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Behind Bars II:
Substance Abuse and America's Prison Population

February 2010

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Table of Contents

Foreword and Accompanying Statement by Joseph A. Califano, Jr., Chairman and President

Consider these facts:

- We in the United States, though only five percent of the world's population, consume two-thirds of the world's illegal drugs.

- We in the United States, though only five percent of the world's population, incarcerate 25 percent of the world's prisoners.

It is no coincidence that of the 2.3 million inmates in U.S. prisons, 65 percent--1.5 million--meet the DSM-IV medical criteria for alcohol or other drug abuse and addiction. Another 20 percent--458,000--even though they don't meet the DSM-IV medical criteria for alcohol and other drug abuse and addiction nevertheless were substance involved; i.e., were under the influence of alcohol or other drugs at the time of their offense, stole money to buy drugs, are substance abusers, violated the alcohol or drug laws, or share some combination of these characteristics.

This report, *Behind Bars II: Substance Abuse and America's Prison Population*, uncovers these troubling facts and, even more disturbingly, finds that the situation has been getting worse since The National Center on Addiction and Substance Abuse (CASA) at Columbia University issued its first report on this subject, *Behind Bars*, just over a decade ago.

Between 1996 and 2006, as the U.S. population rose by 12 percent, the number of adults incarcerated rose by 33 percent to 2.3 million inmates, and the number of inmates who were substance involved shot up by 43 percent to 1.9 million inmates.

This new report constitutes the most exhaustive analysis ever undertaken to identify the extent to which alcohol and other drugs are implicated in the crimes and incarceration of America's prison population. This report, following more than a decade after CASA's initial analysis, finds that despite greater recognition of the problem and

potential solutions, we have allowed the population of substance-involved inmates crowding our prisons and jails--and the related costs and crimes--to increase.

Skyrocketing corrections and Medicaid costs are bankrupting states at a time of serious fiscal and economic crisis. In 2005, federal, state and local governments spent $74 billion on incarceration, court proceedings, probation and parole for substance-involved adult and juvenile offenders. In contrast, these governments spent less than one percent of that amount--$632 million--on prevention and treatment for such offenders. Only 11 percent of inmates with substance use disorders receive any type of treatment during incarceration; few of those receive evidence-based care. Without treatment, the odds are that substance-involved offenders will end up back in prison.

The tragedy is that we know how to stop spinning this costly and inhumane revolving door. It starts with acknowledging the fact that addiction is a disease for which evidence-based prevention and treatment programs exist and that these programs can be administered effectively through the criminal justice system. Providing treatment and training to inmates and employing treatment based alternatives to incarceration through drug courts or prosecutors both saves taxpayer dollars and reduces crime.

If all inmates with substance use disorders who are not receiving treatment were provided evidence-based treatment and aftercare, we would break even on this investment in one year if just over 10 percent of those receiving such services remained substance and crime free and employed. For each succeeding year that these inmates remained substance and crime free and employed, the nation would reap an economic benefit of $90,953 per inmate in reduced crime, lower arrest, prosecution, incarceration and health care costs, and economic benefits from employment. That's a return on investment that would satisfy even the greediest Wall Street bankers.

Even greater savings can come from treatment-based diversion programs, like drug courts and prosecutorial initiatives such as Brooklyn's Drug Treatment Alternative to Prison (DTAP), which avoid the high cost of incarceration. Incarceration costs per state inmate per year average $25,144 but can exceed $65,000. The National Institute on Drug Abuse estimates a savings of $12 in reduced substance-related crime and criminal justice and health care costs for every dollar spent on treatment.

This report sets out steps we can take to reduce crime and the taxpayer costs of prisons by addressing treatment needs of offenders while holding them accountable for their crimes. We provide treatment for other chronic disease like hypertension and diabetes. We should do so for the disease of addiction where treatment offers the added benefits of significant reductions in crime and incarceration costs. What is required is for public officials to use the currency of common sense instead of squandering taxpayer dollars to build more and more prisons in order to incarcerate men and women whose core problem is alcohol and other drug abuse and addiction.

Susan E. Foster, MSW, CASA's Vice President and Director of Policy Research and Analysis, was the principal investigator and staff director for this effort. The data analysis was conducted by CASA's Substance Abuse and Data Analysis Center (SADAC^{SM}), headed by Roger Vaughan, DrPH, CASA Fellow and Professor of Clinical Biostatistics, Department of Biostatistics, Mailman School of Public Health at Columbia University, and associate editor for statistics and evaluation for the *American Journal of Public Health*. He was assisted by Elizabeth Peters and Sarah Tsai. Others who worked on the project are: CASA consultants, Hung-En Sung, PhD, Associate Professor, Department of Criminal Justice, John Jay College of Criminal Justice, and Linda Richter, PhD; Sara Blachman; Akiyo Kodera; Nina Lei; CASA's librarian David Man, PhD, MLS; and library research specialist Barbara Kurzweil. Jennie Hauser managed the bibliographic database and Jane Carlson handled administrative details.

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While many individuals and institutions contributed to this effort, the findings and opinions expressed herein are the sole responsibility of CASA.

Chapter I
Introduction and Executive Summary

In 1998, CASA released its landmark report, *Behind Bars: Substance Abuse and America's Prison Population,* revealing that four out of five of America's 1.7 million prison and jail inmates were substance involved in 1996. This report provides an update of that work, finding that despite growing evidence of effective strategies to reduce the prevalence and costs of substance-involved offenders, the burden of substance misuse and addiction to our nation's criminal justice system actually has increased. Today 2.3 million adults are behind bars in America; 1.9 million are substance involved and almost two-thirds (64.5 percent) meet medical criteria for an alcohol or other drug use disorder.

Governments' continued failure to prevent and treat addiction actually increases crime and results in a staggering misuse of government funds; in 2005, federal, state and local governments spent $74 billion in court, probation, parole and incarceration costs of adult and juvenile substance-involved offenders. In comparison, federal and state governments spent only $632 million on prevention and treatment for them.

An overwhelming body of evidence exists documenting that substance use disorders are preventable and treatable health conditions, and that cost effective screening, intervention and treatment options are available that can be administered effectively through the criminal justice system. Implementing these options can save taxpayers millions of dollars and reduce crime. Failure to do so makes no sense--particularly in this time of fiscal crisis.

To conduct this study, CASA analyzed data on inmates from 11 federal sources, reviewed more than 650 articles and other publications, examined best practices in prevention and treatment for substance-involved offenders, reviewed accreditation standards and analyzed costs and benefits of treatment.

Substance-Involved Inmates on the Rise

Between 1996 and 2006,[*] the U.S. population grew by 12.5 percent. While the percentage of adults incarcerated in federal, state and local correctional facilities grew by 32.8 percent during that period, the percentage of substance-involved offenders behind bars in America rose even more rapidly, by 43.2 percent.[†]

Substance misuse and addiction are key factors in the continuous growth of the U.S. inmate population. By 2006, a total of 2.3 million people[‡]--one in every 133 adult Americans--were behind bars;[1] 84.8 percent of all inmates (1.9 million) were substance involved; 86.2 percent of federal inmates (0.2 million), 84.6 percent of state inmates (1.1 million) and 84.7 percent of local jail inmates (0.6 million).

Alcohol and Other Drug Use Is Implicated in all Types of Crime

Substance misuse and addiction are overwhelming factors in all types of crime, not just alcohol and drug law violations. Thirty-seven percent of federal, state and local prison and jail inmates in 2006 were serving time for committing a violent crime as their controlling offense;[§] of these inmates, 77.5 percent were substance involved. Those serving time for property crimes comprise 19.2 percent of the inmate population; 83.4 percent were substance involved. Those whose controlling offense was a supervision violation, public order offense, immigration offense or weapon offense comprise 13.3 percent of the inmate population; 76.9 percent were substance involved.

Alcohol Plays a Dominant Role; Few Incarcerated for Marijuana Possession Only

Alcohol is implicated in the incarceration of over half (56.6 percent) of all inmates in America. In addition to the inmates who were convicted of an alcohol law violation, 51.6 percent of drug law violators, 55.9 percent of those who committed a property crime, 57.7 percent of inmates who committed a violent crime, and 52.0 percent of those who committed other crimes were either under the influence of alcohol at the time of the crime, had a history of alcohol treatment or had an alcohol use disorder.

While illicit drugs are implicated in three-quarters of incarcerations (75.9 percent), few inmates are incarcerated for marijuana possession as their controlling or only offense. Inmates incarcerated in federal and state prisons and local jails for marijuana possession as the controlling offense accounted for 1.1 percent (25,235) of all inmates and 4.4 percent of those incarcerated for drug law violations. Those incarcerated for marijuana possession as their only offense accounted for 0.9 percent (20,291) of all inmates and 2.9 percent of those incarcerated for drug law violations.

Tobacco Use High Among Inmates

In 2005, 37.8 percent of state inmates and 38.6 percent of federal inmates smoked in the month of their arrest. In contrast, approximately 24.9 percent of the population was a current smoker.[**] [2] State and federal inmates who met clinical criteria for alcohol or other drug use disorders had even higher rates of use; 66.5 percent of state inmates and 51.5 percent of

[*] CASA has used the time frame of 1996 to 2006 for purposes of analysis because 1996 was the latest year of CASA's first *Behind Bars* analysis and 2006 was the latest year in final federal, state and local data at the time of analysis.

[†] The inmate data in 1996 did not permit us to identify the number of inmates who met medical criteria for substance use disorders. The data for 2006 do permit such analysis and it should be noted that the percentage of substance-involved inmates in 2006 includes 60,907 inmates who do not meet any other criteria for substance involvement than having a substance use disorder. See Appendix A.

[‡] Including 0.2 million in federal prisons, 1.3 million in state prisons, and 0.8 million in local jails.

[§] The most serious crime for which they have been incarcerated.

[**] Age 12 and over who smoked in past 30 days.

federal inmates with a substance use disorder smoked in the month of their arrest.

Arrests, Convictions, Sentencing and Recidivism

While arrest rates have declined overall between 1998 and 2004, arrests for drug law violations have increased. The number of arrestees convicted of a crime is up overall including federal convictions for drug law violations, but the number of state convictions for these offenses has declined. The number of convicted offenders sentenced to prison or jail also has risen overall, as have the number of federal and state drug law violators sentenced to prison or jail. Although re-incarceration rates have declined slightly, they remain high, particularly among substance-involved offenders. In 2006, 48.4 percent of all inmates had a previous incarceration, down from 50.3 percent in 1996.

Substance-involved inmates are likelier to begin their criminal careers at an early age and to have more contacts with the criminal justice system than inmates who are not substance involved. Among substance-involved inmates, those who have committed a crime to get money to buy drugs have the highest average number of past arrests (6.6), followed by inmates who had a history of alcohol treatment (6.3) or were under the influence of alcohol or other drugs at the time of their crime (5.9).

Substance Use and Mental Health Disorders

Substance use disorders among inmates are at epidemic proportions. Almost two-thirds (64.5 percent) of the inmate population in the U.S. (1.5 million) meet medical criteria for an alcohol or other drug use disorder. Prison and jail inmates are seven times likelier than are individuals in the general population to have a substance use disorder. One-third (32.9 percent) of the 2.3 million prison and jail inmates has a diagnosis of a mental illness. A quarter (24.4 percent) of prison and jail inmates has both a substance use disorder and a co-occurring mental health problem.[*]

Female inmates make up 8.4 percent of the total inmate population--up from 7.7 percent in 1996. Women inmates are somewhat likelier to have a substance use disorder than are male inmates (66.1 percent vs. 64.3 percent) and significantly more likely to have co-occurring substance use and mental health disorders (40.5 percent vs. 22.9 percent). These co-occurring conditions are linked to the fact that female inmates are more than seven times likelier to have been sexually abused and almost four times likelier to have been physically abused before incarceration than male inmates.

Income, Education, Age and Family History

Compared with inmates who are not substance involved, substance-involved inmates are:

- four times likelier to receive income through illegal activity (24.6 percent vs. 6.0 percent);
- almost twice as likely to have had at least one parent abuse alcohol or other drugs (34.5 percent vs. 18.4 percent);
- 40.6 percent likelier to have some family criminal history (42.6 percent vs. 30.3 percent);
- 29.2 percent less likely to have completed at least high school (30.4 percent vs. 39.3 percent).
- 20.0 percent likelier to be unemployed a month before incarceration (32.1 percent vs. 26.8 percent); and

Inmates who are substance involved also are likelier than those who are not substance

[*] Substance use disorders are defined by inmate and general population answers to questions that define clinical criteria as presented in the DSM-IV. Mental health disorders are defined as any past diagnosis of a psychiatric disorder or a history of treatment.

involved: to be younger (average age 33.9 vs. 36.2); to have lived only with their mother during childhood (39.6 percent vs. 32.5 percent); and to have ever spent time in foster care (12.2 percent vs.7.3 percent).

Juvenile or Youthful Offenders

Half (52.4 percent) of juvenile or youthful offenders incarcerated in state prisons and local jails meet clinical criteria for alcohol or other drug disorders. These offenders totaled 0.7 percent (15,340) of the total inmate population in 2006.[*] The problem is particularly severe among youth incarcerated in local jails where 54.3 percent meet such clinical criteria compared with 36.7 percent of juvenile inmates in state prison. State and local juvenile and youthful offenders are likelier to have co-occurring mental health and substance use disorders than non-youthful offenders (27.8 vs. 25.4 percent).

Children of Inmates

In 2006, American prisons and jails held an estimated 1.0 million substance-involved parents with more than 2.2 million minor children; 73.7 percent (1.7 million) of these children are 12 year of age or younger. The minor children of inmates are at a much higher risk of juvenile delinquency, adult criminality and substance misuse than are minor children of parents who have not been incarcerated. Almost four-fifths of incarcerated mothers (77 percent in state prison and 83 percent in federal prison) reported being the primary daily caregiver for their children prior to their imprisonment compared with 26 percent of fathers incarcerated in state prisons and 31 percent incarcerated in federal prisons.

[*] Juvenile and youthful offenders who had been tried in adult court. Such offenders rarely are incarcerated in federal facilities; therefore, they are not included in this analysis. CASA's analysis of *Surveys of Inmates in Federal Prisons* showed only 127 juvenile or youthful offenders in federal prisons in 2006.

The Role of Race and Ethnicity

Relative to the population at large, blacks and Hispanics are overrepresented in America's prisons and jails. Substance involvement does not explain this overrepresentation since black and Hispanic inmates report lower rates of drug use in the month prior to their arrest and have lower rates of substance use disorders than white inmates. Blacks make up 12.3 percent of the U.S. population, but comprise 41.0 of the inmate population; 60.2 percent have substance use disorders. Hispanics make up 14.8 percent of the U.S. population but comprise 18.8 percent of the inmate population; 58.3 percent have substance use disorders. Whites total 66.4 percent of the U.S. population and 34.6 percent of the inmate population; 73.1 percent have substance use disorders.

The Treatment Gap

Of the 1.5 million prison and jail inmates who met clinical diagnostic criteria for a substance use disorder in 2006, only 11.2 percent had received any type of professional treatment since admission. Only 16.6 percent of facilities offer treatment in specialized settings which can produce better outcomes for offenders as measured by drug use and arrests post-release. Few inmates actually receive evidence-based services, including access to pharmacological treatments, and the availability of highly trained staff is limited. Simply offering treatment, even in specialized settings, does not mean that the treatment is available to all who need it or of adequate quality. Nicotine dependence rarely is addressed even though it is an essential part of addiction treatment.[3] In terms of adjunct services, 22.7 percent of inmates with substance use disorders participated in mutual support/peer counseling and 14.2 percent received drug education; however, such services alone are unlikely to create lasting behavioral changes among those in need of addiction treatment.

Other conditions that frequently co-occur with substance use disorders are Hepatitis C, HIV/AIDS and mental health disorders. Most facilities screen, test and treat Hepatitis C and

progress has been made in addressing HIV/AIDS among inmates, but significant gaps exist in the treatment of co-occurring mental health disorders.[4]

While critical to recovery and reduced recidivism, the percentage of inmates participating in education and job training services declined between 1996 and 2006. The percentage of federal prison inmates who report participating in education or vocational programs while confined fell from 67 percent in 1996 to 57 percent in 2006. The participation rate among state inmates also declined from 57 percent in 1996 to 45 percent in 2006.

Inmate participation in religious and spiritual activities provided by volunteers has increased, but chaplain positions have declined.[5]

Reentry of Substance-Involved Inmates

Substance-involved offenders are likelier to recidivate than those who are not substance involved. Over half (52.2 percent) of substance-involved inmates have one or more previous incarcerations compared with 31.2 percent of inmates who are not substance involved. High rates of recidivism translate into burdensome incarceration costs for society, averaging $25,144 per inmate, per year and ranging from a low of $10,700 in Alabama to a high of $65,599 in Maine. Breaking the cycle of re-arrests and re-incarceration requires breaking the cycle of addiction.

In 2006, an estimated 1.6 million individuals age 18 and over were on parole or other restricted release from state or federal prison and were in the process of reentry and reintegration after having served a prison term of at least one year. These offenders are twice as likely to have used drugs and/or engaged in binge drinking in the past 30 days as members of the general population who were not on parole or other restricted release (55.7 percent vs. 27.5 percent), and more than four times likelier to have substance use disorders (36.6 percent vs. 9.0 percent).

Components of Effective Treatment

A substantial body of professional standards has been developed for providing addiction treatment in prisons and jails. With the exception of mandated accreditation for those who provide treatment for opioid addiction, however, no mechanism has been put in place to ensure the use of existing scientific guidelines and professional standards.

Offenders who receive a full course of evidence-based treatment and recovery services have the best outcomes, including reduced relapse and recidivism rates.

Essential elements of treatment include:

- screening to determine the extent and nature of risky substance use or addiction;
- comprehensive assessment of the nature and extent of the criminal justice patient's substance-related problem and treatment needs;
- individualized treatment plans that are tailored to the unique needs of the offender;
- aftercare including community supervision, case management and integrated services (medical and psychiatric, housing, childcare, social support, vocational and employment assistance); and
- monitoring of substance use and relapse episodes followed by prompt rewards and sanctions.

To assure that these practices are implemented appropriately, training of correctional staff is essential.

Providing addiction treatment to offenders has benefit for the correctional system as well. In correctional facilities where therapeutic community treatment occurs, correctional staff report a less stressful job environment, a higher level of job satisfaction, lower rates of staff sick leave, less inmate-on-inmate and inmate-on-staff

assault and less disruptive behavior among inmates. Violent behavior is more then twice as likely to occur among inmates in the general population compared with those in treatment programs; occupational injuries related to assaults are almost 10 times less likely to occur in the treatment facilities.[6]

Overcoming Barriers to Intervention and Treatment

Providing effective treatment and aftercare to offenders with substance use disorders is simple common sense. Barriers to action include mandatory sentences that eliminate the possibilities of alternative sentencing and/or parole, lack of a clear legal mandate to provide treatment, economic interests in prison expansion and the failure of public policy to reflect the science of addiction and changing public attitudes about addiction and justice. Fortunately, there is some good news; mandatory sentencing practices are being reversed, more examples exist of cost-effective evidence-based practices, and public sentiment has changed about the value of treatment for offenders with substance use disorders.

In order to meet the health needs of substance-involved offenders and reduce crime and its costs to society, the criminal justice system must address risky substance use as a preventable health problem and addictive disorders as medical problems.

Every cost-benefit analysis of criminal justice-based treatment that CASA could identify shows that the monetary benefits of treatment outweigh the costs.[7] Addressing the substance use issues of the criminal justice population can save billions in government dollars each year:

- Providing the most comprehensive option of prison based treatment and aftercare for offenders with substance use disorders who are not now receiving treatment would cost an additional $9,745 per inmate.

- If less than *11 percent* of those who receive such services remain substance and crime free and employed--a conservative success rate--the investment would more than pay for itself one year post release.

- For each additional year that a former inmate stays substance free, employed and out of prison, society would receive an economic benefit of approximately $90,953.

Even greater opportunities for cost control can come from treatment-based diversion programs because additional court and treatment costs generally are lower than costs of incarceration. According to a comprehensive review by the National Institute on Drug Abuse, the return of investing in treatment may exceed 12:1; that is, every dollar spent on treatment can reduce future burden costs by $12 or more in reduced substance-related crime and criminal justice and health care costs. [8]

Continued failure to meet the health care needs of inmates with substance use disorders or to intervene with those at high risk of developing such disorders increases crime and its cost to society.

Recommendations and Next Steps

Following are key recommendations to improve health and reduce crime and its costs to society. The full list of recommendations is found in Chapter VIII.

The Criminal Justice System:

- Use appropriately trained health care professionals to screen, assess and treat substance-involved offenders using comprehensive, evidence-based approaches tailored to the needs of offenders.

- Provide appropriate care for co-occurring physical and mental health problems; offer and encourage participation in literacy, education, job training and parenting programs; and, increase the availability of religious, spiritual, and mutual support services.

- For inmates with substance use disorders, provide comprehensive pre-release planning to assure transition to a broad range of integrated reentry services.

- Expand the use of treatment-based alternatives to jail and prison--including drug courts and prosecutorial diversion programs--and post-release supervision for substance-involved offenders.

Federal, State and Local Governments:

- Require that addiction treatment be provided in criminal justice settings, that it be medically managed and that pharmacological treatments be available.

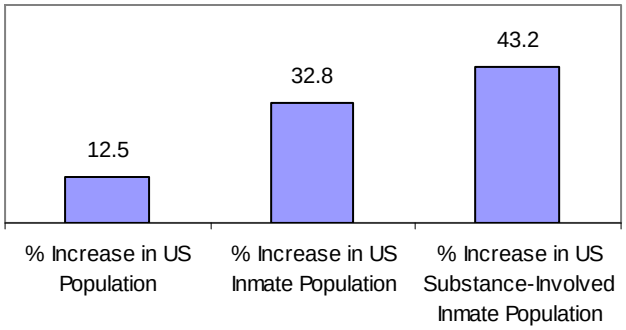
- Require the accreditation of prison- and jail-based treatment programs and providers.

- Expand federal grants to states and localities for integrated evidence-based and promising practices.

Chapter II
Substance-Involved Inmates on the Rise

Figure 2.A

Percent Increase in U.S. and Inmate Populations, 1996-2006



Source: CASA analysis of U.S. Census Bureau (2000 and 2008); CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (1991 and 2004), *Survey of Inmates in State Correctional Facilities* (1991 and 2004), *Survey of Inmates in Local Jails* (1989 and 2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in* (1996 and 2006).

Despite the unprecedented decline in violent and property crimes during the past 15 years, incarcerations linked to alcohol and other drugs have continued to grow. More substance-involved offenders are crowding our prisons and jails than ever before as our nation's criminal justice system maintains a costly loop of untreated addiction and criminal recidivism.

Between 1996 and 2006,[*] the U.S. population grew by 12.5 percent.[1] In 2006, 2.3 million American adults were incarcerated in federal (0.2 million), state (1.3 million) and local (0.8 million) correctional facilities[2]--up 32.8 percent from 1.7 million in 1996.[3] By 2006, there were 1.9 million substance-involved offenders behind bars in America, an increase of 43.2 percent from 1996.[† 4] (Figure 2.A)

[*] CASA has used the time frame of 1996 to 2006 for purposes of analysis because 1996 was the latest year of CASA's first *Behind Bars* analysis and 2006 provided a decade interval and was the latest year in common and verified federal, state and local data at the time of analysis.

[†] Unless otherwise noted in this chapter, percentage and numerical estimates are either drawn directly from or based on CASA's analysis of the *Survey of Inmates in Federal Correctional Facilities* (1991 and 2004), *Survey of Inmates in State Correctional Facilities* (1991 and 2004), and the *Survey of Inmates in Local Jails* (1989 and 2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 1996 and 2006*. Although the percentages of federal, state and local inmates are derived from 1989 and 2002 (local jails) and 1991 and 2004 (prisons) data, these percentages are applied respectively to the 1996 and 2006 estimates of the prison population. In an effort to refine our analysis and present a more complete description of those substance-involved individuals behind bars in America, CASA used a slightly different method to calculate the percent of inmates who were substance involved than we used in our original analysis. To provide a direct comparison between 1996 and 2006, CASA also recalculated the 1996 data. See Appendix A, Methodology.

The United States has the highest incarceration rate in the world; although we have less than five percent of the world's population, we have almost a quarter of the world's prisoners.[5] One in every 31 adults, or 3.2 percent of the population, is under some form of correctional control.[6] One in every 133 adult Americans is behind bars;[7] 84.8 percent of inmates are substance involved.[*]

Table 2.1
Substance-Involved Federal, State and Local Inmates 1996 and 2006

	1996		2006	
	Number	**Percent**	**Number**	**Percent**
Federal Prison	84,787	80.3	164,521	86.2
State Prison	871,636	81.0	1,101,779	84.6
Local Jail	380,677	73.4	648,664	84.7
Total Substance-Involved Inmates	**1,337,099**	**78.6**	**1,914,964**	**84.8**

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (1991 and 2004), *Survey of Inmates in State Correctional Facilities* (1991 and 2004), *Survey of Inmates in Local Jails* (1989 and 2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in* (1996 and 2006).

Substance-Involved Inmate Population Continues to Rise

Substance misuse and addiction are key factors in the continuous growth of the U.S. inmate population. Substance-involved inmates comprised 84.8 percent of all incarcerated offenders in federal, state and local prisons and jails in 2006--86.2 percent of federal inmates, 84.6 percent of state inmates and 84.7 percent of local jail inmates--up 6.2 percent from 1996. The largest increase in the percent of substance-involved inmates was in the jail population (11.3 percent). (Table 2.1)

Substance-involved inmates are those who either:

- had a history of using illicit drugs regularly;[†]
- met medical criteria for a substance use disorder;
- were under the influence of alcohol or other drugs when they committed their crime;
- had a history of alcohol treatment;[‡]
- were incarcerated for a drug law violation;
- committed their offense to get money to buy drugs;
- were incarcerated for an alcohol law violation; or
- had some combination of these characteristics.[8]

Types of Substance-Involved Inmates

Of the six categories of substance-involved inmates that CASA examined, the largest increase in the *number* of substance-involved inmates was found in the group who reported ever using illicit drugs regularly. (Table 2.2)

Among substance-involved offenders, the largest increases in the percent of offenders in the six categories were seen in the percents incarcerated for alcohol or drug law violations. (Table 2.3)

[*] The inmate data in 1996 did not permit us to identify the number of inmates who met medical criteria for substance use disorders. The data for 2006 do permit such analysis and it should be noted that the percentage of substance-involved inmates in 2006 includes 60,907 inmates who do not meet any other criteria for substance involvement than having a substance use disorder. For comparison between 1996 and 2006 of inmates without including this additional 60,907 inmates, see Appendix B.

[†] One or more times a week for at least a month.

[‡] As measured by prior participation in treatment for alcohol abuse.

Table 2.2
Number of Inmates Who Are Substance Involved, by Type

	1996	2006	Increase 1996-2006	Percent Increase
Used illicit drugs regularly	1,201,158	1,527,506	326,348	27.2
Met medical criteria for substance use disorder	N/A	1,456,851	N/A	N/A
Under the influence of alcohol or other drugs at the time of crime	703,788	967,046	263,258	37.4
History of alcohol treatment	403,384	586,490	183,106	45.4
Drug law violation	357,734	567,366	209,632	58.6
Committed crime for money to buy drugs	225,623	338,563	112,940	50.1
Alcohol law violation	53,950	99,955	46,006	85.3
Substance-Involved Inmates	**1,337,099**	**1,914,964**	**577,865**	**43.2**

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (1991 and 2004), *Survey of Inmates in State Correctional Facilities* (1991 and 2004), *Survey of Inmates in Local Jails* (1989 and 2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in* (1996 and 2006).

Table 2.3
Percent of Inmates Who Are Substance Involved, by Type

	1996	2006	Percent Change 1996-2006
Used illicit drugs regularly	70.6	67.6	-4.3
Met medical criteria for substance use disorder	N/A	64.5	N/A
Under the influence of alcohol or other drugs at the time of crime	41.4	42.8	+3.5
History of alcohol treatment	23.7	26.0	+9.5
Drug law violation	21.0	25.1	+19.4
Committed crime for money to buy drugs	13.3	15.0	+13.0
Alcohol law violation	3.2	4.4	+39.5
Substance-Involved Inmates	**78.6**	**84.8**	**+7.8**

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (1991 and 2004), *Survey of Inmates in State Correctional Facilities* (1991 and 2004), *Survey of Inmates in Local Jails* (1989 and 2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in* (1996 and 2006).

Used illicit drugs regularly. The largest group of substance-involved inmates includes those who have used illicit drugs regularly--more than 1.5 million individuals. The total number of offenders in this category showed the largest increase (326,348) among categories of substance-involved offenders, growing by 27.2 percent from 1996 to 2006. This group makes up 67.6 percent of inmates; however, because of increases in other categories of offenders, the share this group represents is down from 70.6 percent in 1996.

Met medical criteria for substance use disorder. Almost 1.5 million (1,456,851) inmates met medical criteria for alcohol and/or drug abuse and/or dependence in the year prior to their arrest. This group constitutes 64.5 percent of the inmate population.[*] Seventy-six percent (76.1 percent) of substance-involved inmates have a substance use disorder diagnosis.

