meet the requirements of VCCLEA, and to further facilitate inmate reentry as outlined in the Second Chance Act of 2007, a request for an additional $15.0 million to expand RDAP capacity was included in the President's 2012 Congressional Budget Request. These resources are vital to allow expansion of drug treatment capacity, and will help BOP reach the goal of providing 12 month sentence credits to all eligible inmates.

Coordinating with the Department of Health and Human Services

In fiscal year 2011, the BOP expanded its relationship with NIDA, by examining working with them on a number of Criminal Justice-Drug Abuse Treatment projects. These projects include the use of Medicated Assisted Treatment in the BOP and an HIV/AIDS data collection project. In addition, the Bureau of Prisons has worked with the Department of Health and Human Services (HHS) and other

various components of the Department of Justice in the crafting the new Drug Control Strategy for the Office of National Drug Control Policy.

The Federal Consortium to Address the Substance Abusing Offender was established and funded by BJA as the mechanism to facilitate this collaboration. The consortium includes representatives from many parts of the federal criminal justice system, as well as representatives from HHS, such as NIDA and SAMHSA, the Department of Housing and Urban Development (HUD), the Department of Education (DOE), the National Highway Traffic Safety Administration (NHTSA), and the Centers for Disease Control and Prevention (CDC). 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.

Again, with the ONDCP, the BOP was made a lead agency, in cooperation with the BJA, NIC and SAMHSA in developing and disseminating documents and a web site to ensure evidence based residential drug treatment programs are developed in Federal and state prisons.

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 – 2010)

PROGRAM	1990	1991	1992	1993	1994*	1995	1996	1997	1998
DRUG EDUCATION	5,446	7,644	12,500	12,646	11,592	11,681	12,460	12,960	12,002
NON RESIDENTIAL			644	1,320	1,974	2,136	3,552	4,733	5,038
RESIDENTIAL	441	1,236	1,135	3,650	3,755	4,839	5,445	7,895	10,006
COMMUNITY TRANSITION			123	480	800	3,176	4,083	5,315	6,951

PROGRAM	1999	2000	2001	2002	2003	2004	2005	2006	2007
DRUG EDUCATION	12,460	15,649	17,216	17,924	20,930	22,105	22,776	23,006	23,596
NON RESIDENTIAL	6,535	7,931	10,827	11,506	12,023	13,014	14,224	13,697	14,392
RESIDENTIAL	10,816	12,541	15,441	16,243	17,578	18,278	18,027	17,442	17,549
COMMUNITY TRANSITION	7,386	8,450	11,319	13,107	15,006	16,517	16,503	15,466	15,432

PROGRAM	2008	2009	2010	2011	TOTAL
DRUG EDUCATION	23,230	30,775	47,885	41,243	417,693
NON RESIDENTIAL	14,208	14,613	14,507	15,211	182,095
RESIDENTIAL	17,523	18,732	18,868	18,527	255,967
COMMUNITY TRANSITION	15,466	16,123	16,912	16,873	206,625

*** 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 TREATMENT PROGRAM LOCATIONS

NORTHEAST REGION	NORTH CENTRAL REGION	SOUTHEAST REGION
FCI Danbury (CT)✳	FPC Duluth (MN)	FCI Coleman (FL)
FCI Elkton (OH)	FCI Englewood (CO)	FPC Edgefield (SC)
FCI Fairton (NJ)	FPC Florence (CO)	FCI Jesup (GA)
FCI Fort Dix (NJ)	FCI Florence (CO)	FCI Marianna (FL)
FPC Lewsiburg (PA)	FPC Greenville (IL) ✳	FPC Miami (FL)
FPC McKean (NJ)	FPC Leavenworth (KS)	FPC Montgomery (AL)
	USP Leavenworth (KS)	FPC Pensacola (FL)
	FCI Milan (MI)	FCI Talladega (AL)
	FCI Oxford (WI)	FCI Tallahassee (FL) ✳
	FPC Pekin (IL)	FCI Yazoo City (MS)
	FCI Sandstone (MN)	
	USMCFP Springfield (MO) ★	
	FCI Waseca (MN) ✳	
	FPC Yankton (SD)	

MID-ATLANTIC REGION	SOUTH CENTRAL REGION	WESTERN REGION
FPC Alderson (WV)✳	FCI Bastrop (TX)	FCI Dublin (CA) ✳
FPC Beckley (WV)	FPC Beaumont (TX)	FPC Dublin (CA) ✳
FCI Beckley (WV)	FCI Beaumont – Med (TX)	FCI Herlong (CA)
FCI Butner (NC)	FCI Beaumont – Low (TX)	FPC Lompoc (CA)
FPC Cumberland (MD)	FPC Bryan (TX) ✳	FPC Phoenix (AZ) ✳
FCI Cumberland (MD)	FMC Carswell (TX) ✳★	FCI Phoenix (AZ)
FCI Morgantown (WV)	FCI El Reno (OK)	FPC Sheridan (OR)
FMC Lexington (KY)★	FCI Forrest City - Low (AK)	FCI Sheridan (OR)
FCI Petersburg – Low (VA)	FCI Forrest City - Med (AK)	FCI Terminal Island (CA)
FCI Petersburg – Med (VA)	FMC Fort Worth (TX)	
	FCI La Tuna (TX)	
	FCI Seagoville (TX)	
	FPC Texarkana (TX)	

CONTRACT FACILITY
RCI Rivers (NC)

KEY

FCI = Federal Correctional Institution
FMC = Federal Medical Center
FPC = Federal Prison Camp
FSL = Federal Satellite Low
MCFP = Medical Center for Federal Prisoners
USP = United States Penitentiary
RCI = Rivers Correctional Institution
✳= Female Facility
★= Co-Occurring Disorder Program