Under the influence at time of crime. Almost one million inmates (967,046) were under the influence of alcohol or other drugs at the time of their crimes, up 37.4 percent from 1996--the second largest numerical increase (263,258) of the categories of substance-involved offenders. This group comprises 42.8 percent of the inmate population, up from 41.4 percent in 1996.

History of alcohol treatment. Among U.S. inmates, 586,490 have a history of alcohol treatment. The total number of inmates in this category jumped 45.4 percent between 1996 and

[*] 20.3 percent (458,113) of the inmate population is substance involved but does not meet medical criteria for a substance use disorder.

2006. This group comprises 26.0 percent of the inmate population, up from 23.7 percent in 1996.

Drug law violation. In 2006, 567,366 inmates were incarcerated for drug law violations, an increase of 58.6 percent from 1996. Drug law violations include possession or use, substance trafficking, or other unspecified substance offenses. This group comprises 25.1 percent of the U.S. inmate population, up from 21.0 percent in 1996. Eighty-two (82.0) percent of those incarcerated for drug law violations also have a history of alcohol treatment or regular drug use, or were under the influence of alcohol or other drugs at the time of their crimes.

Committed crime for money to buy drugs. Our nation's prisons and jails housed 338,563 inmates in 2006 who committed their crimes to get money to buy drugs, up 50.1 percent since 1996. This group constitutes 15.0 percent of inmates, increasing from 13.3 percent in 1996.

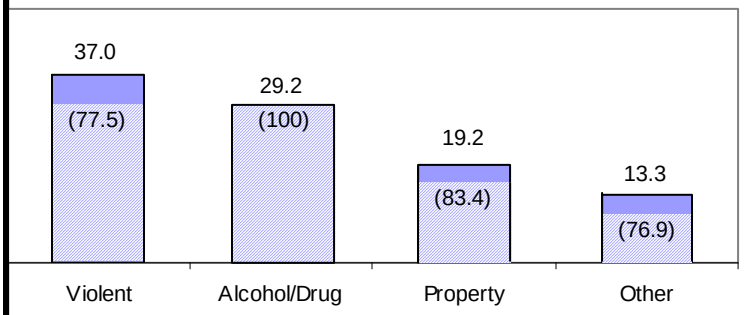
Alcohol law violation. Just under 100,000 inmates (99,955) were in prison or jail in 2006 for alcohol law violations, an increase of 85.3 percent from 1996. Alcohol law violations include driving under the influence, drunkenness/vagrancy/disorderly conduct, and liquor law violations. This group makes up 4.4 percent of the inmate population, up from 3.2 percent in 1996.

Substance Involvement by Type of Crime

To examine the extent to which substance involvement varies by crime type, CASA examined the following categories of controlling offenses:[*] violent, property, substance (alcohol/other drug), other, and unspecified offenses.[†] Substance involvement is an overwhelming factor in all types of crime. (Figure 2.B)

Figure 2.B

Percent of Federal, State & Local Inmates by Type of Crime Committed and (Percent that Are Substance Involved)



Note: Totals equal percent of inmates incarcerated by type of crime; shaded areas equal percent of inmates who are substance involved. An additional 1.3% of inmates committed crimes that were not specified; 51.2% were substance involved.

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Violent Crimes. The controlling offense for more than a third (37.0 percent) of federal, state and local prison and jail inmates was committing a violent crime including murder, forcible rape, robbery or aggravated assault.[‡] Of these inmates, 77.5 percent were substance involved; that is, they were under the influence of alcohol or other drugs at the time of the crime, committed their crime to get money to buy drugs, had a history of alcohol treatment, a history regular drug use, or had a substance use disorder.

Substance Crimes. Federal, state and local inmates who were incarcerated for alcohol or drug law violations make up 29.2 percent of inmates. By definition, all of these inmates were substance involved.

Property Crimes. Federal, state and local inmates who were incarcerated for property crimes--burglary, larceny-theft, car theft and

[*] A controlling offense is the most serious of the offenses for which the inmate has been incarcerated.

[†] Includes inmates who were being held for probation/parole violation hearings, awaiting arraignment or waiting to stand trial on these counts. Such inmates constitute 0.6 percent of federal inmates, 1.4 percent of state inmates and 51.9 percent of the local jail population.

[‡] Robbery and aggravated assault account for 50.2 percent of incarcerations for violent crimes.

arson--comprise 19.2 percent of the inmate population. Of this group, 83.4 percent are substance-involved meaning they were under the influence of alcohol or other drugs at the time of the crime, committed their crime in order to get money to buy drugs, had a history of alcohol treatment, a history regular drug use, or had a substance use disorder.

Other Crimes. Federal, state and local inmates incarcerated for other crimes including supervision violations,* public order offenses (e.g., tax law violations, antitrust, racketeering and extortion), immigration offenses and weapon offenses comprise 13.3 percent of the inmate population. Of these offenders, 76.9 percent are substance involved--they were under the influence of alcohol or other drugs at the time of the crime, committed their crime in order to get money to buy drugs, had a history of alcohol treatment, a history regular drug use, or had a substance use disorder.

Inmates incarcerated for probation and parole supervision violations account for 45.5 percent of the category of other crimes; 83.2 percent of supervision violators were under the influence of alcohol or other drugs at the time of the crime, committed their crime in order to get money to buy drugs, had a history of alcohol treatment, a history regular drug use, or had a substance use disorder.

Conviction Unspecified. For 1.3 percent of inmates, the controlling offense was unknown.† Among those inmates for whom the type of crime for which they had been convicted was not specified, 51.2 percent were under the influence of alcohol or other drugs at the time of the crime, committed their crime to get money to buy drugs, had a history of alcohol treatment, a history regular drug use, or had a substance use disorder.

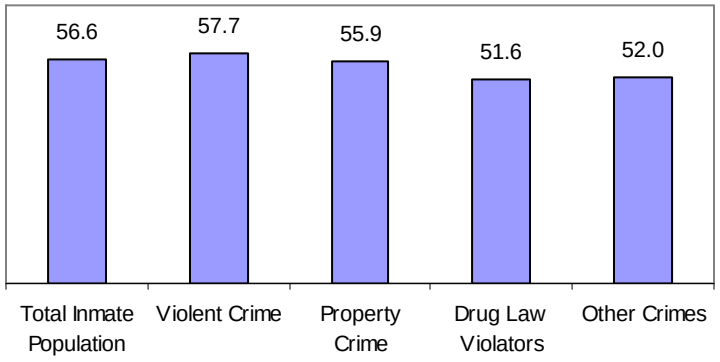
* Violated the terms of their probation or parole.
† National data sets reported "missing, don't know or refused" in this response category.

The Dominant Role of Alcohol

Alcohol is implicated in the incarceration of over half (56.6 percent) of all inmates in America. In addition to the inmates who were convicted of an alcohol law violation, 51.6 percent of drug law violators, 55.9 percent of those who committed a property crime, 57.7 percent of inmates who committed a violent crime, and 52.0 percent of those who committed other crimes were either under the influence of alcohol at the time of the crime, had a history of alcohol treatment or had an alcohol use disorder. (Figure 2.C)

Figure 2.C

Percent of Inmates Who Are Alcohol Involved by Type of Crime



Note: An additional 1.3% of inmates committed crimes that were not specified; 33.8% were alcohol involved.

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

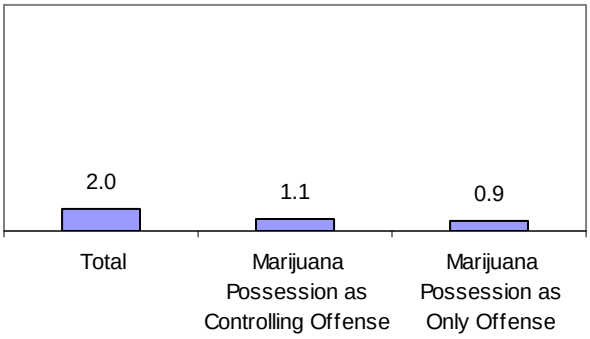
The Role of Illicit Drugs

Illicit drugs are implicated in the incarceration of three-quarters (75.9 percent) of all inmates in America. In addition to the inmates who were convicted of an drug law violation, 54.3 percent of alcohol law violators, 77.2 percent of those who committed a property crime, 65.4 percent of inmates who committed a violent crime, and 67.6 percent of those who committed other crimes either committed their crime to get money to buy drugs, were under the influence of drugs at the time of the crime, had a history of regular drug use or had a drug use disorder.

Inmates incarcerated in federal and state prisons and local jails for any marijuana charge as the controlling offense account for 2.0 percent of all inmates and 7.9 percent of all those incarcerated for drug law violations. Those incarcerated for *marijuana possession as the controlling offense* account for 1.1 percent (25,235) of all inmates and 4.4 percent of those incarcerated for drug law violations. Those incarcerated for *marijuana possession as their only offense* account for 0.9 percent (20,291) of all inmates and 2.9 of those incarcerated for drug law violations. (Figure 2.D)

Figure 2.D

Percent of All Inmates Incarcerated for Marijuana Possession



Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Non-Substance Involved Inmates

Non-substance involved inmates represent only 15.2 percent of the U.S. inmate population. These inmates have not been convicted of an alcohol or drug law violation, were not under the influence of alcohol or other drugs at the time of their crime, did not commit their crime to get money for drugs, have not used drugs regularly, have no history of alcohol treatment and no substance use disorder.

Non-substance involved offenders fall into two categories: those who report never using an illicit drug; and those who have used illicit drugs but never regularly:

- 63.4 percent of non-substance involved inmates report never using an illicit drug, including 68.6 percent of federal prison inmates; 63.4 percent state prison inmates and 62.3 percent local jail inmates;

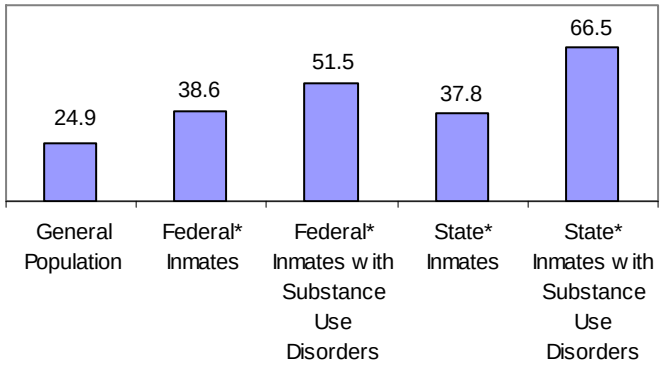
- 36.6 percent of non-substance involved inmates say they have used drugs but never regularly, including 31.2 percent of federal prison inmates, 36.6 percent of state prison inmates and 37.7 percent of local jail inmates.

Tobacco Use

In 2005, 37.8 percent of state inmates and 38.6 percent of federal inmates smoked in the month of their arrest.[*] In contrast, approximately 24.9 percent of the population was a current smoker.[† 9] State and federal inmates who met clinical criteria for substance use disorders had even higher rates of tobacco use; 66.5 percent of state inmates and 51.5 percent of federal inmates with substance use disorders smoked in the month of their arrest. Of current smokers, 19.3 percent of state inmates and 22.3 percent of federal inmates started or resumed smoking with their incarceration. (Figure 2.E)

Figure 2.E

Percent Current Smokers



* Smoked in month before arrest.

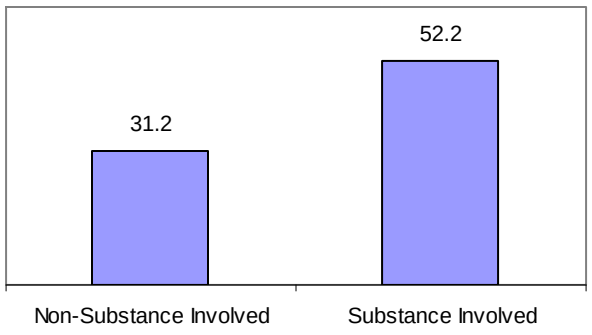
Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004) and *Survey of Inmates in State Correctional Facilities* (2004) [Data files]; Substance Abuse and Mental Health Service Administration (2006).

[*] No information on local jail inmate smoking patterns were available in the survey data.
[†] Age 12 and over who smoked in past 30 days.

Chapter III
Arrests, Convictions, Sentencing and Recidivism

Figure 3.A

Percent of Prison and Jail Inmates with Previous Incarcerations



Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Although violent and property crime rates and victimizations reported to the police remain well below the highs of the mid-1990s,[1] the number of individuals convicted and sentenced to prison or jail has continued to increase. Between 1998 and 2004, the arrests for drug law violations have increased as have the number of federal convictions and federal and state sentences for these offenses; the number of state convictions for drug law violations declined during this period.[*] Although re-incarcerations have declined slightly, they remain high, particularly among substance-involved offenders. (Figure 3.A)

Total Arrests[†] Down, Drug Law Arrests Up

In the 1990s, America experienced an overall decline in arrests and a dramatic decline in arrests for violent and property crime that continued into the 2000s.[2] During this same period, however, arrests for drug law violations increased somewhat and was the only category of arrests to increase at the federal, state and local levels; the number of federal arrests for other offenses, such as weapons, public order and immigration offenses, and for supervision violations increased more significantly.

[*] Because of data limitations, it is not possible to document trends in the percentage of those arrested, convicted or sentenced for violent, property or other crimes who were substance involved, with the exception of alcohol and drug law violations and supervision violations involving alcohol or drug law offenses.

[†] Arrests for crimes are classified into four basic types: violent, property, substance (alcohol and other drug violations) and other offenses (e.g., tax law violations, antitrust, racketeering and extortion, immigration offenses, weapon offenses and supervision violations).

Federal Arrests Up Overall and for Drug Law Violations and 'Other' Offenses[*] [3] [†]

Between 1998 and 2004,[‡] the total number of federal arrests increased by 35.2 percent (from 104,119 to 140,755). Almost a quarter (23.4 percent) of federal arrests in 2004 were for drug law violations.[§] While the number of arrestees booked for federal violent and property offenses dropped by 2.7 percent and 7.0 percent, respectively between 1998 and 2004, the number arrested for federal drug offenses increased by 9.9 percent and the number arrested for other offenses such as public-order offenses, weapon offenses, immigration offenses and supervision violations (probation and parole) increased by 66.5 percent. (See Table 3.1) Supervision violations constituted 26.7 percent of the category of 'other federal offenses' in 2004, up 54.4 percent from 1998.

Table 3.1
Federal Arrests by Type of Crime
1998 and 2004[a]

	1998		2004		1998-2004
Arrest Category	**Number**	**Percent**	**Number**	**Percent**	**Percent Change in Number of Arrests**
Drug offenses[b]	30,012	28.8	32,980	23.4	+9.9
Violent offenses	4,714	4.5	4,587	3.3	-2.7
Property offenses	16,786	16.1	15,609	11.1	-7.0
Other offenses[c]	52,607	50.5	87,579	62.2	+66.5
Total	**104,119**	**100.0**	**140,755**	**100.0**	**+35.2**

Source: CASA analysis of the BJS *Federal Justice Statistics Program Website* (http://fjsrc.urban.org).
Note: Because of rounding, percentages may not add to 100.
[a] Federal fiscal years: October 1, 1997-September 30, 1998; October 1, 2003-September 30, 2004.
[b] Drug offenses are the only substance offenses handled at the federal level; alcohol-related offenses are handled at the state and local levels.
[c] Other offenses include public order offenses (antitrust, food and drug, civil rights, tax law violations, racketeering and extortion, etc.), immigration offenses, weapon offenses, material witness supervision violations, missing and unknown offenses.

In 2004, 57.9 percent of federal drug arrests involved conspiracy (29.4 percent), and distribution/possession with the intent to deliver (28.5 percent). Simple possession of drugs accounted for 13.9 percent of all federal drug arrests. Manufacturing and related drug arrests totaled 11.4 percent of federal drug arrests, while other drug arrests totaled 16.8 percent.[**] [4]

Of those arrested for federal drug law violations in 2004, cocaine was the primary drug involved totaling 36.9 percent of all arrests for drug law violations, down from 41.5 percent in 1998. Drug arrests that involved marijuana as the primary drug constituted 24.6 percent of all drug law violation arrests in 2004, down from 27.8 percent in 1998. Similarly, heroin drug arrests as a percent of all arrests for drug law violations decreased from 6.2 percent in 1998 to 5.7

[*] Unless otherwise noted in this section on federal arrests, all percentage and numerical estimates are either drawn directly from or based on CASA's analysis of the Bureau of Justice Statistics *Federal Justice Statistics Program Website* (http://fjsrc.urban.org). See Appendix A, Methodology.
[†] These data differ from those presented below for state and local arrests in that for the federal data, the unit of analysis is the individual arrestee who may have several arrests, whereas for the state and local data, the unit of analysis is the arrest itself.
[‡] 1998 is the earliest year federal arrest data are available, and 2004 is the latest year conviction and sentencing data are available from the U.S. Bureau of Justice Statistics. In order to present data in a consistent time frame, data from 1998 and 2004 are used for comparison.
[§] Drug offenses are the only substance offenses handled at the federal level; alcohol-related offenses are handled at the state and local levels.

[**] Because the presentation of data for 1998 does not include the breakdown of drug arrests by offense, no comparison is possible.

percent in 2004. On the other hand, amphetamine/ methamphetamine arrests for drug law violations almost doubled from 1998 to 2004, rising from 9.7 percent of all drug arrests to 15.8 percent.[5]

Table 3.2
State and Local Arrests by Type of Crime
1998 and 2004

	1998		2004		
Arrest Category	**Number**	**Percent**	**Number**	**Percent**	**Percent Change**
Drug offenses	1,559,100	10.7	1,746,570	12.5	+12.0
Alcohol offenses	2,743,500	18.9	2,598,581	18.6	-5.3
Violent offenses	675,900	4.7	586,558	4.2	-13.2
Property offenses	1,805,600	12.4	1,644,197	11.8	-8.9
Other offenses[a]	7,744,200	53.3	7,362,165	52.8	-4.9
Total	**14,528,300**	**100.0**	**13,938,071**	**100.0**	**-4.1**

Source: CASA analysis of *Crime in the United States, 1998* and *Crime in the United States, 2004*.
Note: Because of rounding, percentages may not add to 100.
[a] These include public order offenses (vandalism, vagrancy, curfew violations and loitering, etc), weapon offenses, gambling and others.

State and Local Arrests Down Overall but Up for Drug Law Violations[*] [6]

Between 1998 and 2004, the total number of state and local arrests decreased by 4.1 percent. Approximately one-third (31.1 percent) of state and local arrests in 2004 were for alcohol and drug law violations, up from 29.6 percent in 1998. Between 1998 and 2004, arrests for drug offenses increased by 12.0 percent while arrests for alcohol-related offenses decreased by 5.3 percent. During this same period, state and local arrests for violent crimes declined by 13.2 percent. State and local arrests for property crimes dropped by 8.9 percent between 1998 and 2004. For all other offenses, arrests decreased by 4.9 percent. (Table 3.2)

Of state and local arrests for drug law violations, 81.8 percent were for drug possession. Between 1998 and 2004, the proportion of drug law violation arrests that were for drug possession increased by 3.8 percent while the proportion of drug law violation arrests that were for trafficking fell by 14.2 percent. (Table 3.3)

While marijuana is the drug involved in the largest share of state and local arrests or drug law violations (44.3 percent), followed by heroin or cocaine and their derivatives (30.3 percent), the largest increases in arrests for drug law violations were seen in arrests involving synthetic or manufactured drugs[†] (75.9 percent increase from 1998 to 2004) followed by other non-narcotic drugs (21.6 percent increase). (Table 3.3)

Table 3.3
Percent of State and Local Arrests for Drug Law Violations
1998 and 2004

	1998	2004	Percent Change
Types of offense			
Trafficking	21.2	18.2	-14.2
Possession	78.8	81.8	+3.8
Drugs involved[a]			
Heroin or cocaine and their derivatives	36.6	30.3	-17.2
Marijuana	43.8	44.3	+1.1
Synthetic or manufactured drugs	2.9	5.1	+75.9
Other dangerous non-narcotic drugs	16.7	20.3	+21.6

Source: CASA analysis of *Crime in the United States, 1998* and *Crime in the United States, 2004*.
[a] The four drug categories are defined as: opium or cocaine and their derivatives (e.g. morphine, heroin, codeine); marijuana; synthetic narcotics--manufactured narcotics which can cause true drug addiction (e.g. Demerol, methadone); and dangerous non-narcotic drugs (e.g. barbiturates, Benzedrine).

[*] Unless otherwise noted in this section on state and local arrests, all percentage and numerical estimates are either drawn directly from or based on CASA's analysis of Federal Bureau of Investigation's *Crime in the United States* (1998 and 2004). See Appendix A, Methodology.

[†] Methamphetamines, ecstasy and controlled prescription drugs used non medically.

Convictions Up Overall*

Arrested federal and state felony offenders are likelier to be convicted than they were 10 years ago; between 1998 and 2004, conviction rates rose 17.1 percent. Six percent of total felony convictions occur in federal courts and 94 percent in state courts. Conviction rates in the federal court tend to be higher than in the state courts.[7]

Federal Drug Law Convictions Up

Between 1998 and 2004, the total number of federal convictions increased by 31.7 percent (from 50,494 to 66,518). Drug law convictions were 36.8 percent of all federal convictions in 2004--down from 41.3 percent in 1998. However, between 1998 and 2004, the total number of federal convictions that involved drug law violations increased by 17.3 percent. Convictions involving property offenses also increased (4.3 percent) while convictions involving violent crimes decreased by 5.2 percent.

Nine of every 10 (91.7 percent) convictions in federal courts involving drug law violation are for drug trafficking, down from 93.1 percent in 1998. The remaining convictions (8.3 percent) are for drug possession.

State Drug Law Convictions Down

Between 1998 and 2004, the total number of state convictions increased by 16.3 percent (from 927,717 to 1,078,920). Drug law violations comprised 33.6 percent of state convictions in 2004, approximately the same share as in 1998 (33.9 percent). Between 1998 and 2004, the total number of state convictions involving drug law violations decreased by 15.3 percent. In contrast to this pattern, the percent of arrestees convicted of a violent crime rose from 23.2 percent in 1998 to 31.1 percent in 2004; the percent convicted of property crimes† rose from 32.9 to 34.4 percent.

In 2004, 55.6 percent of all state convictions for drug law violations were for drug trafficking--down from 62.0 percent in 1998, while 44.4 percent were for drug possession--up from 38.0 percent in 1998. The percentage of those arrested for drug trafficking who were convicted increased slightly over this period from 68.0 to 71.4 percent. In 2002,‡ 1.7 percent (17,867) of all state convictions were for marijuana possession only, down by 46.5 percent from 1998.

Sentencing Up Overall

Convicted offenders are somewhat likelier to be sentenced to prison, jail or probation than they were 10 years ago. From 1998 to 2004, the percent of convicted offenders in federal courts who were sentenced to federal prison rose from 82 percent to 85 percent.§ During this same period, the percent of convicted offenders sentenced in state court to prison or jail rose from 68 percent to 70 percent.

Federal Prison Sentences for Drug Law Violations Up

The number of persons sentenced to federal prison increased 36.6 percent between 1998 and 2004 (from 41,405 to 56,540). In 2004, two in five (40.3 percent) federal prison sentences were for drug law violations. The percent of offenders convicted of drug law violations who were sentenced to federal prison was 92 percent in 1998 and 93 percent in 2004. Between 1998 and 2004, the total number of federal prison sentences involving drug law violations increased by 18.7 percent.

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* Unless otherwise noted in the sections on convictions and sentences (federal and state), all percentage and numerical estimates are either drawn directly from or based on CASA's analysis of BJS's report on *Felony Sentences in State Courts* (1998 and 2004), and BJS's *State Court Sentencing of Convicted Felons, 2004- Statistical Tables*. See Appendix A, Methodology.

† Data only available for burglary and motor vehicle theft.

‡ Most recent available data.

§ Percentages expressed as whole numbers rather than taken to one decimal place are so presented due to the limitation of the data source.

During this same period, the percent of those with violent crime convictions who were sentenced to federal prison rose from 92 percent to 94 percent, the percent of those convicted of property crimes who were sentenced rose from 59 percent to 60 percent, while the percent who were convicted of other crimes* and sentenced to prison rose from 81 to 86 percent.

Nearly all (91.7 percent) drug law violation sentences to federal prisons were for drug trafficking (20,879 of 22,759 in 2004)--down from 94.1 percent in 1998; eight percent were for drug possession. According to the U.S. Sentencing Commission, of all drug defendants sentenced in Federal Court in 2001 for marijuana crimes, only 2.3 percent received sentences for simple possession of marijuana[8] and approximately a third of those sentenced served time in prison.[9]

State Prison and Local Jail Sentences for Drug Law Violations Up

The number of persons sentenced to state prisons and local jails increased 19.7 percent between 1998 and 2004 (from 630,848 to 755,244). Forty percent of sentences were to state prison and 30 percent to local jails. The remaining 30 percent of convicted felons were sentenced to probation with no jail or prison time or received a sentence that included fines, restitution, treatment, community service or some other penalty.

In 2004, those sentenced to state prisons and local jails for drug law violations made up 32.2 percent of all state felony incarceration sentences. The percent of those sentenced to state prisons and local jails for drug law violations was 68 percent in 1998 and 67 percent in 2004. Between 1998 and 2004, the total number sentenced to state prisons and local jails for drug law violations increased by 20.1 percent.

Persons convicted of a violent felony were most likely to receive an incarceration sentence to prison or jail in 2004 (78 percent), the same percentage as in 1998. During the same period, the percent convicted of property crimes who were sentenced to state prison or local jails rose from 65 to 68 percent; and the percent sentenced for other crimes rose from 63 to 69 percent.

Of sentences in 2004 to state prison or local jails for the controlling offense of a drug law violation, 57.3 percent were for convictions of drug trafficking (139,214 of 243,110), down from 64.8 percent in 1998; 42.4 percent† of such sentences were for convictions of possession of drugs.

Re-Incarceration Down but Still High, Particularly among Substance-Involved Offenders‡ [10]

In 2006, 48.4 percent§ of all inmates had a previous incarceration, down from 50.3 percent in 1996.** Substance-involved offenders are likelier to be re-incarcerated than those who are not substance involved. Although the percentage of offenders who were re-incarcerated†† decreased between 1996 and 2006 for all offenders, the percent of substance-involved offenders who were re-incarcerated was much higher than among non-substance involved offenders, both in 1996 (53.4 vs. 38.9

* Composed of non-violent offenses such as receiving stolen property and vandalism.

† Total does not equal 100 percent due to rounding.

‡ Unless otherwise noted in this section, percentages and numerical estimates are either drawn directly from or based on CASA's analysis of the *Survey of Inmates in Federal Correctional Facilities* (1991 and 2004), *Survey of Inmates in State Correctional Facilities* (1991 and 2004), and *Survey of Inmates in Local Jails* (1989 and 2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in* (1996 and 2006). See Appendix A, Methodology.

§ When only percentages of inmates are reported, data from 2002 (local jails) and 2004 (prisons) are presented. When estimates of actual numbers of inmates are presented, 2002/2004 percentages are applied to the 2006 estimates of the prison population.

** This analysis involves the inmate data sets used in Chapter II which are available for the period 1996-2006.

†† The percent with one or more previous incarcerations.

percent) and 10 years later in 2006 (52.2 percent vs. 31.2 percent).

Substance-involved inmates are likelier to begin their criminal careers at an early age and to have more contacts with the criminal justice system than inmates who are not substance involved. The first arrest for a criminal offense among substance-involved inmates occurs at about age 18.6 compared with the first arrest at age 20.8 years for those who are not substance involved. This pattern is true among federal, state and local jail inmates. (Table 3.4)

Substance-involved inmates also report higher average numbers of past arrests (5.3) than their non-substance involved peers (2.5). Again, the relationship holds for those in federal and state prisons and local jails. (Table 3.4)

Among those inmates who had a history of previous incarcerations, substance-involved inmates have a higher average number of past incarcerations (3.2) than non-substance involved inmates (2.5). This is true among federal, state and local jail inmates. (Table 3.4)

Among substance-involved inmates, those who have committed a crime to get money to buy drugs have the highest average number of past arrests (6.6), followed by inmates who had a history of alcohol treatment (6.3), were under the influence of alcohol or other drugs at the time of their crime (5.9), or had a substance use disorder (5.8). (Table 3.5)

Juvenile Delinquency, Substance Use and Adult Recidivism

Without timely and adequate interventions, youthful offenders are at increased risk of developing persistent criminal careers.[11] In its 2004 report, *Criminal Neglect: Juvenile Justice, and The Children Left Behind*, CASA documented how the juvenile justice system has failed to provide juvenile offenders a safe and therapeutic environment and assist with their reintegration into society.[12] CASA's analysis of more recent data suggests that the failure to prevent and control juvenile involvement in crime and substance use directly contributes to the growth of adult prison and jail populations.

Table 3.4
Comparison of Re-Incarceration Among Prison and Jail Inmates

	Federal Prison		State Prison		Local Jail		Total	
	Non-Substance Involved	Substance Involved	Non-Substance Involved	Substance Involved	Non-Substance Involved	Substance Involved	Non-Substance Involved	Substance Involved
Age at first arrest	21.4	19.7	20.1	18.1	21.8	19.2	20.8	18.6
Number of past arrests	2.1	4.2	2.6	5.6	2.3	5.1	2.5	5.3
Percent had at least one prior incarceration	29.9	41.7	33.8	54.9	27.0	50.2	31.2	52.2
Number of prior incarcerations among those who had at least one prior incarceration	2.2	2.5	2.6	3.1	2.5	3.4	2.5	3.2

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails, 2002* [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Being arrested at an early age, being convicted as a juvenile or youthful delinquent* and beginning alcohol or other drug use at an early age all are related to recidivism.[13] CASA's analysis reveals that whereas first time adult inmates in local jails report an average age at first arrest of 20.6 years, the average age at first arrest for habitual adult jail inmates who had at least three prior prison or jail sentences is 17.6 years.

Earlier initiation of substance use and involvement in criminal activity also powerfully predict adult substance addiction. For example, jail inmates who meet clinical criteria for substance use disorders were younger at the time of their first arrest than were those who do not meet such criteria (19.0 years vs. 21.0 years); they also were younger when they began using alcohol or other drugs (16.3 years for alcohol and 15.6 years for other drugs vs. 17.7 years for both) and more likely to have a juvenile record (62.6 percent vs. 31.2 percent). (Table 3.6)

Table 3.5
Average Number of Past Arrests by Types of Substance Involvement

	Federal Prison	State Prison	Local Jail	Total
Non-substance involved inmates	2.1	2.6	2.3	2.5
Substance-involved inmates	4.2	5.6	5.1	5.3
Had a substance use disorder	4.9	6.1	5.4	5.8
Had a history of using illicit drugs regularly	4.8	5.9	5.4	5.7
Under the influence of drugs and alcohol at the time of crime	5.1	6.1	5.6	5.9
Had a history of alcohol treatment	5.1	6.2	7.0	6.3
Incarcerated for a drug law violation	3.5	5.3	4.4	4.6
Committed crime to get money to buy drugs	4.8	6.9	6.2	6.6
Convicted of an alcohol law violation	2.8	6.3	5.1	5.4

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails, 2002* [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Table 3.6
Underage Criminal Activity and Onset of Substance Use Among Local Jail Inmates

Adult Substance Use Disorder Diagnosis	Age at First Arrest	Percent with Arrest or Incarceration Prior to Age 18	Age When First Drank	Age When First Used Drugs
No substance use disorder	21.0	31.2	17.7	17.7
Substance use disorder	19.0	62.6	16.3	15.6

Source: CASA analysis of the *Survey of Inmates in Local Jails, 2002* [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

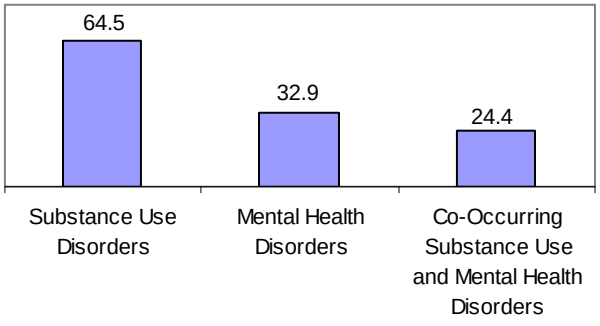
* A juvenile/youthful delinquent is a law-violator who has not yet reached the age of majority and whose disposition is meant to rehabilitate rather than to punish. The specific age requirements vary from state to state. In contrast, a youthful offender is a minor who is subject to more severe punitive dispositions because of the seriousness of his or her illegal acts.

Chapter IV
Profiles of Substance-Involved Inmates

Almost two-thirds (64.5 percent) of the inmate population[*] [1] in the U.S. meet medical criteria for a substance use disorder. Prison and jail inmates are seven times likelier than are individuals in the general population to have a substance use disorder. One-third (32.9 percent) of the 2.3 million prison and jail inmates have a mental health disorder. A quarter (24.4 percent) of prison and jail inmates has both a substance use disorder and a co-occurring mental health disorder.[†] (Figure 4.A)

Figure 4.A

Percent of Inmates with Substance Use and Mental Health Disorders



Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Relative to the population at large, black and Hispanic individuals are overrepresented in America's prisons and jails, yet are less likely than white inmates to have substance use disorders. Substance-involved inmates are likelier to come from families with substance

[*] Unless otherwise noted in the chapter, percentage and numerical estimates of the inmate population are either drawn directly from or based on CASA's analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*. See Appendix A, Methodology.

[†] Substance use disorders are defined by inmate and general population answers to questions that define clinical criteria in accordance with the clinical diagnostic criteria presented in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV)--the main diagnostic reference of mental health professionals in the United States. The questions on substance abuse ask about problems at work, home, and school; problems with family or friends; physical danger; and trouble with the law due to use of prescription drugs. The questions on substance dependence ask about health, emotional problems, attempts to cut down on use, tolerance, withdrawal and other symptoms associated with the use of prescription drugs. Dependence reflects a more severe substance problem than abuse, and persons are classified with abuse of a particular substance only if they are not dependent on that substance. Mental health disorders are defined by inmate answers to questions of any past diagnosis of a psychiatric disorder or a history of treatment.

use problems and criminal histories, to be poorly educated and unemployed, and to have spent time in foster care than are non-substance involved inmates.

Inmate groups with substance use disorders requiring special attention include female inmates, juvenile offenders housed in adult corrections facilities, inmates with minor children, those with HIV/AIDS, Hepatitis C and fetal alcohol spectrum disorder, and veterans.

Characteristics of Substance-Involved Inmates

Substance-involved inmates differ from those who are not substance involved in several key ways. (See Appendix A, Methodology) Compared with inmates who are not substance involved, substance-involved inmates are:

- four times likelier to receive income through illegal activity (24.6 percent vs. 6.0 percent);
- almost twice as likely to have had at least one parent abuse alcohol or other drugs (34.5 percent vs. 18.4 percent);
- 40.6 percent likelier to have some family criminal history (42.6 percent vs. 30.3 percent);
- 29.2 percent less likely to have completed at least high school (30.4 percent vs. 39.3 percent); and
- 20.0 percent likelier to be unemployed a month before incarceration (32.1 percent vs. 26.8 percent).

Inmates who are substance involved also are likelier than those who are not substance involved to be: younger (average age 33.9 vs. 36.2), to have lived only with their mother during childhood (39.6 percent vs. 32.5 percent); and to have ever spent time in foster care (12.2 percent vs.7.3 percent). (Table 4.1)

Table 4.1
Background Characteristics of Substance-Involved and Non-Substance Involved Inmates

	Percent Substance Involved (1,914,964)	**Percent Non-Substance Involved** (344,019)
Average age (years)	33.9	36.2
Gender		
Male	91.7	91.0
Female	8.3	9.0
Participation in religious activities[a]	56.4	58.3
Family criminal history[b]	42.6	30.3
Lived with mother in childhood	39.6	32.5
Parental substance abuse[c]	34.5	18.4
Unemployed	32.1	26.8
Income through illegal activity	24.6	6.0
Married	16.4	20.9
Completed at least high school	30.4	39.3
Ever spent time in foster care	12.2	7.3
Income through welfare/charity	5.5	4.4

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), Survey *of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

[a] Had participated in religious activities such as religious services, private prayer or meditation, or Bible reading or studying in the past week.

[b] Had an immediate family member who had served time in jail or prison.

[c] Had at least one parent abusing alcohol or illicit drugs.

Substance-involved inmates are more likely than non-substance involved inmates to have a mental health problem (34.5 percent vs. 25.7 percent) or to have been on probation or parole at the time of their arrest (44.1 percent vs. 28.9 percent).

Substance Use Disorders (SUDs) at Epidemic Proportions

In 2006, 64.5 percent (1.5 million[*]) of the 2.3 million prison and jail inmates had a substance use disorder--more than seven times the rate for the general population (9.1 percent).[† 2] (Table 4.2)

The lowest proportion of inmates with substance use disorders was among federal inmates. In 2006, 54.8 percent of the federal prison population had a SUD--six times the rate of the general population. Half of federal inmates (51.8 percent) met criteria for substance abuse and 36.8 percent met criteria for substance dependence. In 2006, 65.2 percent of state prison inmates had a substance use disorder--more than seven and one half times the rate of the general population; 62.4 percent met criteria for substance abuse and 47.9 percent met criteria for substance dependence. Among local jail inmates, 65.8 percent had a substance use disorder in 2006; 64.8 percent met criteria for substance abuse and 43.7 percent met criteria for substance dependence. (Table 4.3)

Table 4.2

Percent with Past Year Substance Use Disorders U.S. Inmate Population and General Population Ages 12 or Over

	Inmate Population (2,258,983)	**General Population** (299,398,484)
Substance abuse	62.4	4.9
Substance dependence	45.5	4.7
Substance abuse AND/OR dependence	64.5	9.1

Source*:* CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), Survey *of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006;* CASA analysis of the *National Survey on Drug Use and Health (NSDUH)* (2006) [Data file].

Table 4.3

Prevalence of Substance Use Disorders in Prisons and Jails

	Federal Prison (190,844)		**State Prison** (1,302,129)		**Local Jail** (766,010)	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Substance abuse	96,843	51.8	813,082	62.4	496,517	64.8
Substance dependence	70,178	36.8	623,428	47.9	334,576	43.7
Substance abuse AND/OR dependence	104,529	54.8	848,426	65.2	504,896	65.8

Source: CASA analysis of *the Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006.*

[*] 1,456,851 inmates with SUDs.

[†] Using the most recently available national surveys of inmate populations--2004 for state and federal prisons and 2002 for local jails--CASA imputed prevalence rates for 2006 based on the weighted 2002/2004 datasets and the 2006 prison and jail population estimates published in *Prison and Jail Inmates at Midyear*, 2006, by the Bureau of Justice Statistics. CASA analyzed data from the *2006 National Survey on Drug Use and Health* to determine rates of SUDs for the U.S. population ages 12 or older.

High Rates of Mental Health Disorders

CASA's analysis found that approximately one-third (32.9 percent) of inmates have a mental health disorder.* An estimated one in ten individuals in the general population has such a disorder.[4] In 2005, 45 percent of federal inmates, 56 percent of state inmates and 64 percent of local inmates have mental health problems.†[5] Inmates with mental health problems are likelier than their peers without such problems to be more entangled in the criminal justice system.[6]

> The Los Angeles County Jail, on any given day, holds more people with mental illness than any state hospital or mental health institution in the United States.[9]

A quarter of state and local inmates with mental health problems have had three or more prior incarcerations compared to a fifth of their peers without mental health problems.[7] They also are more likely than are their peers to face homelessness, unemployment, physical or sexual abuse and alcohol or other drug problems.[8]

In 2006, 24.4 percent (550,608) of the 2.3 million prison and jail inmates had both a substance use disorder and a co-occurring mental health disorder. Among local jail inmates, 25.5 percent (195,652) have co-occurring disorders as do 25.4 percent (330,145) of state prison inmates, and 13.0 percent (24,810) of federal prison inmates.

> **Co-occurring Problems of Inmates**
>
> Co-occurring disorders among inmates in the San Francisco County Jail increased the chances that offenders had been incarcerated multiple times regardless of whether they were homeless (52 percent vs. 44 percent) or not (30 percent vs. 17 percent).[3]

Of the inmate population, 40.1 percent (906,243 inmates) had substance use disorders only while 8.5 percent (191,249 inmates) had mental health disorders without substance use disorders. Just 27.0 percent (610,883 inmates) of the entire prison and jail population is free of a substance use or mental health disorder. (Table 4.4)

Table 4.4

Percent of Prison and Jail Inmates with Mental Health and Substance Use Disorders

	Federal Prison (190,844)	**State Prison** (1,302,129)	**Local Jail** (766,010)	**Total** (2,258,983)
Both mental health and substance use disorders	13.0	25.4	25.5	24.4
Mental health disorders only	6.6	9.2	7.7	8.5
Substance use disorders only	41.8	39.8	40.2	40.1
None	38.7	25.6	26.5	27.0
Total[a]	**100.0**	**100.0**	**100.0**	**100.0**

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

[a] Columns may not equal 100 percent due to rounding.

* Defined as any past diagnosis of a psychiatric disorder or history of treatment.

† Defined by a clinical diagnosis, having received mental health treatment during the prior 12 months or experiencing sub-clinical levels of symptoms based on the DSM-IV.

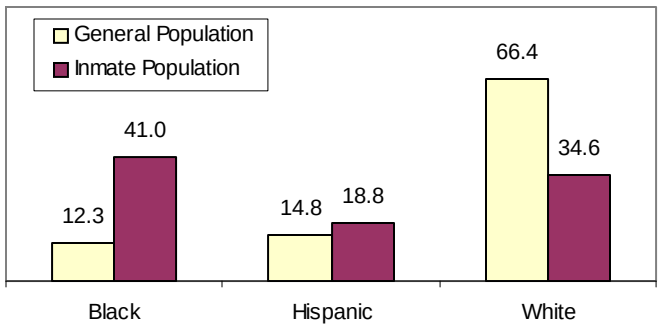
While mental health disorders alone rarely increase the rate or frequency of criminal behaviors, their co-occurrence with substance use disorders dramatically increases the risk of criminal activities.[10] Increased rates of re-incarceration of inmates with co-occurring mental health and substance use disorders suggest that they are not being rehabilitated under the current system and instead are cycling in and out of incarceration.[11]

Most Minorities Over-Represented in Inmate Population

Blacks, Hispanics and Native Americans are overrepresented in our nation's prisons and jails. In 2006, blacks constituted 12.3 percent of the U.S. adult population and 41.0 percent of the inmate population. Hispanics were 14.8 percent of the U.S. population and 18.8 of the inmate population, while Native Americans comprised 0.8 percent of the U.S. population and 3.8 percent of the inmate population. Whites comprised 66.4 percent of the U.S. population and 34.6 percent of the inmate population. (Figure 4.B and Table 4.5)

In the general population, more blacks report having been booked for a crime in the past year (21.5 percent) than whites (16.5 percent) or the population as a whole (16.6 percent). Black inmates whose controlling offenses are a drug charges are more likely to be non-substance using offenders than are whites whose controlling offenses are drug charges (18.5 percent vs. 7.4 percent).[12]

Figure 4.B
Percent of General and Inmate Populations by Race and Ethnicity



Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*; U.S. Census Bureau (2006).

Between 1983 and 1997, the number of black offenders admitted to prison for drug offenses grew more than 26 times, relative to a sevenfold increase for white offenders.[13] As of 2008, more than one in every 100 adults in the U.S. were incarcerated; however, the numbers remain much higher for minority groups. One in 15 black men (one in nine among black men ages

Table 4.5
Percent of Substance-Involved Inmates by Race/Ethnicity Compared with the General Population

	Inmate Population (2,258,983)	**Substance-Involved Inmates** (1,914,964)	**Non-Substance Involved Inmates** (344,019)	**U.S. Adult Population** (299,398,484)
White[a]	34.6	35.4	31.2	66.4
Black[b]	41.0	40.8	42.0	12.3
Hispanic	18.8	18.4	20.5	14.8
Native American	3.8	3.9	3.4	0.8
Other[c]	1.6	1.4	2.7	5.8

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*; U.S. Census Bureau (2006).

[a] Non-Hispanic white.

[b] Non-Hispanic black.

[c] Asian, Hawaiian, Pacific Islanders and others.

20-34) and one in 36 Hispanic men were incarcerated in 2006.[14]

Substance involvement does not explain this overrepresentation since black and Hispanic inmates report lower rates of drug use in the month prior to their arrest and have lower rates of substance use disorders than white inmates. Some explanations that have been offered for the disproportionately high number of incarcerated individuals from minority groups include: the legal provision of harsher sentences for the possession and sale of crack cocaine, a drug more often used by blacks; the law enforcement emphasis on outdoor drug sale venues more frequently found in poor and minority communities; the concentration of police resources in minority and racially mixed neighborhoods of major urban areas; and race-specific sentencing practices by the judges.[15]

Black and Hispanic inmates also are less likely than are white and Native American inmates to have mental health problems; 25.4 percent of black inmates and 22.9 percent of Hispanic inmates have a mental health disorder compared with 46.1 percent of white inmates and 45.4 percent of Native American inmates. This holds true for federal, state and local jail inmates.

Similarly, black and Hispanic inmates had considerably lower rates of co-occurring substance use and mental health disorders than white and Native American inmates; 17.7 percent of black inmates and 16.5 percent of Hispanic inmates compared with 35.9 percent of white inmates and 33.9 percent of Native American inmates. (Table 4.7) This relationship holds true for federal, state and local inmates.

Blacks and Hispanics Have Lower Rates of Substance Use and Mental Health Disorders Than Whites and Native Americans

Even though black and Hispanic inmates are overrepresented in America's prisons and jails, they report fewer risk factors. They are less likely than are white inmates to meet diagnostic criteria for a substance use disorder (60.2 percent of black inmates and 58.3 percent of Hispanic inmates vs. 73.1 percent of white inmates). Native American inmates also are overrepresented in prisons and jails. Like white inmates, they are likelier to have substance use disorders (69.5 percent) than blacks and Hispanics. (Table 4.6) This holds true for inmates in federal and state prisons and local jails.

Table 4.6
Percent of Prison and Jail Inmates with Substance Use Disorders by Race/Ethnicity

	White[a] (782,079)	**Black**[b] (925,831)	**Hispanic** (424,861)	**Native American** (85,948)	**Other**[c] (40,264)
Substance abuse	71.7	57.2	56.6	67.2	49.6
Substance dependence	55.2	39.7	40.0	52.3	36.0
Substance abuse AND/OR dependence	73.1	60.2	58.3	69.5	51.4

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.
[a] Non-Hispanic white.
[b] Non-Hispanic black.
[c] Asian, Hawaiian, Pacific Islanders and others.

Table 4.7

Percent of Prison and Jail Inmates with Mental Health Problems and Co-Occurring Disorders by Race/Ethnicity

	White[a] (782,079)	**Black**[b] (925,831)	**Hispanic** (424,861)	**Native American** (85,948)	**Other**[c] (40,264)
Diagnosed with a mental health disorder	46.1	25.4	22.9	45.4	24.9
Co-occurring substance use disorder and mental health disorder	35.9	17.7	16.5	33.9	17.3

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

[a] Non-Hispanic white.

[b] Non-Hispanic black.

[c] Asian, Hawaiian, Pacific Islanders and others.

Black and Hispanic inmates also report significantly less exposure to stressful or traumatic life events than do white and Native American inmates. Across all types of correctional facilities, the white and Native American inmates are more likely than black and Hispanic inmates to report ever having been homeless, having been physically or sexually abused, having spent time in foster care, or having parents or guardians who were themselves substance abusers. The only exceptions to this general trend is the large proportion of black inmates who have family members in prisons or jails and did not have legal income in the month before arrest. (Table 4.8).

Table 4.8

Percent of Prison and Jail Inmates with Other Incarceration-Related Risk Factors by Race/Ethnicity

	White[a] (782,079)	**Black**[b] (925,831)	**Hispanic** (424,861)	**Native American** (85,948)	**Other**[c] (40,264)
Ever been homeless	11.1	9.0	8.6	13.9	8.5
Did not have legal income in month before arrest	19.4	25.1	17.8	18.2	16.5
Ever physically abused before admission	22.1	9.9	10.8	29.1	12.0
Ever sexually abused before admission	11.7	5.2	5.1	15.1	6.5
Ever lived in foster home, agency or institution while growing up	14.2	9.4	8.8	19.8	9.5
Parents or guardians ever abused alcohol/drugs while growing up	38.3	27.7	26.5	45.5	18.8
Family members ever incarcerated	37.2	45.3	35.3	52.1	22.2

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

[a] Non-Hispanic white.

[b] Non-Hispanic black.

[c] Asian, Hawaiian, Pacific Islanders and others.

Female Inmates Have Higher Rates of Substance Use and Mental Health Disorders Than Male Inmates

Female inmates make up 8.4 percent of the total inmate population--up from 7.7 percent in 1996.[16] Female inmates are likelier to have a substance use disorder than are male inmates (66.1 percent vs. 64.3 percent). (Table 4.9) This holds true for both state prisons and local jails, but among inmates in federal prisons, males have higher rates of substance use disorders than do females. (Table 4.10)

Table 4.9
Percent of All Prison and Jail Inmates with Past Year Substance Use Disorders, by Gender

	Male (2,069,027)	**Female** (189,956)
Substance abuse	62.3	63.5
Substance dependence	44.9	52.6
Substance abuse AND/OR dependence	64.3	66.1

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Female inmates also are likelier to have mental health problems than are male inmates.[18] An estimated 54.7 percent of female inmates (vs. 30.8 percent of males) have a mental health disorder as reflected by past diagnosis or treatment history. Female inmates are likelier than are male inmates to suffer from co-occurring substance use and mental health disorders (40.5 percent vs. 22.9 percent). While female inmates are likelier than male inmates to have only a mental health disorder (14.2 percent vs. 7.9 percent), they are significantly less likely to have only a substance use disorder (25.6 percent vs. 41.5 percent). (Table 4.11)

Among women, regular drug use can be either the impetus for or the byproduct of other crimes. In a focus group with drug-involved female inmates in St. Louis, Missouri, nearly half the women who reported engaging in prostitution did so to support their habit, while others described using drugs to numb the emotional impact of the sex trade which they participated in to support themselves and their families.[17]

Table 4.10
Percent of Federal and State Prison and Local Jail Inmates with Substance Use Disorders, by Gender

	Federal Prison (190,844)		**State Prison** (1,302,129)		**Local Jail** (766,010)	
	Male (177,468)	**Female** (13,376)	**Male** (1,214,206)	**Female** (87,923)	**Male** (677,353)	**Female** (88,657)
Substance abuse	52.2	46.3	62.3	64.3	64.8	65.3
Substance dependence	36.5	40.3	47.2	56.9	42.8	50.2
Substance abuse AND/OR dependence	55.2	49.5	65.0	67.6	65.6	67.1

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Table 4.11

Percent of Prison and Jail Inmates with Mental Health and Substance Use Disorders by Gender

	Male (2,069,027)	**Female** (189,956)
Both mental health and substance use disorders	22.9	40.5
Mental health disorders only	7.9	14.2
Substance use disorders only	41.5	25.6
None	27.7	19.7
Total	**100.0**	**100.0**

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Female inmates in federal, state and local correctional facilities are likelier than male inmates to have been exposed to stressful or traumatic life events, many of which are significant risk factors for substance use and mental health disorders.[19] Compared with male inmates, female inmates are:

- more than seven times likelier to have been sexually abused before incarceration;
- almost four times likelier to have been physically abused before incarceration;
- 77.6 percent likelier to have had a mental health problem in the year before incarceration;
- 57.5 percent likelier to have ever been homeless; and
- 30.7 percent likelier as children to have had parents or guardians who abused alcohol or other drugs.

Female inmates also were likelier to have lived in a foster home or institution and to have family members who had been incarcerated than were male inmates. (Table 4.12)

The incarceration of women who are substance-involved mothers has a particularly disruptive effect on disadvantaged families, many of which are female-headed households.[20] Failure to address their substance-related problems can perpetuate both high recidivism rates and a high rate of juvenile delinquency among their children.[21]

Table 4.12

Prevalence and Risk Factors of Mental Health Problems and Co-Occurring Disorders by Gender

	Male (2,069,027)	**Female** (189,956)
Ever sexually abused before incarceration	5.1	37.6
Ever physically abused before incarceration	12.2	46.1
Ever had a mental health problem in the year	30.8	54.7
Ever been homeless	9.4	14.8
Parents or guardians ever abused alcohol or drugs while growing up	30.9	40.4
Family members ever incarcerated	39.5	50.5
Ever lived in foster home, agency or institution while growing up	11.2	13.4
Did not have legal income in month before arrest	21.5	19.2

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Women Behind Bars in New Hampshire[22]

In New Hampshire, more than 2,800 women are behind bars, under correctional supervision in the community or released from county houses of correction on any given day during the past year. Two-thirds of incarcerated women in New Hampshire have children and 45 percent of them are single mothers. Each year, an estimated 1,300 or more children are affected by their mother's incarceration; 85 to 92 percent of these women are substance involved. Two-thirds of the incarcerated women say they have had previous diagnoses of mental illness; 14 to 20 percent have a primary diagnosis of mental illness confirmed while at the jail. Half of the women report having both substance use problems and a history of mental illness.

Juvenile or Youthful Inmates* at High Risk

In 2006, 0.7 percent (15,340) of the 2.3 million offenders incarcerated in state prisons and local jails were juveniles or youthful offenders who had been tried in adult court.†

In 2006, half (52.4 percent) of juvenile or youthful offender inmates in state prisons and local jails met clinical criteria for substance use disorders. The problem is particularly severe among youth incarcerated in local jails where 54.3 percent met such clinical criteria compared with 36.7 percent of juvenile inmates in state prison. (Table 4.13)

Table 4.13

Percent of Inmates Convicted as Juvenile or Youthful Offenders and Confined in State Prisons and Local Jails who have Substance Use Disorders

	State Prison		Local Jail		Total	
	Non-Juveniles (1,300,474)	**Juveniles** (1,655)	**Non-Juveniles** (752,325)	**Juveniles** (13,685)	**Non-Juveniles** (2,052,799)	**Juveniles** (15,340)
Substance abuse	62.5	36.7	65.0	53.8	63.4	52.0
Substance dependence	47.9	21.2	43.9	29.2	46.5	28.3
Substance abuse AND/OR dependence	65.2	36.7	66.0	54.3	65.5	52.4

Source: CASA analysis of the *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

* The category of juvenile or youthful offenders, established by statute in some states, has an age limit usually above that of juvenile delinquents (often refers to youth ages 18 to 25). Youthful offenders are not sentenced as adults and special correctional commitments and special record sealing procedures are made available. They are distinguished from juvenile delinquents who are youth sentenced to juvenile court. Age limitations of juvenile delinquents vary among the states from 16 to 21 years of age, with the most common upper limit being 18 years.

† Juvenile and youthful offenders rarely are incarcerated in federal facilities; therefore, they are not included in this analysis. CASA analysis of *Surveys of Inmates in Federal* prisons showed only 127 juvenile or youthful offenders in federal prisons in 2006.

State and local juvenile and youthful offenders are somewhat likelier to have co-occurring mental health and substance use disorders than are non-youthful offenders (27.8 percent vs. 25.4 percent). The largest difference is evident in local jails, where 29.6 percent of inmates who are juvenile or youthful offenders have both a mental health disorder and a substance use disorder, compared to 25.5 percent of non-juvenile inmates. Juvenile and youthful offenders are almost twice as likely to have a mental health disorder with no co-occurring substance use disorder than are non- juvenile inmates (12.8 percent vs. 8.6 percent). However, juveniles and youthful offenders are only half as likely as non-juvenile offenders to have substance use disorders (25.0 percent vs. 40.1 percent). (Table 4.14)

Juvenile and youthful offenders are 52.0 percent likelier than non-juvenile offenders to have ever lived in a foster home, agency, or institution while growing up (17.7 percent vs. 11.7 percent). (Table 4.15)

Between 1992 and 2000, 45 states passed or amended legislation making it easier to prosecute juveniles as adults, resulting in the doubling of the number of youth under age 18 confined in adult prisons and jails.[23] In 2000, that trend reversed.[24]

Table 4.14

Percent of Inmates Convicted as a Juvenile or Youthful Offenders and Confined in Prisons and Jails who have Mental Health and Substance Use Disorders

	State Prison		**Local Jail**		**Total**	
	Non-Juveniles (1,300,474)	**Juveniles** (1,655)	**Non-Juveniles** (752,325)	**Juveniles** (13,685)	**Non-Juveniles** (2,052,799)	**Juveniles** (15,340)
Both mental health and substance use disorders	25.4	9.0	25.5	29.6	25.4	27.8
Mental health disorders only	9.2	20.9	7.6	11.8	8.6	12.8
Substance use disorders only	39.8	27.8	40.5	24.7	40.1	25.0
None	25.6	42.3	26.4	33.9	25.9	34.6

Source: CASA analysis of the *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Table 4.15

Percent of Inmates Convicted as a Juvenile or Youthful Offender and Confined in Prisons and Jails Who Had Been in Foster Care Placement

	State Prison		**Local Jail**		**Total**	
	Non-Juveniles (1,300,474)	**Juveniles** (1,655)	**Non-Juveniles** (752,325)	**Juveniles** (13,685)	**Non-Juveniles** (2,052,799)	**Juveniles** (15,340)
Ever lived in foster home, agency or institution while growing up	12.7	8.7	9.8	18.8	11.7	17.7

Source: CASA analysis of the *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Substance-Involved Inmates Are Parents to More Than 2.2 Million Minor Children

In 2006, American prisons and jails held an estimated 1.0 million substance-involved parents with more than 2.2 million minor children. (Table 4.16) Approximately three-fourths (73.7 percent or 1.7 million) of these children are 12 year of age or younger. More than half of all substance-involved inmates (55.1 percent) have at least one child under age 18: 63.6 percent of substance-involved federal prison inmates, 52.8 percent of substance-involved state prison inmates and 57.0 percent of substance-involved local jail inmates. One-quarter of substance-involved incarcerated parents are married.

While male inmates with substance use disorders are likelier than female inmates with substance use disorders to have minor children under age 18 (77.7 percent vs. 71.5 percent), female inmates with substance use disorders who have minor children were likelier than their male counterparts to have lived with their minor children before incarceration (55.3 percent vs. 41.3 percent). Almost four-fifths of incarcerated mothers (77 percent in state prison and 83 percent in federal prison) reported being the primary daily caregiver for their children prior to their imprisonment, compared with 26 percent and 31 percent of fathers incarcerated in state and federal prisons, respectively.[25]

Although there is limited research on the topic, losing a parent to prison or jail appears to interrupt a child's natural maturational progress.[26] The minor children of inmates are likely to experience a sense of parental rejection and shame, disrupted living arrangements, financial hardship and poor quality of care.[27] They also are at a much higher risk of juvenile delinquency and adult criminality.[28] Children may experience social, emotional and developmental problems due to their parents' incarceration,[29] including traumatic stress, particularly if they are present during the parent's arrest.[30] Children may experience social and peer isolation due to the stigma of having an incarcerated parent, and may eventually develop antisocial behavior.[31]

During adolescence, the incarceration of a parent may interrupt key developmental tasks such as learning to control and express emotions, work well with others, resolve conflicts, develop an identity and engage in adult work and relationships. Poor school performance and increased delinquency are other noted effects.[32] Children of parents with substance use disorders may have experienced increased neglect and abuse including violence in their homes, in turn increasing their chances of alcohol and other drug use.[33]

Table 4.16
Minor Children of Substance-Involved[a] Incarcerated Parents

	Federal Prison (164,521)	**State Prison** (1,101,779)	**Local Jail** (648,664)	**Total** (1,914,964)
Percent of substance-involved incarcerated parents with at least one minor child	63.6	52.8	57.0	55.1
Average number of minor children per parent with at least one minor child	2.3	2.1	2.2	2.1
Estimated number of children with substance-involved incarcerated parents	247,147	1,211,680	800,529	2,259,356

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

[a] The number indicates only substance-involved inmates per CASA definition.

Some of these negative effects might be mitigated by frequent communication and visitations,[34] but 62 percent of parents in state prisons and 84 percent of parents in federal prisons are housed more than 100 miles from their last place of residence making regular visits difficult.[*] [35] In fact, 59 percent of parents in state prisons and 45 percent of parents in federal prisons report that their children have never come to visit them.[36] The inability to afford transportation to prison facilities, humiliating or uncomfortable visiting procedures, visiting rooms that are inhospitable to children and new caregivers who are unwilling to facilitate visits are other obstacles that may prevent visitation.[37]

Maternal absence increases adult children's chances of being convicted of a crime or being on probation by 75 percent.[38] The adult children of incarcerated mothers are nearly four times likelier to serve time on probation and nearly three times likelier to be convicted of a crime than are adult children whose mothers had not been incarcerated.[39] The adult children of incarcerated mothers are 2.5 times more likely to be incarcerated themselves than the adult children of incarcerated fathers. [40] If their mother was also a regular drug user, then the chance an adult child is incarcerated triples.[41]

Percent of Inmates with HIV/AIDS Declining

CASA's 1998 *Behind Bars* report highlighted that ever since the systematic tracking of HIV/AIDS cases in federal and state correctional systems began in 1991, injection drug use, needle sharing among drug injectors and sex with infected drug users rendered the prevalence of HIV infections disproportionately higher among the inmate population than among the general population.[42] In 1999, the estimated rate of confirmed AIDS cases in federal and state prisons was nearly five times higher than in the general population; by 2005 it was 2.7 times higher.[43]

HIV/AIDS cases among federal and state prison inmates have declined from 2.5 percent (20,651 inmates) of the inmate population in 1992 (1.2 percent of federal inmates and 2.6 percent of state inmates) to 1.7 percent (22,480 inmates) in 2005 (1.0 percent of federal inmates and 1.8 percent of state inmates).[44] Self-reports of state prison inmates indicate that HIV infection rates were slightly higher for inmates with substance use disorders than those without such diagnoses, for women and for African American inmates.[45] Among federal inmates in 2004, HIV infection rates were highest among African American female inmates (2.6 percent).[46]

CASA's analysis suggests that the decline in HIV prevalence among federal and state inmates may in part be a function of reduced risk behavior. The proportion of federal and state prison inmates who reported ever having injected drugs declined from 23.2 percent to 17.0 percent between 1996 and 2006, and the percent of federal and state inmates who had ever shared needles for drug injection declined from 11.1 percent to 7.0 percent.[47] (Table 4.17)

Hepatitis C a Significant Problem among Inmates

According to the U.S. Centers for Disease Control and Prevention, Hepatitis C is the most common blood-borne viral infection in the U.S.;[48] between 12 and 35 percent[†] of adult prison inmates has chronic Hepatitis C infection.[49] For jail inmates, the infection rate is six times higher than in the general population and for prison inmates it is seven times higher.[50] Primary risk factors for contracting Hepatitis C are injection drug use and needle sharing, two behaviors among inmates that may continue during incarceration.[51]

[*] Eleven percent of state prisoners and 43 percent of federal prisoners are held more than 500 miles from their last place of residence.

[†] Rates vary by geographic region.

Table 4.17
Percent of Federal and State Inmates with HIV-Risk Behaviors

	Federal Prison		State Prison		Total	
	1996[a] (105,544)	**2006**[b] (190,844)	**1996**[a] (1,076,625)	**2006**[b] (1,302,129)[e]	**1996**[a] (1,182,169)	**2006**[b] (1,492,973)
Ever injected drugs	13.8	11.1	24.1	17.9	23.2	17.0
Ever shared needles	6.2	4.3	11.6	7.4	11.1	7.0

[a] Reported in CASA's 1998 *Behind Bars* report.
[b] CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (1991 and 2004), *Survey of Inmates in State Correctional Facilities* (1991 and 2004) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 1996 and 2006*.

Substance-involved inmates are twice as likely to report having had a diagnosis of hepatitis[*] as non-substance involved inmates (9.0 percent vs. 3.1 percent), and two and a half times likelier to report still having problems with hepatitis (4.8 percent vs. 1.4 percent).

Inmates with Fetal Alcohol Spectrum Disorders *(*FASD*)* Rarely Diagnosed

Individuals with Fetal Alcohol Spectrum Disorder (FASD) are at high risk for coming into contact with the criminal justice system.[52] FASD is a term used to describe a range of outcomes[†] that characterize the central nervous system damage caused by maternal alcohol consumption during pregnancy. This damage may be manifested physically, cognitively and behaviorally with evidence of difficulty in academic performance, language, communication, memory, attention and decision-making.[53] First identified in the early 1970s, FASD was found in 0.5 to two cases per 1,000 births in the 1980s and 1990s.[54] It is the leading non-genetic cause of mental retardation in the world,[55] yet is severely under-diagnosed, primarily due to the difficulty of making the diagnosis but also because of limited training in this area among physicians, other health care professionals and social services providers.[56]

In addition to the increased risk for criminal behavior that children of alcoholics face, features of FASD itself, such as poor impulse control, inability to comprehend consequences of behavior, poor short-term memory, poor anger management skills and poor judgment, increase vulnerability to criminal behavior.[57] One study found that 60 percent of individuals ages 12 and older with FASD in the United States have been in trouble with authorities, charged or convicted at some point in their lifetime.[58] Although data on the prevalence of individuals with FASD in the adult criminal justice system are not available, one national study estimated that there might be up to 28,036 undiagnosed cases of FASD and alcohol-related neurodevelopmental disorders in U.S. prisons and jails; indeed far less than one percent of expected cases have been identified in the criminal justice system.[59]

Veterans in the Criminal Justice System

One in 10 (10.0 percent) federal, state and local inmates are veterans--9.8 percent of federal inmates, 10.4 percent of state inmates and 9.3 percent of local inmates, compared with 11.7 percent of the U.S. adult[‡] population. Inmates who are veterans are less likely to be substance involved than are non-veterans (74.7 percent vs. 82.9 percent). Veteran inmates are, however, more likely than non-veteran inmates to be incarcerated for an alcohol law violation (6.4 percent vs. 3.9 percent). Female inmates who

[*] Type not specified.
[†] Fetal Alcohol Syndrome (FAS), partial Fetal Alcohol Syndrome (pFAS) or Alcohol-Related Neurodevelopmental Disorder (ARND).

[‡] Age 18 and over.

are veterans are likelier than non-veteran female inmates to have a history of past treatment for alcohol dependence (29.1 percent vs. 21.7 percent) and to have committed a crime to get money to buy drugs (20.7 percent vs. 19.8 percent). Male inmates who are veterans are likelier than male inmates who are not veterans to be incarcerated for committing an alcohol law violation (6.3 percent vs. 3.9 percent).

Inmates who are veterans are less likely than inmates who are not veterans to meet clinical criteria for substance use disorders (60.9 percent vs. 64.8 percent). This relationship holds true for both state (60.3 percent vs. 65.6 percent) and local (63.1 percent vs. 65.9 percent) inmates. Federal prison inmates who are veterans are somewhat more likely than are non-veteran inmates to meet such criteria (56.2 percent vs. 55.1 percent).

Untreated substance use disorders and depression account for much of the risk of incarceration among veterans. The rate of post-traumatic stress disorders, a mental health problem common among all returning veterans, is significantly higher among incarcerated veterans than among their non-incarcerated peers (19 percent vs. seven percent).[60]

In one study, incarcerated veterans who had received any type of medical, surgical, psychiatric or inpatient services for a substance use disorder at a Connecticut VA hospital between 1993 and 1997 were significantly more likely than their non-incarcerated peers to have received a drug abuse (49 percent vs. seven percent) or alcohol abuse (44 percent vs. 13 percent) diagnosis.[61]

Substance-Involved Multiple Recidivists

Among substance-involved offenders in federal, state, and local prisons and jails, those with three or more prior incarcerations are likelier than those with no prior incarcerations to be male, older than 30, to have less than a high school education, be unemployed, and to have received income through welfare or charity. They also are likelier to have spent time in foster care and to have a history of parental substance abuse. (Table 4.18)

Table 4.18
Percent of Substance-Involved Federal, State and Local Inmates with Prior Incarcerations by Risk Factors

	No Prior Incarcerations (766,660)	**3+ Prior Incarcerations** (486,683)
Older than age 30	56.6	69.3
< high school education	61.9	74.1
Unemployed	30.4	35.7
Income through welfare/charity	4.9	7.6
Ever spent time in foster care	9.0	19.7
Parental substance abuse	31.5	41.3

Note: 662,394 substance-involved offenders had 1 or 2 prior incarcerations.
Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

More than three-quarters (77.3 percent) of convicted prison and jail inmates who have been incarcerated three or more times prior to their current sentence suffer from a substance use disorder, compared with 67.0 percent of those with one or two prior incarcerations and 54.8 percent of those with no prior prison or jail sentences. (Table 4.19)

Table 4.19

Number of Prior Incarcerations and Prevalence of Substance Use Disorders Among Federal, State and Local Inmates

Number of Prior Incarcerations	**No Substance Use Disorders** (802,132)	**Substance Use Disorders** (1,456,851)
None	45.2	54.8
1 or 2 prior incarcerations	33.0	67.0
3 or more prior incarcerations	22.7	77.3

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

Chapter V
The Treatment Gap

Of the 64.5 percent of prison and jail inmates who met clinical diagnostic criteria for a substance use disorder in 2006, only 11.2 percent had received any type of professional treatment since admission.[*] [†] [2] Of those who do receive treatment, few receive evidence-based services, including access to pharmacological treatments, and the availability of highly trained staff is limited. Only 16.6 percent of facilities offer treatment in specialized settings which can produce the best outcomes for offenders. Tobacco addiction is rarely addressed even though it is an essential part of addiction treatment. In terms of adjunct services, 22.7 percent of inmates participated in mutual support/peer counseling and 14.2 percent received drug education;[‡] however, such services alone are unlikely to create lasting behavioral changes among those in need of addiction treatment.

Twenty-eight years ago, I woke up in a jail cell following my last alcoholic blackout. I had been arrested for disorderly conduct and resisting arrest. I am alive and sober today only because I had access to addiction treatment that turned my life around.[1]

--Former Congressman Jim Ramstad, MN

While critical to recovery and reduced recidivism, the percentage of inmates participating in education and job training services declined between 1996 and 2006; significant gaps also exist in the treatment of co-occurring mental health disorders. Most facilities screen, test and treat Hepatitis C and progress has been made in addressing HIV/AIDS among inmates. Inmate participation in religious and spiritual activities provided by

[*] Unless otherwise noted in the chapter, percentage and numerical estimates are either drawn directly from or based on CASA's analysis of the *Survey of Inmates in Federal Correctional Facilities* (1991 and 2004), *Survey of Inmates in State Correctional Facilities* (1991 and 2004), and the *Survey of Inmates in Local Jails* (1989 and 2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 1996 and 2006*. See Appendix A, Methodology.

[†] Comparison with previous surveys is not possible because data on those meeting clinical criteria for substance use disorders were not included prior to the current surveys.

[‡] Participation in specific types of professional treatment or addiction-related services is not mutually exclusive.

volunteers has increased, but chaplain positions have declined.

The enormous gap between treatment need and access exists despite a growing array of interventions of proven efficacy and practice guidelines for addressing the needs of substance-involved offenders.

> *Even violent offenders need treatment in prison and re-entry counseling, upon release, to prevent recidivism. It's a matter of public health and public safety.*[3]
>
> --Anne Swern, First Assistant District Attorney
> Kings County, NY

Few Inmates with Substance Use Disorders Receive Treatment

Of the 1.5 million inmates with substance use disorders in 2006, CASA estimates that only 163,196 (11.2 percent[*]) received any type of professional treatment, including treatment in a residential facility or unit (7.1 percent), professional counseling (5.2 percent) or pharmacological therapy such as methadone, antibuse or naltrexone (0.2 percent). Less than one percent (0.9 percent) received detoxification services. Inmates were likeliest to receive the adjunct services of mutual support/peer counseling (22.7 percent) or education (14.2 percent). (Table 5.1)

Table 5.1
Percent of Prison and Jail Inmates with Substance Use Disorders Receiving Treatment or Addiction-Related Services[a] Since Admission

	Federal Prison (104,529)	**State Prison** (848,426)	**Local Jail** (503,896)	**Total** (1,456,851)
Detoxification	0.9	0.9	1.0	0.9
Any professional treatment since admission	15.7	14.2	5.2	11.2
Residential facility or unit	8.8	9.2	3.1	7.1
Counseling by a professional	7.8	6.5	2.3	5.2
Maintenance drug	0.3	0.2	0.1	0.2
Other addiction-related services since admission	39.7	36.0	13.1	28.4
Mutual support/peer counseling	22.3	29.9	10.7	22.7
Education	29.2	17.7	5.0	14.2

Source: CASA's analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.
[a] Participation in specific types of professional treatment or addiction-related services is not mutually exclusive.

Federal prison inmates with substance use disorders were more likely to receive treatment including residential services, professional counseling or pharmaceutical therapies (15.7 percent) than state prison inmates (14.2 percent) or local jail inmates (5.2 percent). However, since the state prison system houses more inmates than the federal and local correctional systems, most inmates who received professional treatment did so through the state prison system.

In terms of other addiction-related services, state prisoners were likelier to receive mutual support/peer counseling (29.9 percent) compared with their federal (22.3 percent) or local jail (10.7 percent) counterparts. Federal prison inmates were likelier to receive substance-related education services (29.2 percent) than state (17.7 percent) or local jail inmates (5.0 percent).

[*] 7.2 percent of the total inmate population.

Women Likelier to Receive Treatment Than Men

Female inmates with substance use disorders are more likely than their male counterparts to receive residential treatment (9.6 percent vs. 6.8 percent), professional counseling (6.1 percent vs. 5.1 percent), pharmacological therapies (0.6 percent vs. 0.2 percent) or detoxification services (1.6 percent vs. 0.9 percent). They also are likelier than male inmates to participate in mutual support/peer counseling (25.5 percent vs. 22.4 percent) but less likely to receive some type of addiction-related education (13.3 percent vs. 14.3 percent). With the exception of detoxification services in federal prisons, these patterns hold true among federal, state and local jail inmates. (Table 5.2)

Whites and Native Americans Likelier to Receive Treatment Than Blacks and Hispanics

While white inmates have the highest rate of substance use disorders (73.1 percent), only 13.2 percent of those with such disorders receive any professional treatment; 69.5 percent of Native American inmates meet clinical criteria for substance use disorders and 13.1 percent of those with substance use disorders receive professional treatment. Among blacks, 60.2 percent meet criteria for substance use disorders while 10.1 percent of those with such disorders receive treatment. Hispanic inmates, 58.3 percent of whom meet clinical criteria for a substance use disorder, are the least likely to have received treatment (8.6 percent). (Table 5.3)

Table 5.2

Percent of Prison and Jail Inmates with Substance Use Disorders Receiving Treatment or Addiction-Related Services[a] Since Admission, by Gender

	Federal Prison		State Prison		Local Jail		Total	
	Male (177,468)	**Female** (13,376)	**Male** (1,214,206)	**Female** (87,923)	**Male** (677,353)	**Female** (88,657)	**Male** (2,069,026)	**Female** (189,957)
Detoxification	0.8	0.6	0.8	2.1	1.0	1.1	0.9	1.6
Any professional treatment	15.2	23.7	13.7	21.2	5.0	6.4	10.9	14.3
Residential facility or unit	8.3	16.2	8.8	14.6	3.0	3.8	6.8	9.6
Counseling by a professional	7.6	10.3	6.3	9.1	2.3	2.7	5.1	6.1
Maintenance drug	0.3	0.8	0.2	0.8	0.1	0.3	0.2	0.6
Other addiction-related services since admission	39.2	47.5	35.8	38.7	12.2	19.2	28.2	29.9
Mutual support/peer counseling	21.5	33.7	29.7	33.0	9.8	17.0	22.4	25.5
Education program	29.2	29.4	17.7	18.5	4.9	6.2	14.3	13.3

Source: CASA's analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

[a] Participation in specific types of professional treatment or addiction-related services is not mutually exclusive.

Table 5.3

Percent of Prison and Jail Inmates with Substance Use Disorders Receiving Treatment or Addiction-Related Services[a] Since Admission by Race and Ethnicity

	White[b] (782,079)	Black[c] (925,831)	Hispanic (424,861)	Native American (85,948)	Other[d] (40,264)
Detoxification	1.0	0.6	1.2	1.2	1.8
Any professional treatment	13.2	10.1	8.6	13.1	12.5
Residential facility or unit	8.4	6.4	5.3	7.3	9.2
Counseling by a professional	6.2	4.5	3.9	6.7	5.1
Maintenance drug	0.2	0.3	0.2	0.3	0.0
Other addiction-related services since admission	30.3	27.6	24.8	33.5	23.3
Mutual support/peer counseling	24.8	21.7	19.5	26.3	17.0
Education program	14.8	14.1	12.4	17.0	10.8

Source: CASA's analysis of the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.

[a] Participation in specific types of professional treatment or addiction-related services is not mutually exclusive; therefore, the percentages do not add up to 100.

[b] Non-Hispanic white.

[c] Non-Hispanic black.

[d] Asian, Hawaiian, Pacific Islanders and others.

Most Treatment Services Offered Are Not Evidence-Based

Most correctional facilities that offer addiction-related services continue to employ approaches not grounded in research, despite a considerable body of evidence to guide effective treatment in correctional settings.[4] In 2007, the *National Criminal Justice Treatment Practices* survey estimated the prevalence of evidence-based practices (EBPs) of addiction treatment services that are employed in correctional facilities.[*] The survey included the following 13 evidence-based practices:[5]

1. standardized risk assessment;
2. standardized substance abuse assessment and treatment matching;
3. use of techniques to engage and retain clients in treatment;
4. use of therapeutic community, cognitive-behavioral or other standardized treatment orientation;
5. a comprehensive approach to treatment and ancillary needs;
6. addressing co-occurring disorders;
7. involvement of family in treatment;
8. a planned treatment duration of 90 days or longer;
9. integration of multiple systems to optimize care and outcomes;
10. continuing care or aftercare;
11. use of drug testing in treatment;
12. use of graduated sanctions; and
13. incentives to encourage progress.

[*] The design consisted of a mail survey of both correctional administrators and treatment program directors, who could report up to 13 or 15 EBPs, respectively.

Of these 13 evidence-based practices, correctional administrators reported only offering an average of 5.9; in local jails the average was 1.6. Nearly two-thirds (64.7 percent) of the surveyed prisons, jails, and probation/parole departments provided only three or fewer of the 13 possible EBPs.[6]

In addressing substance use disorders, behavioral approaches are the most commonly used interventions. Evidence-based behavioral interventions include cognitive therapies that teach coping and decision-making skills, contingency management therapies that encourage behavioral changes and motivational therapies.[7] However, correctional facilities tend to provide alcohol and other drug education or low-intensive outpatient counseling sessions rather than evidence-based, intensive treatment.[8] Services in local jails are even less intensive, structured and accessible because of the high turnover rate and short facility stay of jail inmates.[9]

Only half of administrators in state and federal prisons and one-third in local jails report addressing co-occurring disorders. The least prevalent evidence-based practice reported by administrators in prisons (19 percent) and local jails (10 percent) is family involvement in treatment.[10] (Table 5.4)

Table 5.4
Percent of Facilities Offering Evidence-Based Practices in Prison- and Jail-Based Treatment Services as Reported by Correctional Administrators

Evidence-Based Practices (EBPs)	**Federal/State Prisons** (98)	**Local Jails** (41)
Standardized substance abuse assessment	60	51
Standardized assessment/treatment matching	20	12
Engagement techniques	36	24
Treatment approach	21	12
Comprehensive approach	84	90
Address co-occurring disorders	50	32
Family involvement in treatment	19	10
Planned duration greater than 90 days	54	49
System integration	53	73
Continuing care/aftercare	48	32
Drug testing	32	34
Graduated sanctions	32	27
Incentives	81	54
EBPs per correctional facility (mean)	5.9	1.6

Source: Friedmann, PD, Taxman, FS, & Henderson, CE (2007).

Limited Availability of Highly Trained Staff

Most facilities that provide addiction counseling report that they employ paid staff with at least a bachelor's degree to deliver these services.[11] One survey of inmates found a perceived lack of understanding of substance use disorders and the needs of substance-involved inmates among correctional staff providing treatment services.[12]

The ratio of paid staff to those receiving treatment varies from 7:1 in federal prisons to 25:1 in state prisons. Thirteen percent of federal prisons, 24 percent of state prisons and 33 percent of local jails report using volunteer staff for counseling.[13] (Table 5.5)

Table 5.5
Percent of Correctional Facilities Offering Addiction Counseling by Type of Staffing

	Federal Prisons (129)	**State Prisons** (1,183)	**Local Jails** (3,114)
Use paid staff for counseling	100	98	98
Use volunteer staff for counseling	13	24	33
Ratio of patients to paid staff	7:1	25:1	10:1
Employ psychologists or other PhD level staff	87	15	32
Employ bachelor's or master's level staff	91	88	78

Source: SAMHSA (2002).

Federal prisons report the highest academic credentialing standards for professional treatment providers in their system. Eighty-seven percent of federal correctional facilities that provide addiction counseling services include doctoral-level mental health professionals on their clinical staff compared to only 15 percent of state prisons and 32 percent of local jails.* [14] (Table 5.5) Having an advanced degree, however, does not mean that such individuals are trained appropriately in treating substance use disorders. There currently is no universal system in place to ensure provider competency in specific evidence-based practices.[15]

Table 5.6
Duration of Addiction-Related Services Among Non-Specialty Prisons and Jails *Offering* Such Services

	Federal/State Prison (74)		Local Jail (57)	
	Percent Offering Service	**Percent Offering > 90 Days**	**Percent Offering Service**	**Percent Offering > 90 Days**
Therapeutic community				
Segregated	19.5	74.8	26.2	97.9
Non-segregated	9.2	66.0	<1.0	75.4
Group counseling				
Up to 4 hours/week	54.6	58.0	59.8	48.1
5-25 hours/week	46.0	72.9	21.3	8.9
≥26 hours/week	11.2	24.3	1.1	92.3
Drug/alcohol education	74.1	65.3	61.3	19.9
Relapse prevention group	44.5	62.0	50.7	93.6
Case management	6.9	40.7	22.8	89.8

Source: Taxman, FS, Perdoni, ML, & Harrison, LD (2007).

Treatment Duration Makes a Difference

To be effective, addiction treatment typically must provide a sufficient dose and duration to make a difference. A growing body of evidence suggests that better outcomes are associated with treatment interventions that last at least 90 days.[17]

A study of data from the National Criminal Justice Treatment Practices survey found that while more than half of the counseling†, relapse prevention and therapeutic community services that exist in federal and state prisons were available for more than 90 days, these programs exist for the most part in half or fewer of non-specialty prisons and jails‡ and less than a quarter of inmates have daily access to them.[18] (Table 5.6)

The Treatment Gap in New York

Drug users, both in and out of prison, have a right to access health care that should include drug dependence treatment and harm reduction measures to reduce health risks such as transmission of HIV and Hepatitis B and C. Prison treatment programs should be available, accessible, appropriate and of good quality. But in the New York State prisons, drug treatment programs are filled to capacity. Prisoners face long waiting lists for treatment. Despite overwhelming evidence that Medication-Assisted Therapy is the most effective treatment for opioid dependence, the majority of New York State prisoners dependent on heroin or other opioids have no access to methadone or buprenorphine. Between 1996 and 2005, 27 prisoners died of overdose of illegal drugs in New York State prisons.[16]

--Human Rights Watch, 2009

* Information on the education and training standards or requirements for treatment providers in correctional settings is largely unavailable.
† 25 hours or less per week
‡ 94 percent of all prisons and 100 percent of jails are non-specialty facilities.

Few Inmates Have Access to Pharmacological Therapy

Despite evidence of efficacy, pharmacological therapies remain under-utilized by the corrections system.[19]

Researchers estimate that as few as 1,600 prisoners in the country are receiving methadone treatment and no more than 150 receive buprenorphine--an evidence-based pharmacological treatment for opioid dependence. Forty-three percent of medical directors in prisons and jails report that they do not believe or do not know whether methadone is appropriate for treating inmates with addiction. Fifty-nine percent feel similarly about buprenorphine. Department of Corrections medical directors cite preferences for drug-free detoxification, security concerns, administrative opposition and prohibitive cost as the primary reasons they do not provide opioid replacement therapy (ORT).[20]

Only 28 medical directors of the Departments of Corrections (DOC) of 49 states, the federal government and the District of Columbia report that they provide methadone to any of their inmate; over half of those who offer this therapy exclusively use it for pregnant women, for acute opiate withdrawal or for chronic pain management. Buprenorphine is only offered in seven corrections departments nationwide.[21] Jails are almost four times more likely than prisons to offer pharmacotherapy for addiction, but only a third of jails provide such treatment.[22]

Referrals for ORT treatment upon release also are infrequent. Only 23 corrections departments refer ex-convicts to methadone clinics and just 15 make referrals to buprenorphine providers. Limited partnerships with community providers licensed to provide these therapies, preferences for drug-free detoxification and focus on inmate health during incarceration rather than upon release were the primary reasons given for why inmates did not receive referrals upon their release.[23]

Methadone has been used for over 40 years as a pharmacological treatment for opioid addiction.[24] In addition to helping with withdrawal symptoms during detoxification, the medication prevents cravings and blocks the euphoric effects of opiate use.[25] Buprenorphine was approved by the FDA to treat opioid addiction in 2002.[26] It provides moderate relief from opioid withdrawal and has even less risk of misuse and overdose than methadone.[27] Both medications have been found to reduce health problems related to heroin use such as infectious disease transmission and overdose deaths.[28]

In a randomized clinical trial,[*] ORT was shown to be an effective treatment for opioid-addicted inmates. Six months following release from prison, inmates who started methadone treatment before leaving prison and were referred to counseling and a methadone clinic upon their release were less likely to commit new crimes and less likely to resume their substance use than their peers who only received counseling referrals (28 percent of methadone patients tested positive for opioids and 58 percent tested positive for cocaine compared to 65 percent and 75 percent, respectively, of referral-only patients). Methadone patients spent, on average, more than 100 days in community-based treatment compared to their peers who spent only 14 days. Methadone patients also reported participating in fewer days of criminal activity than their peers (an average of 29 days vs. 57 days).[29]

Another clinical trial compared the effectiveness of buprenorphine to methadone maintenance for opioid-dependent jail inmates. The results of the study indicate that the outcomes of buprenorphine and methadone treatment initiated in a jail setting are similar in most respects, and that decisions about which to use (including using both) may be based on clinical and administrative considerations in specific jurisdictions. Buprenorphine did appear to be more effective than methadone in that there was greater expressed interest and willingness of jail

[*] The study was limited to male inmates in a Baltimore-based prison facility, limiting the generalizability of these findings.

inmates who were not in methadone treatment to continue buprenorphine in the community after release. However, Suboxone (buprenorphine) is about 10 times as expensive as generic methadone.[30]

Another pharmacological therapy for the treatment of SUDs is naltrexone. Naltrexone dampens the perceived reward of drinking by blocking opioid receptors.[31] Naltroxene also blocks the rewarding effects of opiate use and is used to treat opioid addiction.[32] With naltrexone therapy, there are no opiate-related side effects, no overdose risks and no possibility for diversion.[33] Oral naltrexone as approved by the FDA to treat alcohol use disorders in 1984; injectable naltrexone was approved by the FDA in 2006 as an extended release medication given as a monthly injection.[34]

CASA could find no evidence of the extent to which naltrexone is used in the corrections system. A meta-analysis of nine randomized, placebo-controlled trials examining the efficacy of naltrexone as a treatment for alcohol addiction found that compared to patients taking placebos, those taking naltrexone were less likely to return to drinking heavily during the study periods, had significantly fewer drinking days during the study periods and were likelier to remain abstinent.[35] In a randomized, controlled, clinical trial of probationers with a history of opiate addiction, 26 percent of parolees who received standard parole supervision and naltrexone relapsed and were reincarcerated within six months following the their release compared with 56 percent of those who received standard parole supervision but not naltrexone.[36]

The negative stigma associated with pharmacological therapies, misperceptions about the chronic nature of addiction and incorrect associations between curing dependence and forced detoxification prevent many prisoners nationwide from benefitting from these treatments.[37]

Tobacco Addiction Largely Untreated

State-of-the-art treatment for substance use disorders calls for addressing patients' use of all addictive substances including tobacco.[38] In spite of the significant health consequences of tobacco use and exposure, fewer prevention and cessation resources are allocated to this threat to the public health in the corrections system than to other drug use.[39]

One survey of 500 correctional facilities[*]--including jails, prisons and juvenile facilities--found that 63 percent of the facilities reported that inmates' smoking and nicotine dependence are assessed at intake; however, more than 80 percent of respondents reported that their facilities had no tobacco cessation programs at all. Respondents to the survey also estimated that at least three-quarters of inmates who stop smoking in prison or jail end up resuming smoking upon release. Particularly discouraging was that nearly half of the respondents (44 percent) said that they did not think it would be possible to reduce tobacco use in correctional facilities, even given sufficient resources.[40]

> Correctional health care practitioners and others need to see tobacco control as an important, high-profile public health issue with the same sort of status as HIV or tuberculosis. Otherwise, it will continue to get the short end of the attention and health care resources.[41]

Since the mid-1980s, policies regarding tobacco use in prisons and jails have become more restrictive.[42] A 2007 survey of 52[†] corrections departments found that 60 percent reported total tobacco bans on prison grounds; another 27 percent reported only an indoor ban on tobacco use.[43] Since the survey's publication, additional states have begun or completed the transition to tobacco-free environments.[44]

[*] Accredited by the National Commission on Correctional Health Care.

[†] 50 state departments, the District of Columbia and the Federal Bureau of Prisons.

Even most inmates housed in tobacco-free facilities are expected to quit on their own, "cold turkey."[45] This may be because tobacco bans often are accompanied by the termination of tobacco cessation programming[46] in the mistaken belief that they no longer are needed.

Despite the increase in tobacco-free correctional facilities, tobacco products remain prevalent.[47] In many states, cigarettes are a high-priced commodity and thus a currency in the prison environment.[48] In some cases, a black market has arisen where control of the market rests within the hands of prison staff rather than the inmate population, resulting in reduced security and increased institutional corruption.[49] Because staffing at most correctional facilities is limited, monitoring smoking behavior among inmates and guards is difficult.[50]

> *In spite of overwhelming scientific evidence demonstrating that pharmacological treatment for addiction has greater health and social benefits than abstinence-only policies, many prison directors are philosophically opposed to treating substance use… These trends contribute to high re-incarceration rates and have detrimental impacts on community health...changing these policies may require an enormous cultural shift within correctional systems.*[51]
>
> --Amy Nunn ScD, MS
> Assistant Professor of Medicine (Research) at the Warren Alpert Medical School of Brown University

Reducing tobacco use in the correctional system is essential to address a costly public health threat. It also is important because smoking is related to an increased risk of relapse for alcohol addiction,[52] putting inmates at greater risk of recidivism.[53] Further, research has demonstrated that smoking cessation does not adversely affect alcohol and other drug treatment outcomes.[54] Converting jails and prisons to tobacco-free facilities reduces the rate of smoking-related health problems--such as respiratory illness and Hepatitis A* as well as those associated with exposure to environmental tobacco smoke--and their associated costs, and reduces cigarette-related fires and smoking-related violence via intentional burns.[55]

Women Need Tailored Treatment

Although female inmates are likelier to receive treatment for substance use disorders than male inmates, there is no evidence to suggest that the treatment they receive is tailored to their needs.[56]

Many women begin and continue to use drugs in different ways and for different reasons than men; for example, women's drug use is often triggered by negative experiences or stress or motivated by anxiety or depression.[57] Women have been found to be more likely to report using drugs to alleviate emotional or physical pain or for social reasons rather than to engage in pleasure seeking behavior, which is more commonly cited by men.[58] This is not surprising since women with a history of abuse are three times likelier than other women to have an alcohol use disorder during their lifetime and four times likelier to have a drug use disorder.[59]

While interventions tailored to the specifics of women's problems can reduce women's involvement in substance-related crime,[60] most treatment options are modeled on men's experiences with addiction.[61] Women whose addiction is tied to prior incidents of abuse may be less inclined to participate actively in group counseling programs or 12-step programs that emphasize personal disclosure.[62] Gender-specific treatment programs may provide a safer environment for survivors of sexual abuse and domestic violence.[63] The research base suggests that these programs should focus on empowerment, support, skill building and identifying strengths rather than confrontation.[64]

Incorporating the appropriate ancillary services into treatment programs serving women also is important. Incarcerated women are more likely

* Acquired via saliva when tobacco products are shared.

than their male peers to need support services in the form of medical and mental health care, victim services, and--for women offenders in community treatment reentry programs or in lieu of incarceration--childcare, housing and employment assistance.[65] If trauma-specific services are unavailable, researchers recommend a trauma-informed approach to treatment in which providers have been educated on the impact that abuse can have on women's lives and treatment success.[66] Interventions that include family components or activities that focus on building healthy familial and peer relationships also have been associated with reduced reoffending among women.[67]

Few Receive Treatment in Specialized Settings

Specialized units segregated from the general prison population, such as therapeutic communities, can produce better outcomes, as measured by drug use and arrests post-release, at least in part because they prevent the "prison culture" from derailing the recovery process.[*] [68] The existence of specialized units does not, however, necessarily mean that quality care is offered.

A 2002 analysis of national data (1997) by the Substance Abuse and Mental Health Services Administration (SAMHSA)[†] found that 94 percent of federal prisons, 56 percent of state prisons and 33 percent of jails reported that they provided some type of treatment for substance use disorders[‡] with an average daily attendance of approximately 147,000 inmates. Only a small percentage of the inmate population had access to such services on a daily basis.[§] [69] In correctional facilities that provided treatment for substance use disorders, the majority delivered their services within the general population setting of their facilities (94 percent in federal prisons, 82 percent in state prisons and 79 percent in local jails). In facilities that offered such services, addiction treatment was offered in specialized treatment units in 41 percent of federal facilities, 33 percent of state facilities and 31 percent of local facilities.[70] (Table 5.7)

Table 5.7
Treatment for Substance Use Disorders by Settings Among Correctional Facilities Offering Such Services (1997[a])

	Federal Prisons (129)	**State Prisons** (1,183)	**Local Jails** (3,114)
Percent offering within the general correctional population	94	82	79
Percent offering in specialized units	41	33	31
Percent offering in a hospital or psychiatric unit	6	6	8

Source: SAMHSA (2002).
[a] The most recent data provided by SAMSHA.

By 2000, only 200 of the 1,208 federal and state confinement facilities (16.6 percent) reported offering specialized alcohol and/or other drug treatment,[**] up from 192 in 1995.[71]

Setting up treatment programs in local jails has been particularly difficult because the population of jail inmates--including those awaiting trial or sentencing or those serving a sentence of less

[*] To varying degrees, incarcerated offenders become socialized to the inmate subculture that values the solidarity among fellow inmates and the resistance of official correctional goals (Sykes & Messinger, 1960). The threat of peer violence and the deprivation of basic needs also force many inmates to seek protection and privileges through gang affiliation (Compton & Meacham, 2005; Kalinich & Stojkovic, 1985; Valdez, 2009). This climate is not conducive to effective treatment.
[†] The most recent data provided by SAMSHA.
[‡] Includes services such as detoxification, group or individual counseling, rehabilitation, and methadone or other pharmaceutical therapies.

[§] The *National Criminal Justice Treatment Practices* (NCJTP) survey is a nationally representative survey of correctional agencies (e.g., prisons, jails and probation and parole) conducted in 2005 by a consortium of researchers to understand the breadth and availability of drug treatment services in the criminal justice system.
[**] In 2000, there were 84 federal, 1,320 state and 264 private correctional facilities.

than one year--is largely transient.* [72] Although local jails may not be ideal settings to deliver the long-term and intensive interventions that effective treatment of incarcerated offenders require,[73] there are several examples of successful jail-based treatment programs, such as those models implemented and evaluated in Linn County, Oregon, and Monroe County, New York, that are worthy of emulating.[74]

Monroe County, New York provides treatment for substance use disorders to nonviolent offenders who volunteer to participate. Since offenders do not receive reduced sentences or special perks for participating in the program, a key incentive to volunteer is their desire to recover. The program is based on a 12-step model that focuses on an offender's recognition of his/her addiction and desire to control it. Offenders must participate in daily group counseling sessions for 60 to 90 days; they have access to a personal counselor and receive follow-up treatment after their release. More than half (56 percent) of participants were not arrested during the year following their release from jail compared to 26 percent of offenders in a comparison group.† Half of the comparison group was rearrested at least twice during the year following their release compared to 21 percent of the treatment group. Monroe County officials estimate the reductions in recidivism from the program equal approximately $1.5 million in savings over one year.[76]

The benefits of treatment in specialized setting extend beyond inmates themselves. In correctional facilities where therapeutic community treatment occurs, correctional staff report a less stressful job environment, a higher level of job satisfaction, lower rates of staff sick leave, less inmate-on-inmate and inmate-on-staff assault and less disruptive behavior among inmates. Violent behavior is more then twice as likely to occur among inmates in the general population compared with those in treatment programs; occupational injuries related to assaults are almost 10 times less likely to occur in the treatment facilities.[75]

Treatment for Co-Occurring Disorders

In the inmate population, several other health conditions frequently co-occur with substance use disorders: mental illness, HIV/AIDS, Hepatitis C and Fetal Alcohol Spectrum Disorder (FASD). Among incarcerated substance-involved veterans, Post-Traumatic Stress Disorder (PTSD) is likely to co-occur. Progress has been made in addressing HIV/AIDS, and most state adult correctional facilities screen for Hepatitis C--more than two-thirds have policies to test and treat this condition.[77] However, the financial and human resources required for effective treatment of co-occurring mental health disorders and to address the needs of those with FASD and PTSD to date largely have been unavailable in the criminal justice system.[78]

Mental Health Treatment Limited

The correctional system has become one of the largest systems housing the mentally ill in the country, in part driven by substance use disorders and co-occurring mental health conditions.[79] Although over 550,000 prison and jail inmates in 2006 (24.4 percent) had a substance use disorder and a co-occurring mental health problem,[80] only one-half of the prisons and one-third of the jails surveyed in 2007‡ report addressing co-occurring disorders in any way in their addiction-related services.[81]

* Urban jails routinely are used to house violators of probation, parole or bail bond; absconders from court-managed diversion programs; illegal immigrants; and juveniles with pending disposition.

† Since program participation is voluntary, offenders were not able to be randomly assigned to treatment and comparison groups. Researchers randomly selected comparison group participants from inmates who were released during the same periods as the study groups and who shared similar sociological and offender characteristics as the treatment group, but who did not volunteer for treatment.

‡ The *National Criminal Justice Treatment Practices* (NCJTP) survey.

A quarter (24 percent) of federal inmates with mental health problems received some type of treatment since their current incarceration, as did 34 percent of state inmates with mental health problems and 18 percent of local jail inmates in need. The most common form of intervention is the use of prescribed medications (20 percent among treated federal inmates, 27 percent among treated state inmates and 15 percent among treated local jail inmates).[82]

A key feature of effective treatment is specialized assessment that leads to a reliable psychiatric diagnosis and addresses differences between offenders with personality disorders and those with severe mental illnesses.[83] Inmates with diagnosed co-occurring mental health and substance use disorders require an integrated treatment approach including behavioral therapies of demonstrated effectiveness--such as cognitive-behavioral therapy, contingency management or involvement in a specialized therapeutic community,[84] pharmacological therapies where appropriate and mutual support programs as adjuncts to treatment.[85]

A survey of 41 American state correctional systems found that 85 percent of responding systems reported screening inmates for mental health symptoms at intake. Less than half (18 of 41) reported that the number of mental health-related therapists they had was adequate for the identified population.[86]

Most local jails do not offer a comprehensive range of mental health services; these institutions tend to focus on screening and evaluation for suicide prevention.[87] Even if most jail detainees and inmates return to their communities in a few weeks or months, delays in treatment can exacerbate mental health and/or substance use disorders.[88]

Progress in Addressing HIV/AIDS

AIDS was the fourth leading cause of death among inmates of state prisons between 2001 and 2004, behind heart disease, cancer and liver diseases.[89] The proportion of state inmate deaths caused by AIDS has decreased steadily from 9.4 percent in 2001 to 4.0 percent in 2006. During this period, 1,154 state inmates died from AIDS.[90]

In 2004, 77 percent of inmates were tested for HIV in federal prisons, up from 70 percent in 1997; 69 percent were tested in state prisons, up from 59 percent.[91] In 2002, 19 percent were tested in local jails, up from 18 percent in 1996.[92] In 2006, 21 states reported testing all inmates for HIV, either when the were admitted or sometime during their time in custody. Federal prisons and forty-seven states reported testing inmates if they requested such a test or if they had HIV-related symptoms; federal prisons and forty states reported testing inmates if they were involved in an incident where they were exposed to a possible HIV transmission. Federal prisons and 16 states reported that they test inmates in "high-risk" groups.[93]

Although HIV-risk behaviors occur prior to and during incarceration,[94] preventive and therapeutic interventions in prison have proven useful in reducing both risk behaviors and recidivism.[95] The long term efficacy of these efforts is meaningful, however, only if they include prison-based treatment programs that help inmates recover from addiction, reduce their HIV-risk behaviors and provide HIV/AIDS health care and counseling services (that meet national guidelines for corrections-based HIV/AIDS interventions) for those already infected.[96]

Providing linkages between correction-based services and community-based services is an effective tool for HIV prevention among jail inmates.[97] Although prevention programs have been developed specifically for prison and jail populations, these programs have not been widely implemented.[98]

Most Facilities Address Hepatitis C

Another infectious disease that has wreaked havoc among inmates with substance use disorders is Hepatitis C, a viral disease that attacks the liver and can cause cirrhosis of the liver, cancer, liver failure and death. Hepatitis C is spread through infected blood, most

commonly in shared needles used to inject drugs.

Nearly eight in 10 state prison facilities reported screening inmates for Hepatitis C either by testing all at some time, testing at admission, testing a random sample, testing high-risk inmates, testing upon inmate request or testing upon medical indication. Among the 70 percent of facilities that tested a targeted group, a third of the tests were confirmed positive; among nine percent of facilities that tested more broadly, slightly more than a quarter of all tests were confirmed positive.[99]

More than two-thirds (70 percent) of state facilities reported that they had a policy to treat inmates for Hepatitis C; most commonly they reported that their policy was to treat those Hepatitis C positive inmates for whom treatment was recommended or those at the greatest risk rather than all positive inmates. Twenty-seven percent of facilities reported not having a Hepatitis C treatment policy.[100]

Fetal Alcohol Spectrum Disorder (FASD) Rarely Addressed

The criminal courts rarely take FASD into account or consider it a mitigating factor in a crime when determining a defendant's culpability.[101] This is despite the fact that a person with FASD may not be capable of controlling his or her actions, providing an accurate account of his or her criminal behavior or its consequences, or fully comprehending the Miranda warnings should he or she be arrested.[102]

Justice system personnel are not well trained to address the needs of offenders with FASD.[103] Appropriate responses include recognizing FASD as a mitigating or even exculpatory factor in criminal cases, developing alternative sentencing options for those suffering from these disorders and providing individuals with FASD appropriate services and support at every point in the criminal justice process, from arrest to imprisonment to reentry.[104]

Veterans Treatment Court

The first Veterans Treatment Court was started in Buffalo, New York in January 2008 to address the associated problems of addiction and crime in a manner that is sympathetic to the difficulty veterans often have transitioning back to civilian life. Since then the program has spread to other counties and states across the nation. The court operates in a similar manner to other drug courts. Non-violent offenders charged with alcohol or drug related crimes are diverted from the traditional court system and their sentences are replaced with a period of treatment provided by the Veteran's Medical Center. The defendant maintains contact with both the court and a veteran mentor during that time. Mentors provide support and help to make sure the judge's orders are carried out. As with most drug courts, veterans have their records sealed upon completion of the program.[105]

Special Problems of Veterans

Returnees with substance use and addiction-related problems and co-occurring PTSD and other mental health problems who are discharged without treatment or are undiagnosed run significant risk of involvement with the justice system, further isolating them from reintegration and delaying treatment. These problems have prompted the creation of several veterans' drug treatment courts designed to meet the addiction related needs of veterans and reduce future contact with the justice system.[106]

Other Components of Effective Treatment

A considerable body of evidence demonstrates the importance of access to educational opportunities to help reduce recidivism.[107] Similarly, strong evidence exists that religious or spiritually-based programs are effective as adjuncts to treatment in fostering pro-social values and lifestyles and contributing to the reduction of recidivism.[108] Unfortunately, the rate of participation in education and training services has declined in the nation's prisons and jails. More inmates are involved in volunteer

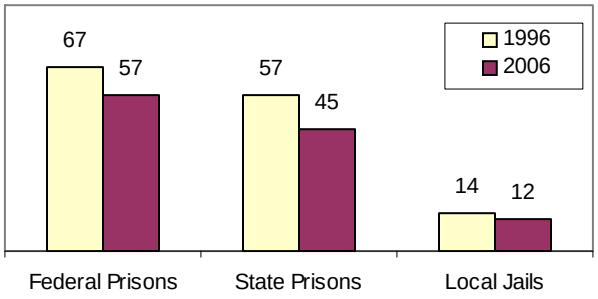
led spiritually-based programs, but fewer trained chaplains are available to them.[109]

Less Education and Training Available to Inmates

Educational and job training programs for prison and jail inmates can help them secure employment after release, build self-esteem and increase literacy skills.[110] Some type of educational programming is available in all federal prisons and most state and private prisons,[111] but the rate of participation has been declining since 1991, due to an expanding inmate population. The percentage of federal prison inmates who report participating in education or vocational programs while confined fell from 67 percent in 1996 to 57 percent in 2006. The participation rate among state inmates also declined from 57 percent in 1996 to 45 percent in 2006. Participation in educational programs is extremely low in local jails. The percentage of jail inmates who report participating in educational or vocational services declined from 14 percent in 1996 to 12 percent in 2006. (Figure 5.A)

Figure 5.A

Percent of Inmates Participating in Educational or Vocational Programs



Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (1991 and 2004), *Survey of Inmates in State Correctional Facilities* (1991 and 2004), *Survey of Inmates in Local Jails* (1989 and 2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in* (1996 and 2006).

The disparity between prisons and jails in the availability of educational programs has at least three major causes. First, jails serve short-term populations; second, they often do not have the space that is available in prisons for educational programs; and third, jail inmates lack the incentives of parole and good-time credit toward sentence reductions available to their prison inmate counterparts.[112]

Most corrections-based college programs are offered in federal and state prisons; only 3.4 percent of local jails offer one or more college-level courses.[113] Prison and jail education programs are for the most part financed by the state, but some states also use Title I federal funding, which includes Perkins Grants and Youthful Offender Grants, as well as private funds.[114]

The elimination of the Pell Grant for the higher education of state and federal prison inmates in 1994 was a devastating blow to the effort to help reduce recidivism through education. The Pell Grant is a federal grant subsidizing college education costs for students from low-income families; it extended to inmates participating in a prison-based post-secondary education.[115] In 1994, as public sentiments turned more punitive toward criminal offenders, incarcerated offenders were excluded from the program. The inmate exclusion does not apply to students incarcerated in local jails, or to those under supervision in halfway houses, home detention or serving weekend sentences.[116] A survey of state prison systems revealed that the number of prison systems offering college education programs decreased from 82.6 percent in 1994-1995 to 63.0 percent in 1995-1996.[117]

A federal or state drug conviction also can disqualify a student for other federal student aid* if the conviction occurs during a period of enrollment for which the student is receiving aid.[118] During academic year 2003-2004 alone, about 41,000 applicants were disqualified from receiving federal postsecondary education loans and grants because of drug convictions.[119]

* Title IV.

Increased Participation in Religious and Spiritually-Based Programs

CASA's analysis found that participation in religious activities has increased in recent years among substance-involved prison inmates. In 2006, 56.4 percent of substance-involved prison and jail inmates participated in religious activities in the past week. In 2006, over half of federal (54.8 percent) and state (55.1 percent) inmates did so, up from 1996 (39.0 percent and 31.1 percent, respectively.)* [120]

Since the 1990s, chaplain positions in prisons and jails have been declining in states because of expense and the difficulty of meeting the growing diverse religious needs of inmates under a professional chaplaincy. This trend has encouraged the involvement of volunteers to provide religious services to inmates, and the growth of correction-community alliances which combine criminal justice resources with religious organizations and local church volunteers. [121]

Although research has demonstrated that religiosity and spirituality when combined with evidence-based treatment are more effective than either alone and are related to less drug use among incarcerated offenders,[122] there is little published information on the impact of faith-based programs on substance-involved inmates in the United States. One religious program that has been evaluated is The Prison Fellowship which offers weekly Bible classes to inmates;[123] however, the study showed no difference in the median time to re-arrest or re-incarceration between those participating in the Prison Fellowship program and other inmates. Although program participants with higher levels of participation in Bible studies were less likely to be rearrested in years two and three post-release, the effects diminished over time. The program hosted more than 57,000 in-prison Bible study meetings in 2004, with a monthly attendance of more than 180,000 inmates.[124]

An Israeli study compared emotional and behavioral changes in participants of a prison-based treatment program including social support and spiritual program components with participants of a similar program that included social support components only. Inmates participating in the spiritually-oriented program showed a gradual reduction in anxiety, depression and hostility--all factors related to substance use--and a greater sense of coherence and meaning in their lives than those participating in the program without spiritual components.[125]

Random Drug Testing

Although assuring abstinence during incarceration should not be confused with treatment, random drug testing has the potential to decrease drug use.[126] Treatment of inmates typically involves routine drug tests accompanied by the use of sanctions to facilitate behavior change. Random drug testing among inmates is not employed uniformly across the country.[127]

Smuggling of illegal addictive substances into prisons remains a significant disruption to correctional management. Officers often accept drug trafficking and consumption as inevitable features of the inmates' world. Illicit substances generally are brought into the prison or jail through corrupt staff, friends and family during visits or in the prisoners' mail.[128]

Between 1999 and 2001, the California Department of Corrections conducted a pilot program at four institutions that included random drug testing (urinalysis) and systematic interdiction practices including drug detecting equipment and K-9 teams. Drug interdiction measures included the use of drug-detecting K-9 teams and drug detecting equipment; for-cause urine tests were required of the inmates if drugs were detected. Standard drug interdiction procedures (monitoring of phone calls, visiting areas, and inmate trust accounts and for-cause urine tests) were employed at all sites. Three of the sites were designated intervention sites, while the fourth was designated a comparison site. The baseline prevalence of drug use of 8.9 percent was reduced to 2.1 percent by the end of the study. Analysis indicated that random drug

* No comparative data available for jails.

tests accounted for most of the reduction in drug use.[129]

Some Inmates *Without* Substance Use Disorders Receive Treatment and Adjunct Services

In 2006, 2.9 percent (23,498) of federal, state and local inmates *who do not meet clinical criteria for* substance use disorders received some type of addiction treatment while incarcerated, either in residential units, by professional counselors or through maintenance therapy; 11.1 percent (88,889) participated in mutual support/peer counseling or educational services. While inmates who do not yet meet clinical criteria for substance use disorders may benefit from some type of intervention, comprehensive screenings and assessments are critical in order to link inmates to appropriate and effective care and services, and to assure appropriate use of scarce resources.

Practice Guidelines Are Available for Addiction Treatment in the Correctional System

Effective treatment of substance use disorders among inmates is based on recognition that addiction is a chronic disease requiring a disease management approach. According to the National Institute on Drug Abuse's *Principles of Drug Abuse Treatment for Criminal Justice Populations*, the importance of monitoring and managing offenders' substance use over the long term is no different than it is for the general population.[130]

A chronic care management approach includes ongoing symptom management by a team of health professionals, and provides the assistance of qualified recovery supports to help patients enact and maintain lifestyle changes. This approach is designed to increase patients' knowledge, skills and confidence in managing their illnesses.[131]

The first step in the treatment process is a thorough assessment of the nature and extent of the patient's substance-related problem and treatment needs, including assessment of co-occurring physical and mental health or behavioral problems that need to be addressed in the course of treatment. Services must then be tailored to the individual needs of criminal justice patients based on their demographic characteristics, problem severity, and levels of motivation and social support.[132]

Careful monitoring of patients' substance use and relapse episodes is necessary to intervene quickly and effectively, including drug tests, rewards and sanctions. Rewards and sanctions work best when they are perceived to be fair and when they immediately follow the targeted behavior.[133]

Treatment approaches should take into account the attitudes and beliefs that are associated both with substance use and criminal behavior and provide cognitive skills training to help patients improve their judgment, decision making and coping skills.[134]

Best practice coordinates treatment goals with correctional planning and supervision and includes links to community-based treatment and other reentry assistance services such as housing, childcare, medical and psychiatric services, social support services and vocational and employment assistance. Offenders who receive a full course of evidence-based treatment (in prison or in lieu of incarceration) and then continue with effective community-based treatment and recovery services upon reentry have the best outcomes including reduced relapse and recidivism rates.[135]

Reflecting this approach, a substantial body of professional guidelines and standards dating back almost two decades has been developed by occupational societies and scientific agencies for providing addiction treatment in prisons and jails: (See Appendix B)

- In 1990, the American Correctional Association (ACA), in cooperation with the Commission on Accreditation for Corrections, published *Standards for Adult*

Correctional Institutions (third edition)* recommending policies and procedures for clinical management of inmates with substance use disorders.[136]

- In 1991, the National Institute of Corrections, through its National Task Force on Correctional Substance Abuse Strategies, released the report *Intervening with Substance-Abusing Offenders: A Framework for Action*, which included many specific recommendations for identifying the substance use disorders of offenders, providing effective treatment and support services, and evaluating their impact.[137]

- The Center for Substance Abuse Treatment (CSAT) at the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) first published guidelines for establishing treatment programs for substance use disorders in prisons in 1993.[138] CSAT also has published a series of *Treatment Improvement Protocol* (TIP) reports offering best-practice guidelines for the treatment of substance use disorders among offenders.[139]

- In 2006, the National Institute on Drug Abuse (NIDA) joined the enterprise of providing guidance to corrections-based treatment providers and formulated research-based principles for the effective treatment of offenders with substance use disorders.[140]

The essential elements of these multiple sets of standards are summarized in the following text box. No mechanism has been put in place, however, to ensure use of these guidelines and standards. Because they essentially are non-binding recommendations, their impact on the planning and delivery of addiction treatment services in America's prisons and jails appears to be minimal[141]--frequently ignored by state legislatures and sparsely implemented by correctional authorities.[142]

Essential Elements of a Chronic Care Management Approach to Inmates with Substance Use Disorders†

Comprehensive assessment of:
- Substance use and other health and mental health conditions by trained health care professionals
- Education/training, housing, social and family support needs

Individualized treatment plan including:
- Appropriate behavioral and pharmacological therapies
- Treatment for co-occurring health and mental health conditions
- Education/training, housing, social and family support needs
- Patient education in disease management
- Correctional goals
- Re-entry and aftercare

Patient monitoring for compliance with treatment plan; use of prompt rewards and sanctions.

One mandated accreditation has been developed for the provision of opioid treatment in prisons and jails. Federal rule 42 CFR Part 8, which went into effect in March 2001, requires that all treatment providers who treat opioid addiction with opioid drugs be accredited by certifying bodies approved by SAMHSA. The law also includes a set of federal opioid treatment standards covering administrative and organizational structure; quality improvement; staff credentials; patient admission criteria; required services; record-keeping; patient confidentiality; medication administration, dispensing and use; and interim maintenance treatment.[143]

In 2004, SAMHSA granted the National Commission on Correctional Health Care

* Updated in 2003.

† Drawn from recommended guidelines and standards developed by the American Correctional Association, the National Institute of Corrections, the Center for Substance Abuse Treatment (CSAT) at the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institute on Drug Abuse.

(NCCHC) the authority to accredit these programs. As of 2009, there were five such accredited programs in state and federal prisons.[144] NCCHC has become the only approved accreditation body specialized in correctional settings.[145] Although evaluations of opioid treatment program accreditation have been released,[146] none directly addresses such programs in correctional settings.

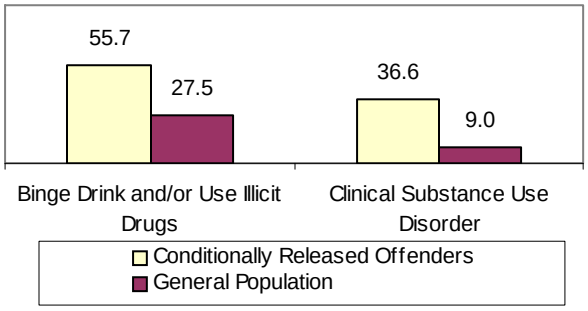
In order to translate scientific knowledge into practice, Physicians and Lawyers for National Drug Policy in partnership with The National Judicial College released in 2008 a resource guide of evidence-based approaches for the justice system for addressing alcohol and other drug problems in the offender population. They also have developed a related training program. These products are designed to improve knowledge and practice among judges, lawyers, probation and parole officers and other court personnel and help link them to health professionals, treatment programs, mutual-support programs, specialty treatment courts and other related resources.[147]

Chapter VI
Reentry of Substance-Involved Inmates

Upon release, incarcerated offenders who have substance use disorders (SUDs) require effective treatment and/or aftercare, including long term disease management, depending on the severity of their illness. Those who engage in risky substance use but do not yet meet criteria for SUDs will require interventions to reduce such behavior. Many also will require help for other co-occurring health problems and assistance in education, training and employment, and with housing and other family and social services.

Figure 6.A

Percent of Conditionally Released Offenders* and the General Population with Substance Misuse and Dependence



* On parole, supervised release or other restricted release from state or federal prison.

Source: CASA analysis of the *National Survey on Drug Use and Health* (NSDUH) (2006) [Data file] (respondents 18 and older), comparing substance use among those who report being on conditional release to that of those who report never having been on conditional release at any time during the 12 months prior to the survey.

Conditionally released offenders[*] are twice as likely as members of the general population age 18 and over to be either current users of illicit drugs or binge drinkers (55.7 percent vs. 27.5 percent), and four times likelier to meet clinical criteria for a substance use disorder (36.6 percent vs. 9.0 percent).[†] [‡] (Figure 6.A) Conditionally released offenders with SUDs are likelier than those who do not have such disorders to be in poor health, unemployed and on public assistance, and poorly educated.

Aftercare programs should include community supervision, integrated services, case management and graduated sanctions. To assure that these practices are implemented effectively, training of probation and parole officers also is essential.

Despite the enormous treatment gap and failure to provide a comprehensive approach to aftercare, conditionally released offenders with SUDs are likelier than individuals in the general

[*] Ages 18 and older, on parole, supervised release or other restricted release from state or federal prison.
[†] Unless otherwise noted in the chapter, percentage and numerical estimates are either drawn directly from or based on CASA's analysis of the *National Survey on Drug Use and Health* (NSDUH) 2006 [Data file]. See Appendix A, Methodology.
[‡] Note that the 9.0 percent refers to the general population who *had not* been incarcerated. This percent differs from the 9.1 percent presented in Chapter IV which includes those who *had* been incarcerated.

population to have received treatment in the past year (35.4 percent vs. 6.7 percent).

The Profile of Released Inmates

There is no national data set that provides information on the characteristics and treatment needs of all released offenders. The closest proxy is the 2006 *National Survey on Drug Use and Health* (NSDUH) which identifies the non-institutionalized population ages 12 and older who have been conditionally released from prison--on parole, supervised release or other restricted release--at any time during the 12 months prior to the survey. No data are available on those released unconditionally from prisons--about 25 percent of released offenders[1]--or those released from local jails.

The population of released offenders has been growing. Between 1998--the year CASA published its original *Behind Bars* report--and 2006, the parole population alone grew by 13.2 percent.[2] In 2006, an estimated 1.6 million[3] individuals age 18 and over had been conditionally released[*] from prison and were in the process of reentry and reintegration after having served a prison term of at least one year.[†]

Conditionally Released Offenders Have High Rates of Substance Misuse

Offenders who have been conditionally released from prison have much higher rates of binge drinking and other drug use than the general population. In 2006, 45.8 percent of conditionally released offenders were binge drinkers[‡] compared with 24.3 percent in the general population.[§] Over two-fifths (44.6 percent) of the 1.6 million conditionally released offenders reported having used illicit drugs during the previous year as compared to 13.6 percent of the general population. Nearly one-third (32.0 percent) of conditionally released offenders had used illicit drugs in the past 30 days compared with 7.9 percent of the general population. Conditionally released offenders were twice as likely as members of the general population to be either current users of illicit drugs or binge drinkers (55.7 percent vs. 27.5 percent). (Table 6.1)

Table 6.1
Percent of Offenders Conditionally Released[a] from Prison and of the General Population, by Substance Misuse

	General Population	Released Offenders
Binge drinking in past 30 days[b]	24.3	45.8
Used illicit drugs in past 12 months	13.6	44.6
Used illicit drugs in past 30 days	7.9	32.0
Used illicit drugs or engaged in binge drinking in past 30 days	27.5	55.7

Source: CASA's analysis of the *National Survey on Drug Use and Health* (NSDUH) (2006) [Data file] (respondents 18 and older), comparing substance use among those who report being on conditional release to that of those who report never having been on conditional release at any time during the 12 months prior to the survey.
Note: Data presented in Chapters III and IV on the rates of substance and misuse in the general population differ slightly from these statistics because the former include the inmates who had been released from prison.
[a] On parole, supervision or other restricted release.
[b] Binge drinking is defined as five or more drinks on the same occasion on at least one day in the past 30 days.

[*] This analysis of the NSDUH includes the population aged 18 and over. These recently released prison inmates do not include and should not be confused with the 2.2 million probationers, who are adult offenders whom courts place on community supervision generally in lieu of incarceration (Glaze & Bonczar, 2007).
[†] Characteristics of conditionally released offenders derived from the NSDUH cannot be compared with characteristics of inmates presented in Chapter III and derived from the prison and jail inmate surveys because they do not contain comparable variables.
[‡] Consumed five or more drinks on the same occasion on at least one day in the past 30 days.
[§] All comparisons with the general population are among those age 18 and over who have not been conditionally released.

Approximately the same proportion of female and male conditionally released offenders reported past-year use of illicit drugs (45.1 percent vs. 44.5 percent). Among conditionally released offenders, women were less likely than men to have used illicit drugs and/or to have engaged in binge drinking during the past 30 days (49.2 percent vs. 57.7 percent).* (Table 6.2)

Table 6.2
Percent of Offenders Conditionally Released[a] from Prison, by Substance Misuse and Gender

	Male Released Offenders	Female Released Offenders
Used illicit drugs in past 12 months	44.5	45.1
Used illicit drugs in past 30 days	32.6	30.2
Binge drinking in past 30 days[b]	49.6	33.6
Used illicit drugs AND/OR engaged in binge drinking in past 30 days	57.7	49.2

Source: CASA's analysis of the *National Survey on Drug Use and Health* (NSDUH) (2006) [Data file] (respondents 18 and older), among those who report being on conditional release at any time during the 12 months prior to the survey.
[a] On parole, supervision or other restricted release.
[b] Binge drinking is defined as five or more drinks on the same occasion on at least one day in the past 30 days.

Conditionally Released Offenders Have High Rates of SUDs

More than one-third (36.6 percent) of the 1.6 million conditionally released offenders age 18 and older meet clinical diagnostic criteria for a substance use disorder--four times the rate (9.0 percent) of the rest of the population age 18 and over. Released inmates are more than three times likelier than the general population to meet clinical criteria for substance abuse (15.1 percent vs. 4.8 percent) and more than five times likelier to meet criteria for substance dependence (25.9 percent vs. 4.7 percent). Female released offenders are less likely to meet clinical criteria for substance abuse than males, and slightly more likely to meet clinical criteria for substance dependence. (Table 6.3)

Table 6.3
Percent of Offenders Conditionally Released[a] from Prison, by Past Year Substance Use Disorders and Gender

	Male Released Offenders	Female Released Offenders
Substance abuse	16.7	9.7
Substance dependence	25.3	27.7
Substance abuse AND/OR dependence	36.5	36.8

Source: CASA's analysis of the *National Survey on Drug Use and Health* (NSDUH) (2006) [Data file] (respondents 18 and older), among those who report being on conditional release at any time during the 12 months prior to the survey.
[a] On parole, supervision or other restricted release.

The difference between the percent of *inmates* with SUDs (64.5 percent) and the percent of *conditionally released offenders* with SUDs (36.6 percent) could be a function of several factors. First, methodological issues could have resulted in an under-estimate of the prevalence of SUDs among recently released prison inmates under criminal justice supervision. The most serious obstacle in the sampling of this difficult-to-reach population is their transient lifestyle. Other plausible contributors to the lower reported prevalence of SUDs among supervised ex-inmates include the deterrent effect of supervision, including drug testing, and the therapeutic impact of treatment among those required to participate. It also is possible that those without substance use disorders might be more likely to be released.

Conditionally Released Offenders with SUDs Report Poor Health

Conditionally released offenders with SUDs have more health problems than their counterparts without SUDs. Of conditionally released offenders age 18 and over with SUDs, only 42.2 percent self-reported their overall

* Females released from prison were less likely than males released from prison to report illicit drug use (29.2 percent vs. 32.4 percent) or heavy drinking 12.6 percent and 15.3 percent) in the past 30 days.

health status as excellent or very good compared to 57.2 percent of the conditionally released inmates without SUDs. Conditionally released offenders with SUDs were nearly twice as likely as those without SUDs to have experienced serious psychological distress* during the past 12 months (29.5 percent vs. 16.7 percent); just 2.3 percent of the general population met these criteria. Female released inmates with SUDs were more than twice as likely as their male counterparts to have experienced serious psychological distress during the past 12 months (50.0 percent vs. 23.0 percent). (Table 6.4)

Table 6.4
Percent of Offenders Conditionally Released[a] from Prison, by Health Status

	Released Offenders without SUDs	Released Offenders with SUDs	Male Released Offenders with SUDs	Female Released Offenders with SUDs
Overall health status				
Excellent/Very Good	57.2	42.2	41.2	45.3
Good/ Fair/Poor	42.8	57.8	58.8	54.7
Serious psychological distress				
Yes	16.7	29.5	23.0	50.0
No	83.3	70.5	77.0	50.0

Source: Source: CASA's analysis of the *National Survey on Drug Use and Health* (NSDUH) (2006) [Data file] (respondents 18 and older), comparing substance use among those who report being on conditional release to that of those who report never having been on conditional release at any time during the 12 months prior to the survey.
[a] On parole, supervision or other restricted release.

One study found that incarcerated offenders released from prisons are nearly 13 times likelier to die during their first two weeks out of prison than individuals in the general population,† with a markedly elevated relative risk of death from drug overdose.[5]

Drug Overdose: The Number One Killer of Offenders Released from Prisons

Among the 30,237 inmates released from Washington state prisons between 1999 and 2003, 38 died within two weeks, 27 of them from a drug overdose. In total, 443 died in the first two years after release. This mortality rate was 3.5 times the expected rate in a population of similar age, gender and cultural background. Among the 443 deaths recorded during the follow-up period, a drug overdose was the leading cause of death (103 deaths), and cocaine was the most common drug involved in the overdose.[4]

* The measure of serious psychological distress is based on six symptoms: feeling nervous, feeling hopeless, feeling restless or fidgety, feeling so sad or depressed that nothing could cheer you up, feeling everything was an effort and feeling no good or worthless. Respondents were asked how frequently they experienced these symptoms during the one month in the past year when they were at their worst emotionally.

† The authors compared the death rate (number of deaths per 100,000 people in the population) between former inmates during the first two weeks after their release and residents of the state of Washington in 1999 and 2003.

Conditionally Released Offenders with SUDs Likelier to be Young and Male

Almost three-quarters (76.2 percent) of conditionally released offenders with SUDs are male. Conditionally released offenders with SUDs are likelier to be younger than those without SUDs; 31.5 percent of those with SUDs are ages 18 to 25 compared with 25.5 percent of those without SUDs. Female conditionally released offenders with SUDs are likelier than their male counterparts to be between the ages of 35 and 49 (41.6 percent vs. 32.3 percent). (Table 6.5)

Table 6.5
Percent of Conditionally Released Offenders[a] with Substance Use Disorders, by Age and Gender

	Released Offenders without SUDs	Released Offenders with SUDs	Male Released Offenders with SUDs	Female Released Offenders with SUDs
18-25 years old	25.5	31.5	32.9	27.3
26-34 years old	33.1	30.4	30.2	31.1
35-49 years old	28.1	34.5	32.3	41.6
50 or older	13.4	3.6	4.7	0.0

Source: CASA's analysis of the *National Survey on Drug Use and Health* (NSDUH) (2006) [Data file] (respondents 18 and older), among those who report being on conditional release at any time during the 12 months prior to the survey.
[a] On parole, supervision or other restricted release.

SUDs Most Prevalent among Black Conditionally Released Offenders

Among conditionally released offenders, Blacks have the highest SUD rates (49.6 percent) compared with whites (35.7 percent), Hispanics (27.3 percent), Native Americans (15.2 percent) and others (34.7 percent). Among whites, conditionally released females are likelier to have SUDs than males (42.5 percent vs. 33.3 percent). For other racial groups, males are likelier than females to have SUDs. (Table 6.6)

Table 6.6
Conditionally Released Offenders[a] Percent by Gender and Race/Ethnicity with Substance Use Disorders

	Male	Female	Total
White	33.3	42.5	35.7
Black	50.4	46.8	49.6
Hispanic	28.4	23.7	27.3
Native American	33.8	4.1	15.2
Other	35.9	0.0	34.7

Source: CASA's analysis of the *National Survey on Drug Use and Health* (NSDUH) (2006) [Data file] (respondents 18 and older), among those who report being on conditional release at any time during the 12 months prior to the survey.
[a] On parole, supervision or other restricted release.

Few Conditionally Released Offenders with SUDs are Married

Table 6.7
Percent of Conditionally Released Offenders[a] with Substance Use Disorders, by Marital Status and Gender

	Released Offenders without SUDs	Released Offenders with SUDs	Male Released Offenders with SUDs	Female Released Offenders with SUDs
Married	28.5	12.7	9.2	24.1
Divorced/ widowed	21.3	17.9	17.0	20.9
Single/ never married	50.2	69.4	73.8	55.0

Source: CASA's analysis of the *National Survey on Drug Use and Health* (NSDUH) (2006) [Data file] (respondents 18 and older), among those who report being on conditional release at any time during the 12 months prior to the survey.
[a] On parole, supervision or other restricted release.

Just over one in 10 (12.7 percent) conditionally released offenders with SUDs are married, compared with 28.5 percent of those without SUDs. Although the absolute majority of released inmates with SUDs are single and never married (55.0 percent for women vs. 73.8 percent for men), women with SUDs are more than twice as likely as males to be married (24.1 percent vs. 9.2 percent). (Table 6.7)

Female conditionally released offenders with SUDs also were likelier than males with such disorders to be living in a household with minor children (63.4 percent vs. 39.9 percent).

Conditionally Released Offenders with SUDs are Likely to be Unemployed

Conditionally released offenders with SUDs are less likely to be employed than such offenders without SUDs (55.7 percent vs. 74.1 percent). Women who have been conditionally released and who have SUDs are much less likely to be employed than their male counterparts (25.5 percent vs. 65.2 percent). They also are more likely to receive public assistance (18.9 percent vs. 4.7 percent); 74.5 percent of conditionally released women with SUDs are not in the labor force.[*]

Most (93.6 percent of women and 86.8 percent of men) conditionally released offenders with SUDs had a family income of less than $50,000. Conditionally released offenders with SUDs were likelier to be living on a total family income of $20,000 or less than those without SUDs (59.4 percent vs. 38.8 percent). (Table 6.8)

Conditionally Released Offenders with SUDs are Poorly Educated

Most of those leaving prison today will be poorly educated and lack marketable job skills.[6] Conditionally released offenders with SUDs are likelier than those without such disorders to have less than a high school education (57.2 percent vs. 41.5 percent) and less than a college education (99.4 percent vs. 93.0 percent). Women with SUDs who have been conditionally released are less educated than their male counterparts (87.3 percent of women have a high school education or less compared to 79.9 percent of men).

[*] Individuals not in the labor force include those who do not have a job and either were not looking for work or were looking for work but did not report making specific efforts to find work in the past 30 days, students, housewives or househusbands, retired individuals, and individuals not working because of a disability.

Table 6.8
Percent of Conditionally Released Offenders[a] with Substance Use Disorders, by Employment, Income and Gender

	Released Offenders without SUDs	Released Offenders with SUDs	Male Released Offenders with SUDs	Female Released Offenders with SUDs
Currently employed				
Yes	74.1	55.7	65.2	25.5
No	25.9	44.3	34.8	74.5
Currently receiving public assistance				
Yes	7.5	8.0	4.7	18.9
No	92.5	92.0	95.3	81.1
Total family income				
Less than $20,000	38.8	59.4	61.4	53.0
$20,000-$49,999	39.2	29.0	25.4	40.6
$50,000-$74,999	10.9	3.2	4.3	0.0
$75,000 or higher	11.1	8.3	8.9	6.4

Source: CASA's analysis of the *National Survey on Drug Use and Health* (NSDUH) (2006) [Data file] (respondents 18 and older), among those who report being on conditional release at any time during the 12 months prior to the survey.
[a] On parole, supervision or other restricted release.

Availability of Aftercare

In 2006, 35.4 percent of conditionally released offenders with SUDs received any form of addiction treatment; women were likelier to receive treatment than men (55.8 percent vs. 29.0 percent).[7] Admissions to addiction treatment with a probation, parole or other conditional release referral were more likely than admissions with no correctional referral to be to non-intensive ambulatory care (72.9 percent vs. 38.6 percent). Admissions with no correctional referrals were likelier to be to short stay rehabilitation than admissions with a conditionally released referral (11.7 percent vs. 5.8 percent).[8] (Table 6.9)

Admissions of females referred to treatment from probation, parole or other conditional release were somewhat likelier than their male counterparts to be for an intensive ambulatory care program (12.2 percent vs. 8.6 percent) or a long stay* rehabilitation program (9.9 percent vs. 7.5 percent). Admissions of women were somewhat less likely to be for treatment in a non-intensive ambulatory treatment program than those of men (68.0 percent vs. 74.4 percent).[9] (Table 6.9)

Despite the enormous treatment gap and failure to provide a comprehensive approach to aftercare, individuals with SUDs who were referred from probation, parole or other conditional release were likelier than individuals in the general population who were not referred by correctional authorities to have received treatment in the past year (35.4 percent vs. 6.7 percent). This difference can be explained in part by the fact that treatment participation is imposed on some parolees as a condition for their release.[10] Also, because of their low income status, they may be more likely than the general population to be eligible for government supported programs. Finally, offenders with substance use disorders may be less likely to be released.

* Over 30 days.

Table 6.9

Percent of Treatment Admissions among Conditionally Released Offenders[a] and the General Population with No Correctional Referral

	General Population No Correctional Referral	With Correctional Referral	Males with Correctional Referral	Females with Correctional Referral
In past year, service received:				
Detoxification	29.6	3.6	3.4	4.1
Treatment				
Hospital-based rehabilitation	0.7	0.1	0.1	0.1
Short stay (less than 30-day) rehabilitation	11.7	5.8	5.9	5.5
Long stay (over 30-day) rehabilitation	7.2	8.1	7.5	9.9
Intensive ambulatory	10.3	9.4	8.6	12.2
Non-intensive ambulatory	38.6	72.9	74.4	68.0

Source: CASA analysis of the *Treatment Episode Data Set* (TEDS)*, 2006 (ICPSR 21540) [*Data file] (admissions of individuals 18 and older).

[a] Includes those on probation, parole or other restricted release; excludes those currently incarcerated, in drug court/alcohol court, referred from DWI or DUI programs, or leaving parole and probation.

In 2006, nearly all parole agencies[*] reported having paroled offenders in a drug treatment program run by formally trained treatment professionals (47 of the 49 state agencies with a known status), having paroled offenders in mutual support programs such as AA or NA (46 of the 49 agencies) and having paroled offenders in a mental health treatment program run by formally trained treatment professionals (47 out of 49 agencies). Just over half[†] reported offering housing assistance to adult parolees in 2006 and 37 agencies reported offering employment assistance. The percentage of parolees in need of such services and who received them, however, is not known. In 2006, the average caseload in state parole supervising agencies was 38 active parolees for each full-time equivalent position devoted to parole supervision.[12]

Justice Policy Institute Report

States that have successfully improved outcomes for people on parole have done so through a combination of the following practices, including:

- *Shifting the supervision modality from a law-enforcement orientation to one more focused on helping people be successful in the community;*
- *Developing systems of graduated responses to supervision behavior that include positive incentives, treatment, and non-incarcerative sanctions; and*
- *Matching intensity of supervision to the level of risk and needs of the individual, so people who have greater needs have more case management, while those with fewer needs are not excessively burdened with parole requirements.*[11]

[*] Information was not available for Illinois, Mississippi or Wisconsin, but includes Washington, DC and the California Juvenile Justice Division which had an adult parole population of 67 in 2006.

[†] 27 out of 50 state agencies.

Data are not available to measure the quality of these services or the prevalence of SUDs and the rate of treatment participation among prison inmates who were released directly into the community without the benefit of community supervision.

Insurance Coverage for Treatment for Released Offenders

Almost two-thirds of admissions for treatment among conditionally released offenders (61.5 percent) were covered by Medicaid (8.8 percent) or other government payments (52.7 percent). By comparison, these services cover 54.0 percent of admissions among the general population with no correctional treatment referral. Male conditionally released offenders were likelier than their female counterparts to have their admissions covered by other government payments (52.9 percent vs. 52.0 percent) or to pay for treatment themselves (13.7 percent vs. 10.1 percent), while female conditionally released offenders were likelier to have their admission covered by Medicaid (16.2 percent vs. 6.5 percent).[13] (Table 6.10)

Components of Effective Aftercare

Effective strategies that should be employed in aftercare programs include: community supervision, integrated services, case management and graduated sanctions. To assure that these practices are implemented effectively, training of probation and parole officers also is essential.[14]

Community Supervision

Since released offenders who remain dependent on substances are much likelier to return to criminal activity, post-release community supervision can be an important tool to assist released offenders access the care they need. Even if treatment is provided during incarceration, treatment gains may be lost if care is not continued after release. Monitoring and coordination of services through the correctional system can provide structure and accountability to manage SUDs and their consequences.[15]

Table 6.10

Percent of Treatment Admissions among Conditionally Released Offenders[a] and the General Population with No Correctional Referral, by Source of Payment[b]

	General Population No Correctional Referral	With Correctional Referral	Males with Correctional Referral	Females with Correctional Referral
Treatment paid for by:				
Self	15.6	12.8	13.7	10.1
Private health insurance	6.5	3.0	3.0	3.0
Medicare, Workers' Compensation	1.3	0.3	0.3	0.4
Medicaid	16.4	8.8	6.5	16.2
Other government payments[c]	37.6	52.7	52.9	52.0
Other source	11.2	7.9	8.3	6.7
No charge	11.5	14.5	15.4	11.7

Source: CASA analysis of the *Treatment Episode Data Set* (TEDS)*, 2006 (ICPSR 21540)* [Data file] (admissions of individuals 18 and older).

[a] Includes those on probation, parole or other restricted release; excludes those currently incarcerated, in drug court/alcohol court, referred from DWI or DUI programs, or leaving parole and probation.

[b] Percentages do not add up to 100 due to rounding.

[c] Includes payments by federal, state or local governments such as Department of Veterans Affairs (CHAMPUS), Temporary Assistance for Needy Families (TANF), drug courts and state health programs, and excluding Medicare, Medicaid and Workers' Compensation.

Integrated Services

Development of an integrated service plan is key to achieving successful re-entry; attaining stable housing, gainful employment, satisfactory health and a stable family life are of critical importance to recovery and reduced recidivism.[16] Achieving these goals will require that released offenders successfully navigate circumstances that increase the risk that they will continue addictive substance use or recidivate, including mental illness, low self-esteem, unemployment and living alone.[17]

Developing integrated service plans will require an effective working relationship between the correctional systems and community-based service providers, including data sharing, in order for aftercare programs to build on the achievements and progress made in prison or jail.[18]

To encourage such collaboration and improve outcomes, the Center for Substance Abuse Treatment has recommended providing incentives for service providers to work together to address the needs of offenders with SUDs, and incentives for released offenders to participate in treatment (e.g., safe housing units, positive parole board review, the return of children to their mothers, or less frequent reporting to parole or probation officers).[20]

Case Management

In order to coordinate the behavioral monitoring, health care and social services for a particular released inmate, best practice research concludes that each inmate should have a case manager. The case manager should assure that transition planning begins before release and is monitored and evaluated periodically. Evaluation should assess the offender's treatment needs, treatment readiness, treatment engagement and treatment progress as well as life skills, employment readiness and status, stress control, psychosocial functioning, emotional support and financial management skills.[21]

Integrated Services

In 1998, the California Department of Corrections initiated a multidimensional parole-based reintegration program called the Preventing Parolee Crime Program (PPCP). The program brought together six networks of community service providers supporting four areas: employment, substance abuse education and recovery, math and literacy skill development and housing.

The employment component involves 12 job development and placement subcontractors; the substance abuse component relies on two treatment providers offering a wide range of therapeutic services; math and literacy training services are provided by a self-paced, computer-assisted instructional program; and the housing services are offered to support homeless parolees' transition to independent living in the community through six residential multi-service centers.

Specific treatment goals were set for participation in these integrated services. Evaluation results showed that, overall, PPCP participants had a re-incarceration rate that was eight percentage points lower than comparable non-PPCP parolees (44.8 percent vs. 52.8 percent). Recidivism rates for PPCP participants meeting one or more of the program's treatment goals were 20.1 percent lower than non-PPCP participants. The re-incarceration rate for PPCP participants who met more than one treatment goal was 47.1 lower than the comparison group.[19]

Graduated Sanctions

Graduated sanctions are structured, incremental punishments for non-compliant behaviors. They are designed to give the supervision officer the ability to respond quickly to noncompliant acts through actions such as a day in jail, more frequent substance testing, more reporting or a curfew.[22] This approach is based on research that shows that the likelihood that a supervised offender will engage in substance use or illegal activity is influenced by the perceived certainty of detection of infractions or recognition of accomplishments, the perceived certainty of

receiving sanctions for infractions or rewards for accomplishments, and the anticipated magnitude of the sanctions and rewards.[23]

Graduated Sanctions

In an experimental evaluation in Washington DC, 240 drug court participants subjected to graduated sanctions in addition to regular drug testing and monitoring were compared to 311 controls who were tested for drug use and monitored on the regular schedule. Participants of the graduated sanctions program tested positive for drugs on 53 percent of the tests administered during the pretrial release period, while control sample subjects tested positive on 71 percent of their tests. While participants of the graduated sanctions were no less likely than the control sample to be re-arrested in the first year following sentencing, they were significantly less likely than the control subjects to be re-arrested in the following year (19 percent vs. 27 percent).[27]

The sanctioning process uses modest steps to deter future rule violations, ensure the integrity of the supervision and maintain the continuity of care. The assignment of less punitive responses for early and less serious non-compliance and increasingly harsher sanctions for more serious or persistent problems is most effective when implemented in conjunction with substance testing.[24]

Addiction is a chronic disease and, like other chronic health conditions, recovery often includes relapse and requires more than one episode of intensive treatment.[25] Research into graduated sanctions suggests that re-incarceration be reserved for circumstances involving a new offense or a recalcitrant pattern of technical violations. Even a few days in jail, out of the structured and supportive environments provided in community-based treatment programs, can disrupt the recovery process. If probationers return to jail they may lose the jobs or housing they gained during the recovery process and cause new or renewed relationships to break down. These repercussions may counteract some of the positive effects of treatment, potentially slowing the recovery process.[26]

Training of Probation and Parole Officers

There appears to be a trend in parole supervision to group parolees with substance use problems under targeted care so that their special needs can be better attended.[29] There also is evidence that probation and parole officers can be trained effectively to integrate assessment and case planning and management with the correctional model and engage the offender in the recovery process though motivational techniques and incentives.[30] In spite of this evidence, however, the practice of community supervision has become more law enforcement oriented since the 1980s, shifting from a casework/ rehabilitation approach to a surveillance/ deterrence approach.[31]

Merely incarcerating offenders without treating underlying substance abuse problems is shortsighted, expensive, and will not solve the crime problem. It simply suspends temporarily the criminal, destructive and costly interactions between offenders and our communities. Between 60 and 75 percent of untreated parolees with histories of cocaine or heroin abuse return to those drugs within three months of release. Failing to provide appropriate testing and treatment means that the cycle of drugs and crime will continue--with huge social, human, and economic costs for our nation.[28]

--U.S. Department of Justice
The Clinton Administration's Law Enforcement Strategy: *Breaking the Cycle of Drugs and Crime*, 1999

When properly trained, probation and parole officers not only can better understand SUDs but also can contribute to the recovery process. In a Canadian experiment, probation and parole officers from western Ontario were trained in and provided Structured Relapse Prevention (SRP) to 55 clients over a one-year period. Evaluation findings showed that officers were enthusiastic about SRP, in spite of its added time demands, and that SRP effectively helped with

the substance use problems of supervised offenders.[32]

Best Practices in Reentry

Release presents offenders with a difficult and risky transition from the structured environment of the prison or jail. Many released inmates with SUDs have no place to live, no job and no family or social supports. They often lack the knowledge and skills to access available resources for adjustment to life on the outside--all factors that significantly increase the risk of relapse and recidivism.[34] Successful reentry and reintegration into their communities can be aided by a combination of prison-based treatment and comprehensive and effective aftercare (including employment) services post release to help manage the addiction and address other health and social problems.[35]

Research has found that integrating in-prison treatment with aftercare, including work release and parole supervision, results in the best social adjustment and the lowest recidivism outcomes among ex-offenders.[36]

Reentry services can either be mandated as pre-release requirements or, where jurisdiction terminates with release, offered as post-release options. However, many of the approximately 14,000 community-based treatment facilities[37] in the U.S. lack capacity to extend services to all those in need who are reentering the community from the justice system. Further, many treatment providers lack the training and appropriate staff to provide effective services to address the multiple needs of ex-offenders. For example, while CASA estimates that over 67 percent of inmates with a substance use disorder have co-occurring mental health problems, only 35 percent of treatment providers have some capacity to serve clients with co-occurring disorders.[38] In addition, many offenders leave jail or prison without a referral to such programs and, even with a referral, many do not access treatment.[39]

Some of the best known treatment and aftercare initiatives have been tested empirically and have been shown to produce significant results in terms of reducing recidivism. Examples include the California and Delaware treatment and aftercare programs. The Sheridan National Model Drug Prison and Reentry Program in Illinois also shows promising results.

> *Our focus has shifted toward offender re-entry from day one. We're giving them every opportunity to change their lives.*[33]
>
> --Katherine Sanguinetti
> Spokesperson for the
> Colorado Corrections Department

California Prison-Based Treatment and Aftercare

Studies that followed ex-offenders several years after treatment found that they had lower rates of substance relapse or recidivism than comparison groups who did not participate in treatment.[40] In a Californian study where inmates with substance use problems were randomly assigned to regular prison-based therapeutic community (TC) only and to TC plus aftercare interventions, only 8.2 percent of the TC plus aftercare completers were re-incarcerated at 12 months after release compared to 40.2 percent of TC only completers and 49.7 percent of those in the control group who received no treatment or aftercare.[41]

Delaware Prison-Based Treatment and Aftercare

One study in Delaware found that substance-involved prisoners who participated in a prison-based TC, a transitional TC in a work release setting and aftercare involving outpatient counseling, refresher sessions at the transitional TC and regular calls to their counselor while under community supervision, had the lowest relapse* and recidivism outcomes among ex-offenders five years following their release. Just over half (52 percent) of those who completed treatment and then attended aftercare were likely

* Relapse to drug use is defined here as *any* illegal drug use since release.

to be rearrested compared to 77 percent of the group without any treatment or aftercare. Among participants who completed treatment and aftercare, 26 percent were likely to remain drug free by 60 months compared with five percent with no treatment or aftercare. [42]

The Sheridan National Model Drug Prison and Reentry Program (Illinois)

The Sheridan Project was initiated in 2004, at an annual cost of 25.5 million, on the premise that offenders' substance abuse and other criminogenic problems must be addressed in order to improve public safety and reduce recidivism.[43] The program admits male inmates who have a substance use problem, are serving between six and 24 months, have no serious mental disorders and are not convicted of murder or sexual assault.[44]

Sheridan, with its 1,300-bed capacity is known as the largest fully dedicated drug treatment facility in the United States.[45] But it is more than a treatment prison. All Illinois prison inmates who meet eligibility criteria for the Sheridan program are transferred to the facility, where they receive a full assessment and evaluation of treatment needs.[46] During the program, inmates receive intensive substance abuse treatment in a therapeutic community, as well as educational and vocational training and other specialized services such as anger management and family reunification. Prior to their release, inmates receive assistance in developing an aftercare plan for meeting treatment and other service needs, such as education, housing and employment. Upon their release, Sheridan participants receive referrals to various services in the community, including aftercare treatment and educational/vocational programs, job placement assistance and linkage to a community mentor.[47]

Community resources are mobilized to provide treatment and services to Sheridan program participants. The Gateway Foundation delivers drug treatment at the Sheridan Correctional Center. The Safer Foundation provides employability training and post-release job referrals and placement. Treatment Alternatives for Safe Communities (TASC) conducts pre-Sheridan screening, post-release treatment referrals and clinical case management. Illinois Valley Community College, the Illinois Manufacturing Foundation and the National Homebuilders Association engage in educational and vocational training.[48]

The Sheridan Project is further supplemented by a comprehensive parole reform plan dubbed Operation Spotlight. Operation Spotlight calls for spending $6.4 million to double the number of parole officers over a four-year period from 370 to 740, reducing their caseloads, increasing their mandatory minimum contacts with parolees and providing them with improved training on risk assessment and case management. Ultimately, the goal is to enable parole officers to determine more quickly which offenders pose a risk to public safety and should be re-incarcerated and which offenders require greater case management to facilitate addiction treatment, mental health services and job preparedness services.[49]

An early evaluation found that six months after release, seven percent of those released from Sheridan had been incarcerated compared to 17 percent of those in the control group. Of participants released from Sheridan and on parole, 56 percent were employed, while 44 percent were employed among the comparison group.[*] [50] More recently, substance-involved offenders released from Sheridan have demonstrated a 20 percent lower likelihood of returning to prison than their peers who were held at a traditional prison facility.[†] Sheridan graduates who completed aftercare had a 52

[*] This research was not published in a refereed journal; however the methods and findings of the analysis were reviewed by an advisory group made up of well-established researchers and academics from the addiction and criminal justice fields.

[†] Re-incarceration was defined as having been returned to prison for either a new crime or for a technical violation of parole as of 31 December 2008, resulting in a minimum time at risk for the Sheridan and comparison groups of 18 months and maximum of 4.5 years.

percent lower likelihood of being returned to prison than the comparison group.* [51]

Despite the enormous need for treatment and aftercare services, and successful models of treatment and transition planning,[52] such services have not been implemented as standard practice.

The Second Chance Act

To address the reentry needs of offenders, Congress enacted the Second Chance Act which was signed into law in April 2008. The goal of this legislation is reduction of recidivism among convicted criminal offenders. The Act calls for the creation of a Federal prisoner reentry initiative, changes the amount of time a federal inmate is entitled to be considered for pre-release placement in community confinement/ service participation from six months to 12 months, and makes aftercare a mandatory requirement for all grant recipients. Grant recipients are required to develop strategic reentry plans containing measurable annual and five-year performance outcomes.[53]

The Second Chance Act authorizes up to $165 million a year† for an array of programs--from employment services to housing to treatment for SUDs. It also authorizes funding for demonstration treatment initiatives, mentoring and transitional service projects for ex-offenders through partnerships with local corrections agencies and community organizations.‡ In fiscal year 2009, Congress only appropriated $25 million dollars for Second Chance Act programs: $10 million in grants for nonprofit organizations providing mentoring and transitional services and $15 million for state and local reentry demonstration projects.[54] Appropriations for this program for 2010 will provide an increase of $75 million over 2009.[55]

* Sheridan inmates who did not complete aftercare actually had a higher likelihood of being returned to prison than the comparison group. This pattern is likely due to the fact that failure to comply with aftercare among the Sheridan ex-inmates is a technical violation of parole and, therefore, might increase the likelihood of return to prison relative to the comparison group, who generally were not subject to mandatory treatment requirements. Also, two critical characteristics--treatment need and motivation/desire for treatment--could not be statistically controlled for between the Sheridan and comparison group inmates. While it would be expected that there would be similarities between the two groups in terms of treatment *need*, given how closely matched they were across almost every characteristic, what cannot currently be determined is the desire for treatment among the comparison group. These data were currently being collected and were therefore not yet available for inclusion in the analyses. Although these findings are preliminary and limited by the inability to account statistically for differences in treatment motivation among the comparison group, they are consistent with the growing body of literature regarding the improvement in recidivism outcomes when prison-based TC participation is following by community-based aftercare.

† Subject to the availability of appropriations.

‡ Funding for research on prisoner reentry, parole and probation violations, best practices for addressing the needs of children of incarcerated parents and the effectiveness of injection naltrexone for treating heroin addiction was also authorized.

Chapter VII
Overcoming Barriers to Intervention and Treatment

> *We know that most of our prisoners are addicts, yet we contain them with no access to treatment in facilities where they continue to abuse drugs and harm themselves. Then we release them and expect them to be fully rehabilitated. How can we be so stupid? How can we, as intelligent people, sit on the sidelines and watch our tax dollars wasted this way every year? Why aren't we outraged?*[1]
>
> Monday, March 2, 2009
> --Terry M. Rubenstein, Executive Vice President of the Joseph and Harvey Meyerhoff Family Charitable Funds

In the face of available evidence that addiction is a medical condition, that there are effective treatments, that failure to provide treatment contributes to mortality and morbidity, and that the criminal justice system can deliver such treatment, withholding such services makes no sense. It also is fiscally irresponsible.

In all cost-benefit analyses of criminal justice-based treatment, the monetary benefits of treatment outweighed the costs. Overcoming the barriers to addressing the substance use issues of the criminal justice population can save billions in government dollars each year. Providing the most comprehensive option of prison-based treatment and aftercare for offenders with substance use disorders who are not now receiving treatment would cost an additional $9,745 per inmate. Such an investment would more than pay for itself one year post release if less than 11 percent of those who receive such services remain substance and crime free and employed. For each additional year that a former inmate stays substance free and crime free and employed, society would receive a net economic benefit of approximately $90,953.

There are many forces that contribute to a failure of leadership and drive government decisions to limit resources to address the substance use disorders of inmates. Fortunately, there is some good news; mandatory sentencing practices are being reversed and public sentiment has changed about the value of treatment for offenders with substance use disorders. It is time for public policy to catch up with science and public opinion.

In order to meet the health needs of substance-involved offenders and reduce crime and its costs to society, the criminal justice system must address risky substance use as a preventable health problem and addictive disorders as medical problems. This will involve training criminal justice personnel on how to screen all offenders for substance use problems; providing

evidence-based treatment, support services and aftercare to all incarcerated offenders with substance use disorders; and providing effective treatment-based alternatives to incarceration.

Barriers to Intervention and Treatment for Substance-Involved Offenders

Government inertia and a failure of leadership to address the widespread problem of substance-involved offenders can be attributed to many factors including mandatory sentencing policies that eliminate the possibilities of alternative sentencing and/or parole, lack of a clear legal mandate to provide treatment, economic interests in prison expansion and the failure of public policy to reflect changing public attitudes about addiction and justice.

Mandatory Sentencing

In the 1970s and 1980s, scholars and politicians alike advocated for harsher punishment and deterrence policies instead of rehabilitation.[2] Criticisms of rehabilitation gained public support as correctional ideals seemed to be abandoned in exchange for a more punitive stance.[3] This distrust in rehabilitation was fueled by the crack-cocaine epidemic of the 1980s which prompted politicians to enact mandatory and lengthy minimum prison sentences for drug offenders.[4]

Public desire for more comprehensive punitive sanctions against criminal offenders contributed to some of the toughest penalties America had ever put into practice.[5] Mandatory sentencing laws that compel judges to deliver fixed prison sentences to convicted offenders regardless of mitigating circumstances became very popular during the period of skyrocketing drug crime in the 1970s and 1980s.[6] Sentences under federal and state mandatory guidelines were based on the weight and type of the drugs and vary from five years to life in prison.[7]

One form of mandatory sentencing is the "three strikes" laws that require lengthy incarceration of chronic offenders who have been convicted of a serious criminal offense on three or more separate occasions.[8] Offenders who were substance involved disproportionately bore the burden of the increased punitive environment. A 2003 study reported that more "third strikers"* in California were serving such a sentence for drug possession than for second-degree murder, assault with a deadly weapon and rape combined.[9]

> *…the war on drugs…soon will mark its 39-year anniversary. Few public policies have compromised public health and undermined the fair and effective functioning of the justice system for so long.*[10]
>
> --American Judicial Society Editorial, 2009

Mandatory sentences, as applied in practice, not only result in prison overcrowding, they unfairly target disadvantaged minority groups.[11] Federal mandatory sentencing laws enacted in 1986 and 1988 required a five-year mandatory sentence for the sale of 500 grams of powder cocaine and the same five-year mandatory sentence for only five grams of crack cocaine. Since users of crack cocaine concentrated in inner city neighborhoods and consumers of powder cocaine were more likely to come from better off communities, significant racial disparities occurred.[12] While blacks represented 43 percent and whites 55 percent of drug felons convicted in state courts in 2002, blacks accounted for 53.5 percent and whites accounted for 33.3 percent of drug felons serving time in state prisons in 2003.[13]

CASA recommended in its 1998 *Behind Bars* report that mandatory minimum sentences that eliminate the possibilities of alternative sentencing and/or parole be modified. Since that time there has been substantial movement toward eliminating this barrier to addressing the needs of substance-involved offenders. Judges and prosecutors have found ways to circumvent these mandatory provisions, departing downward from sentencing guidelines and mandatory minimum sentences in 44 percent of

* Imprisoned for longer periods for a third felony.

all federal drug sentences between 1999 and 2001.[14] Between 2001 and 2002, 20 states either proposed or had already taken steps to reduce sentences, replace prison time with drug treatment or return some discretion to judges.[15] Public sentiment appeared to support these changes. A *New York Times* poll in 2002 reported that 79 percent of New Yorkers favored the restoration of sentencing discretion to judges in drug cases.[16] New York does not appear to deviate from national norms when it comes to attitudes towards drug treatment for offenders.[17]

It has become standard practice in drug cases for defendants to be offered a lighter sentence in exchange for a guilty plea, sparing taxpayers the expense of a trial.[18] For example, in 2004 in Maryland, 71 percent of drug cases settled by plea* received sentences below the state guidelines.[19] From 2001 to 2005, 39 percent of drug offenders who would have been sentenced to prison under Minnesota sentencing guidelines were instead placed on probation. Thirty-seven percent of Minnesota drug offenders who were sentenced to prison received sentences below that state's guidelines.[20] Of the almost 70,000 federal drug sentences imposed between 1999 and 2001 with complete sentencing information, almost half fell below sentencing guidelines. Twenty-eight percent (19,107) departed from guidelines because offenders provided substantial assistance to the prosecution and 16 percent (10,891) departed due to other reasons, such as plea agreements, judges' consideration of mitigating circumstances and fast track programs initiated by prosecutors for low-level drug offenses.[21]

In January 2005, the Supreme Court ruled that federal judges are no longer bound by mandatory sentencing guidelines but need only consult them when they punish federal criminals.[22] The Court decided that the administration of the mandatory sentencing guidelines violated defendants' right to a jury trial because imposed mandatory sentences were not based on a jury's finding of facts beyond a reasonable doubt. Under the ruling, federal judges are free to decide for themselves whether defendants deserve sentences longer or shorter than the ranges prescribed by the guidelines, but their decisions will be subject to reversal if appeals courts find them unreasonable.[23]

Two years later, in December 2007, the U.S. Sentencing Commission unanimously agreed to allow federal inmates serving crack cocaine sentences to seek sentence reductions retroactively. As of July 2008, 10,707 federal prisoners applied for the retroactive reduction of their sentences, and 8,147 (76.1 percent) were granted the approval. Federal courts now administer the application of the retroactive guideline, which is not automatic. In fact, courts refused to grant sentence reductions to 2,560 (23.9 percent) applicants.[24]

The highly publicized 2009 decision of the State of New York to reform the Rockefeller Drug Laws was the next step in the growing movement to rethink how our nation deals with non-violent drug offenders. The changes in New York included the elimination of mandatory minimums and a return to judicial discretion in the sentencing of most drug cases, the expansion of drug treatment and alternatives to incarceration, and the re-sentencing of some incarcerated people who were serving sentences under the old Rockefeller laws.[25]

The return to judicial discretion gives judges the flexibility to link sentences to effective treatment for substance use disorders.

Lack of Clear, Legal Mandate to Provide Treatment

Federal, state and local governments are constitutionally required to provide health care to inmates.[26] In the 1950s, the American Medical Association recognized alcohol addiction as a disease;[27] nonetheless, historically there has been a debate about whether prisons and jails are constitutionally or legally required

* Without a specific agreement with the prosecutor or judge.

to provide treatment for mental health disorders to incarcerated offenders.[*] [28]

In *Marshall v. United States* (1974), the Supreme Court determined that an inmate was not constitutionally entitled to drug treatment. The basis for this ruling was that there was no medical consensus at that time as to the efficacy of known addiction treatment methods and the prospect for the successful rehabilitation of substance-involved offenders largely was shrouded in uncertainty.[29]

Two years later, however, the Supreme Court ruled that correctional administrators cannot ignore the "serious medical needs" of an inmate.[30] In 1992, a federal Court of Appeals ruled that a serious medical need would be a critical medical condition that if left untreated could further exacerbate significant injury, impair daily activities or result in chronic and substantial pain.[31] Some legal experts interpreted this ruling in the 1990s as indicating that addiction treatment for incarcerated offenders is constitutionally mandated only when there could be acute and life-threatening consequences of non-treatment.[32]

Inmates' rights to medical care for withdrawal symptoms and other medical conditions derived from substance misuse and addiction repeatedly have been upheld in *United States ex rel. Walker v. Fayette County, PA*, (1979) and *Pedraza v. Meyer* (1990). For example, when an inmate has been put on opiate maintenance treatment, correctional authorities have been mandated by courts to provide medical care for the individual's withdrawal symptoms, but the continuance of maintenance treatment would not be compulsory.[33]

Paradoxically, screening for substance use problems has had stronger case law support than substance related treatment because correctional authorities are entrusted with the responsibility of detecting and controlling life-threatening medical conditions among prison or jail inmates.[34] Withdrawal symptoms or other medical conditions resulting from substance misuse may be deemed life-threatening in some instances. Despite the existence of a body of case law in this area, there has not been significant use of screening of the inmate population to detect substance use problems.

More progress has been made on the issue of smoking. In 1993, *Helling v. McKinney,* inmate McKinney sued correctional officials of the State of Nevada for showing deliberate indifference to his health by forcing him to share a cell with a fellow inmate who smoked five packs of cigarettes a day. The Court ruled that exposure to conditions that posed an unreasonable risk of serious damage to any inmate's future health constituted a cruel and unusual punishment.[35] Following the decision, prisons had to acquiesce to an inmate's demands for non-smoking living quarters if the inmate could prove their cellmate's smoking was detrimental to their future health. Nevada had already begun to try and separate smoking and non-smoking inmates before the case even reached the Supreme Court. The recent sea change in public opinion about the negative effects of second-hand smoke appears to have encouraged smoking bans in prisons and jails.[36]

In the mid-1990s, courts ruled that special privileges (e.g., family visitation, transfer to lower security units, increased opportunities to earn parole) could not be contingent upon coerced participation in religious or spiritually-based mutual support programs such as Alcoholics Anonymous or Narcotics Anonymous, as it violated the separation of church and state.[37]

Since these rulings, however, science has demonstrated that addiction is a brain disease, and that addictive substances activate and disrupt normal chemical functioning in the reward centers of our brains, and essentially

[*] In the case of mental health care, the Supreme Court's rulings in *Pugh v. Locke* (1978) and *Bowring v. Godwin* (1977) specifically required the provision of psychological and/or psychiatric services, while the *Washington v. Harper* (1990) case sustained incarcerated inmates' rights to decline mental health care. No case yet identifies specific steps to assure that that the guidelines set forth in these suits are followed (McLearen & Ryba, 2003).

"hijack brain circuits that exert considerable dominance over rational thought, leading to progressive loss of control over drug intake in the face of medical, interpersonal, occupational and legal hazards."[38] Untreated, addiction causes and contributes to more than 70 other medical conditions requiring hospitalizations and increasing the risk of illness and death.[39] Research has demonstrated that there are effective strategies to initiate and maintain the recovery process,[40] and that the criminal justice system has proved to be a competent sponsor of successful treatment.[41] Research has demonstrated further that incarceration for crimes committed is compatible with rigorous corrections-based treatment[42] and that investing in treatment will yield reductions in crime and much greater social and monetary benefits to society than relying on incarceration alone. (See Chapters V and VI)

A 2009 Human Rights Watch publication argued that recent advances in our understanding of addiction obligate us to revisit the issue of addiction as a medical illness.[43] The courts have been one of the most successful catalysts of criminal justice reform in the U.S. The convergence of new findings in addiction science with the burgeoning inmates' rights movement has created an unprecedented opportunity to mobilize judicial power to intervene on behalf of inmates suffering from substance use disorders. Litigation or the threat of litigation can provide correctional authorities with a basis for demanding more resources and stimulate innovative ideas about treatment alternatives to incarceration that have proven effective even among chronic felons.[44]

Economic Interests in Prison Expansion

A side effect of the massive reliance on incarceration to fight the war on drugs has been the rise of the private prison industry and the economic dependence of economically disadvantaged communities on prison expansion. As the inmate population exploded following the outbreak of the crack-cocaine epidemic, prison privatization provided an expedient remedy for prison overcrowding. The period from 1984 to 1998 marked the prime of the private prison industry, whose growth has since slowed.[45] By 2006, the proportion of all inmates in federal and state prisons housed in privately operated facilities reached 7.2 percent.[46] The private prison firms, including the Corrections Corporation of America and the Wackenhut Corrections Corporation, have become aggressive lobbyists for tough sentencing laws and major sources of campaign contributions in state politics.[47]

The more than 1.6 million Americans behind bars in federal and state prisons in 2008[48]--the majority of them substance-involved offenders--also mean jobs for economically depressed communities. Some local economies that were dependent on manufacturing and agriculture have experienced steep declines in employment opportunities. In turn, this trend has contributed to a dramatic change in attitudes towards prison-building as a way to create relatively secure, decently paid jobs with health benefits and pensions.[49] The numbers of Americans employed by federal, state and local corrections agencies soared by 119.5 percent in the last two decades, from 348,800 in 1984 to 765,500 in 2006,[50] providing a strong voice against the closing of prisons.

The recent economic downturn adds further strength to the struggle between controlling costs in the justice system and maintaining jobs in the prison industry.[52]

> *The lure of big money is corrupting the nation's criminal-justice system, replacing notions of public service with a drive for higher profits.*[51]
>
> --Eric Schlosser, Journalist
> Atlantic Monthly

Attitudes about Addiction and Justice

Despite scientific recognition that addiction is a chronic disease,[53] this knowledge does not seem to have extended to many policymakers, many in the court system, or even to many of the medical staff of our nation's correctional facilities.[54] Molecular and imaging studies show that addiction is a brain disorder with a strong genetic component.[55] Too often,

however, elected officials, prosecutors and judges, and correctional staff view the concepts of treating addiction as a disease and of holding people accountable for crimes they commit that are linked to their addiction as mutually exclusive.

This collective passion for harsh punishment over rehabilitation and the readiness of the state to incarcerate an unprecedented large number of citizens made penal populism a hallmark of American society among industrialized democracies.[56] Indeed, compared with other countries, more Americans are incarcerated for nonviolent crimes such as minor property offenses and drug use.[57] Prison sentences also are longer in the U.S. than in other countries.[58] Some states and local jurisdictions also punish former prisoners by revoking their eligibility for public assistance, public housing, and financial aid for college; many states also prohibit former inmates from working in many public sector jobs.[59]

The challenge for policymakers, the courts and correctional system medical staff is to understand that individuals suffering from the disease of addiction must be treated as they would be for any other health condition. At the same time, these same individuals should be held accountable through the justice system for criminal behavior linked to alcohol and other drug misuse.

A number of surveys have shown that most Americans support addiction treatment and, when adequately informed, most respondents reject the idea of returning prison and jail inmates to the community without making a conscientious effort to treat the condition and thus reduce the risk of recidivism.[60] In a recent survey, 82 percent of Americans believe that addiction is a chronic health condition that requires long term management and support.[61]

In 2006, the majority (58 percent) of Americans believed our top priority for dealing with crime should be prevention or rehabilitation rather than enforcement (39 percent)--as in more police officers, or punishment, with longer sentences and more prisons.[*] Individuals who were considered informed[†] about the current state of crime in the U.S. favored prevention and rehabilitation by an even wider margin (68 percent versus 30 percent). Eighty-eight percent of Americans believed non-violent drug offenders should often or sometimes be placed in treatment and counseling programs as an alternative to prison, and 78 percent agreed that drug courts were a better way to sentence offenders than the regular court system.[62]

According to another poll[‡] conducted the same year, 87 percent of American voters favored making rehabilitative services available to offenders during incarceration, after release or during both periods. Only 11 percent of voters favored a purely punitive approach. More than half of voters reported that access to job training, mental health services, family support, mentoring and housing are very important components of a person's successful reintegration into society following incarceration. Drug treatment was cited by 79 percent of voters as very important as well. Less than 10 percent of voters believed these services were not important.[63]

One issue that stands in the way of assuring appropriate health and related services for substance-involved offenders is public attitudes

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[*] According to a survey commissioned by the National Center for State Courts; the survey, conducted in spring 2006, was given to a nationally representative sample of over 1,500 adults.

[†] A crime knowledge index was created by combining survey respondents' answers questions related to these three topics: 1) recent trends in the overall crime rate; 2) recent trends in the violent crime rate; and 3) the U.S. incarceration rate vs. that of other countries. Those who answered at least two of these questions correctly and none incorrectly were classified as "informed." Those who had more wrong answers than right answers were classified as "misinformed." The remainder was classified as "uninformed," and less likely to give answers to these questions.

[‡] The National Council on Crime and Delinquency commissioned Zogby International to conduct a nationally representative public opinion poll in 2006. The sample consisted of more than 1,000 U.S. voters.

about race, crime, and substance use that often conflict with the facts. Although a nationally representative survey of white Americans found that most prefer drug treatment or probation to incarceration for individuals who have been found, for the first time, to be in possession of five grams of cocaine, those who favored prison sentences were likelier to make moral judgments about those with substance use disorders and to believe (inaccurately) that blacks are likelier than whites to use cocaine that is snorted or injected.[64]

Public perceptions of racial/ethnic minorities who are incorrectly thought to be more likely to engage in drug use help fuel punitive and ineffective drug policies in the United States.[65] These perceptions extend to individuals working in the criminal justice system. A Northwestern University research team examined 200 cocaine cases from Dorchester County, MA--one-half of the cases involved black and Hispanic arrestees, the other involved white arrestees. They found that minority offenders arrested inside a drug-free zone[*] were more likely to be charged with distribution/intent, a crime that carries enhanced penalties, than white offenders who committed the same crimes. Minorities described in police reports as sellers, carriers or drivers all were more likely to be charged with distribution/intent than similarly described whites.[66]

Overcoming Barriers to Intervention and Treatment for Substance-Involved Offenders

Overcoming these barriers will require political leadership and action on the part of federal, state and local policymakers to train criminal justice personnel to respond appropriately to substance-involved offenders. It will require screening and early detection of risky substance use and substance use disorders and providing evidence-based treatments and aftercare, either as alternatives to or in conjunction with incarceration. It also will require providing education, training and employment to offenders post release.

Training Criminal Justice Personnel

A key first step in overcoming the barriers to treatment in the justice system is to increase training of police, prosecutors, judges and other criminal justice personnel in order to equip them to deal more effectively with substance-related crime. CASA recommended in its 1998 *Behind Bars* report incorporating educational components focusing on the prevention and treatment of addiction into the training curriculum of criminal justice personnel. While some progress has been made in the educational curriculum for probation and parole officers,[67] CASA was unable to find evidence of improvement in the substance-related education of corrections officers and administrators or of corrections medical staff.

In 2002, 34 states required their correctional institutions to perform both punishment and rehabilitation through formal statutes;[68] yet, the basic structure and functional goals of the corrections system largely are at odds with the goals of rehabilitation and treatment. The personnel composition, the recruitment requirements and the physical arrangement of correctional settings almost exclusively are focused on ensuring the effective custody and control of incarcerated offenders; there is virtually no attention to treatment and rehabilitation. For example, as of 2007, 39 state correctional agencies required only a high school diploma or GED for entry-level correctional officers.[† 69] If states were focused on rehabilitation and treatment as well, they

[*] Drug zones range from 300 feet (MN, NC & RI) to three miles (AL) and cover areas surrounding schools and other locations, varying by state (such as parks, housing projects, public pools, etc). Individuals caught committing drug offenses in drug-free zones face substantially increased penalties. The types of offenses carrying enhanced or additional penalties also vary across states; as do the penalty differences between drug crimes committed in and out of the designated zones.

[†] One state had no educational requirements, two states required only that officers pass a written exam and six states did not participate in the survey. Only two states reported that some college was required.

could be expected also to hire individuals with more advanced training in these areas. Multi-state surveys have reported that even professionals working in prison-based treatment settings experience an unusually high rate of job burnout.[70]

Early Detection

CASA recommended in its 1998 report screening of arrestees for risky substance use and substance use disorders.[71] Since that time, the value of screenings, brief interventions and referrals to treatment has been demonstrated in many settings.[72] This approach can reduce risky and costly substance misuse and identify those who need treatment. Early detection followed by appropriate interventions and treatments are key to preventing future substance-related crime.[73]

Drug testing also is a tool for early detection. Pretrial programs have used drug testing to predict and reduce pretrial misconduct. A number of evaluations of pretrial drug testing programs in the late 1980s and early 1990s showed that drug tests results were predictive of pretrial misconduct in certain jurisdictions but that the testing itself did not deter defendants' failure to appear in court.[74]

Although highly accurate and efficient screening methods have been developed for adult arrestees,[75] subjecting non-convicted adult criminals to mandatory screening or drug testing has been implemented in only a handful of jurisdictions.[76] This is due in part to questions raised about constitutional protections from unreasonable search and seizure and the legal assumption of innocence.[77] To date, courts have upheld the constitutionality of pretrial drug testing while requiring that collection and testing procedures meet the legal test of reasonableness.[78]

Rather than using screening or drug testing alone as deterrents, they more appropriately can be used to identify those in need of intervention or treatment and to target services in order to reduce risky and dependent substance use, reduce prison overcrowding, and save taxpayer money.[79]

Treatment and Aftercare

As discussed in Chapters V and VI, a substantial body of knowledge exists to guide the provision of effective treatment for substance-involved offenders, assure that treatment is tailored to the race/ethnicity and gender of inmates, address their co-occurring health and mental health problems, and increase the chances of reentry into the community and reduce recidivism.

An example of tailored treatment is family-based treatment programs that have proven effective for serving the special populations of substance-abusing juveniles and female offenders with children.[80] The geographic remoteness of most correctional facilities is an obstacle to the goal of more widespread implementation of family counseling in prisons and jails.[81]

Aftercare for alcohol and other drug treatment can be provided by the Veterans Administration (VA) for inmates who are veterans upon release. State and federal corrections systems can assist in verifying VA eligibility and can then transfer aftercare responsibility to a VA medical center.[83] To this end, the State of Florida has developed a Memorandum of Understanding with the U.S. Department of Veterans Affairs.[84]

Agreement between the Florida Department of Corrections and the U.S. Department of Veterans Affairs, Veterans Integrated Service Networks (VISN) 8 and 16

The purpose of this Agreement is to establish the general conditions and joint processes that will enable the Department (of Corrections) to collaborate as partners with the VA to implement effective re-entry programs and services for current inmates identified as military veterans who will be potentially eligible for VA care and services upon their release from incarceration, and such military veteran offenders that are on community supervision after their release.[82]

--Secretary Walter A. McNeil
Florida Department of Corrections

Alternatives to Incarceration

The use of treatment alternatives to incarceration has gained momentum in the past decade as witnessed by a rapid expansion of drug treatment courts, prosecutorial diversion programs and treatment interventions supervised by probation and parole; the accumulation of related evaluation studies; and the emergence of advocacy coalitions for treatment alternatives. These criminal justice innovations make treatment for substance use disorders a central component, establish collaboration between justice authorities and treatment providers and hold the offender legally accountable for treatment compliance.

Despite the encouraging growth of diversion and treatment opportunities and evidence of their cost effectiveness, still only a fraction of substance-involved offenders have benefited from treatment alternative programs. For example, of the 1.5 million arrestees likely to have substance use disorders, the Urban Institute's Justice Policy Center estimates that just over 109,900 meet current eligibility requirements for drug court yet there were only 55,300 available drug court slots.[85]

> *No one wants fewer people in prison than the people who run prisons. We get paid the same whether there are 10,000 or 5,000 prisoners, and I'd much rather have 5,000.*[86]
>
> --Commissioner Martin F. Horn
> New York City Department of Corrections

Probation. Deferred, low-probability threats of severe punishment are the basis for most probation systems in the country, yet these systems tend to let repeated violations go unpunished. When punishments eventually are assigned, they tend to be lengthy and expensive sentences. In 2004 Circuit Judge Steve Alm, with the help of other criminal justice and drug treatment professionals, created Hawaii's Opportunity Probation with Enforcement (HOPE) program. The program targets offenders at risk of having their probation revoked. Program participants are informed at

Brooklyn Treatment Court

Judge Jo Ann Ferdinand of the Brooklyn Treatment Court reports that the women who came to her court tended "*to have more serious addictions than the men, have lost more in their lives and have fewer resources*." Female participants also were waiting twice as long as their male counterparts to enter treatment, leading to poorer outcomes. Her court took steps to address the distinct problems facing female substance-involved offenders, including:

- Expanding their intake form from eight to 25 questions to better identify psychological problems and adding items to help reveal sexual and emotional abuse;
- Hiring a Psychiatric Nurse Practitioner to conduct on-site examinations which cut out weeks of wasted time and helped prevent participants from losing their motivation to change their behavior;
- Creating a course of treatment catering to women with less severe co-occurring psychological disorders which incorporates individual psychotherapy, support groups, parenting classes and therapy sessions for mothers and their children;
- Establishing an on-site health clinic to address other medical problems women are more likely to face, for instance 10 percent of female participants vs. three percent of male participants reported having the HIV virus;
- Linking their program with the Brooklyn Family Court and the City's Administration for Child Services so case managers can help mothers navigate both systems and reestablish contact with children placed in foster or kinship care;
- Hiring a vocational counseling specialist to help participants build job-readiness skills, find employment and find childcare options;
- Creating adjunct programs to encourage lower-level offenders to enter treatment and provide poor performing participants a last chance through an in-prison TC program.[87]

warning hearings that the rules of probation will be strictly enforced using immediate and high-probability threats of mild punishment and that they will be required to submit to weekly or bi-weekly random drug tests. Probation violations and failed drug tests lead to swift arrests and short stays in jail, as little as two days. Sentence length increases for each successive violation.[88]

Probationers who continually are unable to comply on their own are required to enter treatment. Treatment services are available to all HOPE probationers on a voluntary basis.[89]

Preliminary results from a randomly assigned comparison showed that six-months after starting the program, HOPE participants reduced their missed appointments by 85 percent and their positive urinalyses by 91 percent. The threat of consistent sanctions alone was enough to deter the drug use of 60 percent of program participants. The rearrest rate of a comparison group of probationers was three times higher than for HOPE participants, and the comparison group's arrest rate for non-technical violations was 111 percent higher than HOPE participants. HOPE probationers also were significantly less likely to have their probation revoked (nine percent vs. 31 percent).[90]

Prosecutorial-based Diversion. Experience with alternatives to incarceration such as the Brooklyn Drug Treatment Alternatives to Prison Program (DTAP) shows that eligibility can safely be expanded to a broad range of offenders.[91] The Brooklyn DTAP program is a residential drug treatment program with educational, vocational and social support services for non-violent, drug addicted, repeat felony offenders. It was one of the first residential drug treatment programs directed at drug sellers who also are drug dependent. A five year evaluation conducted by CASA found that on average DTAP participants had five previous drug arrests and had spent four years behind bars.

The program originally was designed to defer prosecution but was changed to a deferred sentencing program. The defendant pleads guilty to a felony but sentencing is deferred pending completion of the DTAP program at which point the guilty plea is withdrawn and the charges are dismissed. Failure to complete the program results in sentencing on the outstanding charges.

CASA's evaluation found that DTAP graduates compared with a matched group at two years post-program or post-release had 33 percent lower rearrest rates (39 vs. 58 percent), and were 87 percent less likely to return to prison (two vs. 15 percent). DTAP participants also were three and a half times likelier to be employed than they were before arrest. These results were achieved at about half the average cost of incarceration.[92]

Drug Courts. The drug treatment court movement that began in 1989 provides another sign of change in American drug policy. Drug courts were developed as alternative-to-prison programs for non-violent substance-involved offenders that integrate treatment for substance use disorders, mandatory drug testing, sanctions and incentives, and transitional services in a judicially supervised court setting.[93] Substance-involved offenders are generally referred to these programs by judges, attorneys or law enforcement personnel.[94] Participants are then put on probation while they attend treatment* and regularly scheduled monitoring sessions with court and treatment staff. Upon program completion, offenders may have their charges dropped, probation rescinded or have their original sentences reduced.[95] Usually program dropouts face the threat of imprisonment.[96]

As of 2009, there were more than 2,000 drug courts serving just under half of the counties in the United States.[97] According to an analysis by the Government Accountability Office, drug court participants are rearrested and reconvicted fewer times for fewer felonies and drug offenses than their peers. While, most drug courts resulted in higher court costs than standard criminal justice services, all the programs that tracked costs and savings from reduced criminal justice and victimization costs resulted in

* Treatment modalities differ based on programs' specific requirements.

positive net benefits, ranging from $1,000 to $15,000 per participant.[98]

> *For the addicted and the alcoholic, a traditional approach of incarceration or regular probation, whether long- or short-term, does not provide the impetus for the change necessary to stop the criminal behavior. Incarceration is not a cure for addiction. In sharp contrast, the intensive therapeutic approach of drug treatment courts--using aggressive drug and alcohol testing, mandatory treatment, and continual monitoring--can in fact engineer the changes necessary to break the cycle of criminal behavior and transform lives.*[99]
>
> --The Honorable Patrick C. Bowler

The Multnomah County STOP drug court that has served Oregon for more than 18 years has undergone multiple comprehensive reviews and demonstrated exceptional results. During its first 10 years of operation, 6,502 offenders participated in the Multnomah drug court. Five years after entering the STOP program offenders, on average, are rearrested less often (four arrests vs. six arrests) and spend fewer days in jail (46 days vs. 75 days), prison (80 days vs. 105 days) or on probation (529 days vs. 661 days) than their peers who go through the standard adjudication process. The avoided criminal justice costs of their drug court participation totaled more than $50 million. The reductions in violent and property crime also resulted in $35 million in avoided victimization costs bringing the total savings to $85 million.[100]

Driving Under the Influence (DUI) Courts use a drug court model to deter repeat DUI offenders from continuing to drink and drive by providing them with treatment in lieu of traditional sentencing procedures.[101] DUI participants from DUI Courts across the country are three times less likely to be rearrested and 19 times less likely to be rearrested for a DUI compared to their peers who receive traditional probation.[102] The cost-effectiveness of DUI Courts has not been well established in general; however research suggests that the program is an effective alternative when focused on serving repeat offenders with at least two prior DUI arrests.[103] As of 2007 there were only 110 designated DUI Courts and 286 DUI/Drug Court hybrids in the country, leaving room for program expansion.[104]

California's Substance Abuse and Crime Prevention Act. One example of a statewide approach to providing alternatives to incarceration for substance-involved offenders was the passage of California's Substance Abuse and Crime Prevention Act (SACPA, also known as Proposition 36).[105] California voters, who in 1994 initiated the 'three strikes' movement with the passage of Proposition 184,[106] approved SACPA by 61 percent in 2000.[107] This Act went into effect in July 2001, with $120 million for treatment services allocated annually for five years. It allows first and second time nonviolent, simple drug possession offenders the opportunity to receive treatment for substance use disorders instead of incarceration.[108]

The diversion of prison-bound offenders to community-based drug treatment facilities added 80,000 SACPA admissions to California's licensed treatment system during the first two years of implementation. Under such a sudden increase in treatment demand, most SACPA clients were diverted to outpatient treatment which was a more affordable but an inadequate modality of intervention for some addicted offenders, such as those who are homeless or who have a co-occurring mental health disorder and require more structured care. Whereas the reliance on outpatient treatment may have allowed California's treatment system to absorb effectively SACPA clients without dramatically increasing its staffing and service capacities, researchers concluded that the availability of treatment slots for non-SACPA clients may have declined in most California counties due to the displacement of voluntary non-SACPA clients by SACPA clients.[109]

While similar legislative or referendum initiatives have been considered in at least 15 other states,[110] they failed in many of these states. In 2009, California lawmakers cut SACPA funding by 83 percent, or $90 million, due to growing budget constraints.[111]

The Promise of Rehabilitation

Years after SACPA went into effect, California voters were rewarded with reduced prison admissions for drug possession.[112] SACPA demonstrated that the positive impact of diverting drug offenders to treatment is greater than the impact of using incarceration to prevent drug-related crime.[113] SACPA saved the State of California $173 million on the first-year cohort alone through reduced jail and prison admissions, and increased tax revenues.[114]

Kansas-Alternative to Incarceration for Drug Possession Cases. Kansas enacted Senate Bill 123 in 2003, providing an alternative to prison for individuals charged with possession of illegal drugs. Program eligibility includes nonviolent offenders with first- or second-time possession charges (excluding first-time marijuana possession). In lieu of prison, offenders attend a state certified drug treatment program.[115]

Eligible offenders are given a standardized substance misuse assessment by a trained and certified treatment provider and a standardized risk assessment by a court services or community corrections officer. Based on these assessments, sentencing courts determine the proper length and modality of treatment programs and community supervision (not exceeding 18 months). While in treatment, offenders with a high risk of leaving the program and recidivating will be supervised by community correctional services and low-risk offenders will be supervised by court service officers. Community corrections staff also work with treatment staff to ensure the effective supervision of offenders.[116]

Kentucky's Diversion Program. In early 2009, new legislation was enacted in Kentucky that allows substance-involved offenders to participate in diversion programs in lieu of their trial and potential prison sentences. Felony substance-involved offenders can receive pre-trial screenings; those with recent substance use problems can volunteer to enter a secure treatment program for a period of at least 90 days, but no more than one year. Following treatment completion, participants are provided with an aftercare plan including a referral to local treatment providers appropriate to their needs. Kentucky law makers included a provision that allows participants who choose to leave the program to count their time participating in the program toward their new prison sentence.[117] This component addresses the controversial practice, traditionally enacted by some drug courts and diversion programs, of sending treatment drop-outs to prison to serve the entirety of the sentence resulting in longer periods of court custody.[118]

We are never going to build our way out of there being crime. We don't want to put that many people in jail, and we can't afford to.[119]

--Chief District Court Judge Joseph Turner, Guilford County, NC

Education, Training and Employment

Assuring that the education, training and employment needs of offenders are met is an essential component of recovery and long term disease management.[120] One promising practice is California's New Start prison-to-employment program which is based on the State's recognition that key to increasing public safety is employment of parolees. To increase the likelihood that parolees will obtain and retain jobs, the State has strengthened the link between in-prison rehabilitation programs and employment by:

- Using labor market data to determine the types of jobs that will actually be available in each county;
- Matching training and work opportunities in prison to jobs available in communities;
- Providing documents needed to secure employment prior to release from prison (e.g., social security card, birth certificate, selective service registration, etc.);

- Providing essential job prerequisites such as resumes, trade certificates, licenses, trade union membership, etc.; and

- Providing support to seek, secure and maintain employment through a collaborative partnership with the community.[121]

Recognizing the importance of education to reduce recidivism, New Jersey recently enacted legislation requiring that incarcerated individuals attain the 12th grade education proficiency level.[122]

Table 7.1
Direct Financial Costs Associated with the Incarceration of Substance-Involved Offenders, 2006

	Federal (190,844)	**State** (1,302,129)	**Local** (766,010)	**Total** (2,258,983)
Number of substance-involved inmates	164,521	1,101,779	648,664	1,914,964
Annual prison cost per inmate	$27,247	$27,370	$20,769	$25,144
Total annual incarceration costs for substance-involved inmates	$4.48 billion	$30.16 billion	$13.47 billion	$48.11 billion

Source: *Compensation Board* (2004), CASA analysis of the *Corrections Yearbook: Adult Corrections* (2002), the *Survey of Inmates in Federal Correctional Facilities* (2004), *Survey of Inmates in State Correctional Facilities* (2004), *Survey of Inmates in Local Jails* (2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in 2006*.
Note: Dollar numbers reported in the table are expressed in 2006 dollars (converted by the online inflation calculator of the Department of Labor, http://data.bls.gov/cgi-bin/cpicalc.pl).

Costs and Benefits of Treatment

In all cost-benefit analyses of criminal justice-based treatment for adult offenders that CASA could identify, the monetary benefits of treatment--including reduced crime, incarceration and health care--outweighed the costs.[123] According to a comprehensive review by the National Institute on Drug Abuse, the return of investing in treatment may exceed 12:1; that is, every dollar spent on treatment can reduce future burden costs by $12 or more in reduced substance-related crime and criminal justice and health care costs.[124]

In 2005, federal, state and local governments spent $74 billion in court, probation, parole and incarceration costs of substance-involved adult and juvenile offenders. In comparison, federal and state governments spent only $632 million on prevention and treatment for substance-involved offenders.[125] CASA estimates that in 2006, they spent approximately $48 billion alone on the costs of incarceration for prison and jail inmates. The average cost per day to house an inmate is approximately $69--$25,144 a year.[*] [126] (Table 7.1) Annual state incarceration costs range from a low of $10,700 in Alabama to a high of $65,599 in Maine.[127]

Available research of the cost of evidence-based in-prison treatment and aftercare equals an estimated $9,745 per inmate--$3,778 for in-prison treatment and $5,967 for aftercare.[†] [128] If all inmates with substance use disorders who are not receiving treatment were provided this level of care in the year before and after release, the total cost would be $12.6 billion. While such expenditures are in many cases considered prohibitive as state and county governments are struggling to catch up with ballooning prison and jail spending, such investments are the only way to curtail escalating corrections costs. Further, we would break even on this investment in one year if less than 11 percent of those receiving such services remained substance and crime free and employed--a conservative success

[*] The total average cost per day to house an inmate was computed by taking the weighted average of the federal, state and local costs.
[†] Original estimates updated to reflect cost of living increases.

rate. For each succeeding year that these inmates remained substance and crime free and employed, we would realize an economic benefit of $90,953 per inmate, including:

- $6,100 in reduced crime costs, conservatively assuming that drug-using ex-inmates would have committed 100 crimes per year with $50 in property and victimization costs per crime;
- $9,000 in reduced arrest and prosecution costs (assuming that they would have been arrested twice per year);
- $25,144 in reduced incarceration costs (assuming that one of those re-arrests would have resulted in a one year prison sentence);
- $5,937 in reduced health care costs (the difference in annual health care costs between those with substance use disorders and those without such disorders); and
- $44,772 in economic benefits (the average income for an employed high school graduate multiplied by the standard economic multiplier of 1.5 for estimating the local economic effects of a wage).

(See Appendix A, Methodology)

Even greater opportunities for cost control come from treatment based diversion programs because additional court and treatment costs generally are lower than costs of incarceration.

Some states, however, have taken the opposite approach, citing growing budget deficits as reason to cut alcohol and other drug treatment programs. It is not uncommon for governments to cut substance-related programming under the mistaken notion that such services are ancillary rather than a vital part of economic stability and public safety.

California

Substance-abuse treatment, vocational training and educational programs all scheduled to be cut back...The rehabilitation services are being slashed at the moment when they may be most needed. The state is under pressure from federal courts to reduce overcrowding driven by the high rate at which inmates return to prison after they are released.[129]

--Michael Rothfeld, Reporter
Los Angeles Times

Cost-benefit analysis studies conducted in different settings, on different samples, using different methodologies and during different historical periods consistently demonstrate robust monetary savings from treatment for substance use disorders, primarily from significant reductions in criminal justice expenditures associated with lower recidivism and in medical expenditures linked to improved health status.[130]

Vermont Initiative to Reduce Costs

Facing particularly rapid growth in its prison population,[131] the State of Vermont in May of 2008 implemented several diversion, and in-prison and reentry treatment programs for offenders with substance use disorders. These included screening and assessment of criminal offenders prior to sentencing to identify candidates appropriate for prison-based or community-based treatment, the closing and restructuring of several prisons and the establishment of a work camp where treatment for offenders with substance use disorders would be provided.[132] These measures were projected to accrue a cumulative savings of $54 million by 2018. The State also planned to invest the $3.9 million saved in the first two years of the reform in the expansion of the treatment capacity within prisons and in the community and the enhancement of community-based interventions for recidivism reduction.[133]

Chapter VIII
Recommendations for Policy and Practice

Examples of How Addiction Treatment and Aftercare Can Reduce Recidivism

- Delaware: 52 percent completing prison-based treatment and aftercare, including work release under community supervision, were likely to be rearrested five years post release compared with 77 percent not participating in the TC program or in aftercare;[1]
- California: Completion of prison-based TC treatment plus aftercare yields 8.2 percent re-incarceration within one year compared with 49.7 percent of those in control group with no treatment or aftercare;[2]
- Illinois: Completion of prison-based treatment plus aftercare yields 52 percent lower likelihood of being returned to prison than comparison group with no treatment;[3]
- New York: Graduates of prosecutorial-based diversion program were 87 percent less likely to return to prison two years after graduating the program compared with a matched group two years after leaving prison.[4]

Twelve years ago, CASA proposed a comprehensive set of recommendations for addressing the substance use problems of the criminal justice population and their resulting costs. Since that time, these recommendations have been echoed repeatedly in other policy reports, scientific guidelines and clinical manuals published by the most authoritative government agencies in the area of addiction.[5] There also has been a growing body of knowledge about the science of addiction, and increasing array of science-based interventions, many of which are referenced in this report, that demonstrate cost-effective alternatives to current incarceration policies and practices. To date, however, these recommendations and guidelines have not been adopted as mandatory practice nor have cost effective alternatives been adopted in any comprehensive way.

In fact, since CASA's 1998 call for reform, costs to government of our failure to take action have skyrocketed. In the face of these facts, continued failure to meet the health care needs of inmates with substance use disorders or to intervene with those at high risk of developing such disorders makes no sense whether one's interest is reducing crime and increasing public safety, reducing costs to government or assuring appropriate health care to those in need.

As this report shows, the facts are:

- Science has demonstrated that risky substance use is a public health problem and dependence is a medical problem.
- Failure to prevent and treat the condition increases crime and its costs to society.
- Public opinion supports treatment for substance-involved offenders.
- A range of cost effective alternatives exist.

This report is designed to demonstrate that investment in evidence-based prevention and treatment for the criminal justice population is fiscally sound and politically palatable; and to provide a strategy to assure appropriate care and treatment for substance-involved offenders and reduce substance-involved crime and its costs to society.

CASA recommends that:

The Criminal Justice System:

- Use appropriately trained health care professionals to:
    - Screen every arrestee for risky substance use and addictive disorders, including tobacco, alcohol, illicit and controlled prescription drugs; use screening results to inform decision-making in pretrial supervision and sentencing. Connect arrestees who screen positive and who are not convicted with appropriate interventions and treatments.
    - For convicted offenders who screen positive, provide comprehensive health, educational and social assessments. Based on assessment results, provide integrated services including evidence-based addiction treatment for all who need it, and appropriate care for co-occurring physical and mental health problems. Also offer and encourage participation in literacy, education, job training and parenting programs, and increase the availability of religious, spiritual, and mutual support services.
    - Offer tailored treatment and support services to substance-involved offenders, including juveniles in the adult corrections system, female offenders, inmates with co-occurring disorders, inmates with minor children, veterans and multiple recidivists.
- Expand the use of treatment-based alternatives to jail and prison, including drug courts and prosecutorial diversion programs, for substance-involved offenders.
- Eliminate mandatory sentences that eliminate the possibility of alternative sentencing and/or parole, and expand the use of supervised release.
- Keep jails, prisons and other correctional housing and facilities free of tobacco, alcohol and other drugs.
- For inmates with substance use disorders, provide comprehensive pre-release planning to assure transition to a broad range of integrated reentry services including addiction treatment and management, mutual support programs, other health care services, education and training, and family support.
- Train and assist police, prosecutors, public defenders, judges, corrections, parole and probation officers, medical directors of prisons and jails and other criminal justice personnel in best practices for recognizing substance-involved offenders and knowing how to respond.
- Recognize Fetal Alcohol Spectrum Disorder (FASD) as a mitigating factor in criminal cases, develop alternative sentencing options for those suffering from these disorders and provide individuals with FASD appropriate services and support at every point in the criminal justice process, from arrest to imprisonment to reentry.

Federal, State and Local Governments:

- Require that addiction treatment be provided in criminal justice settings, that it be medically managed and that pharmacological treatments be available.
- Require the accreditation of prison- and jail-based treatment programs and providers through organizations such as the American Correctional Association (ACA), the Center for Substance Abuse Treatment (CSAT) at

SAMHSA or the National Commission on Correctional Health Care (NCCHC). Such accreditation should require adherence to best practice standards and include periodic performance reviews by independent experts.

- Expand federal grants to states and localities for integrated evidence-based and promising practices including pre-trial jail diversion programs, prosecutorial diversion options, drug courts, prison-based treatment programs, and community-based treatment and aftercare programs for released offenders upon re-entry into the community; require and provide resources for the documentation of impact.

- Implement a large pilot program in the Bureau of Prisons and in at least one large state corrections system to offer the full range of best practices from arrest to reentry and aftercare and to document costs and benefits.

- Educate public officials about the nature of addiction, the effectiveness of treatment, the social and economic benefits of providing treatment to offenders with substance use disorders and the importance of tracking outcomes.

- Forge partnerships between criminal justice facilities on the federal, state and local levels and community-based health, education and service providers and recovery support programs to increase access to effective aftercare services, including employment, for released offenders and expand use of evidence-based practices.

- Provide family and social support, education and health services--including substance use prevention, intervention and treatment--to children of inmates.

Appendix A
Data Analysis Methodology

To conduct this study, CASA analyzed data from the following sources:

1. *Survey of Inmates in State Correctional Facilities,1991 and 2004;*[1]
2. *Survey of Inmates in State Federal Correctional Facilities,1991 and 2004;*[2]
3. *Survey of Inmates in Local Jails,1989 and 2002;*[3]
4. *Bureau of Justice Statistics, Prisoners in 1996 and in 2006;*[4]
5. *Federal Justice Statistics Program Website, data for 1998 and 2004;*[5]
6. *Crime in the United States, 1998 and 2004;*[6]
7. *Felony Sentences in State Courts, 1998 and 2004;*[7]
8. *State Court Sentencing of Convicted Felons, 2004-Statistical Tables;*[8]
9. *National Survey on Drug Use and Health* (NSDUH), *2006;*[9]
10. *Treatment Episode Data Set* (TEDS), *2006;*[10]
11. *Corrections Yearbook: Adult Corrections, 2002.*[11]

These are the most recent data sets available for this type of analysis.

Inmate Data Analysis

The *Survey of Inmates in State and Federal Correctional Facilities* (1991 and 2004) and the *Survey of Inmates in Local Jails* (1989 and 2002) were used to provide estimates of the prevalence and correlates of substance involvement and substance use disorders among prison and jail

inmates. The prevalence *rates* (i.e., percent of a specific inmate population with a determined characteristic) were derived directly from the weighted datasets.*

To calculate the prevalence *levels* (i.e., the number of inmates with a determined characteristic), CASA applied the prevalence rates obtained from the weighted datasets to the prison and jail population estimates published in *Prisoners in 1996 and in 2006* by the Bureau of Justice Statistics (BJS). This calculation provided the estimated number of inmates under each correctional authority, the estimated total number of inmates across all correctional authorities and the estimated percentage of inmates across all correctional authorities with a determined characteristic.

When individual percentages for specific correctional authorities are reported, only data from 1989/2002 (local jails) or 1991/2004 (prisons) are presented in the text and the tables. When estimates of actual numbers of inmates or percentages across all correctional authorities are reported, the 1989/2002 and 1991/2004 percentages have been applied to the 1996/2006 estimates of the prison population.

Survey of Inmates in State and Federal Correctional Facilities, 1991 and 2004

The 1991 *Survey of Inmates in Federal Correctional Facilities* (SIFCF) was conducted for the Bureau of Prisons and the *Survey of Inmates in State Correctional Facilities* (SISCF) for the Bureau of Justice Statistics by the U.S. Bureau of the Census. The 2004 data series was sponsored and designed by the Bureau of Justice Statistics (BJS) and conducted by the U.S. Census Bureau. Prior surveys of state prison inmates were conducted in 1974, 1979, 1986, 1991 and 1997. Sentenced federal prison inmates were interviewed in the 1991 and 1997 surveys.

These surveys provide nationally representative data on inmates held in state prisons and federally-owned and operated prisons. A two-stage sampling procedure was used: prisons were selected in the first stage and inmates within sampled prisons were selected in the second stage. Weights for estimating populations were included with the data.

Data collection for the 1991 surveys occurred during June, July and August 1991 when inmates in both types of facilities were confidentially interviewed; data collection for the 2004 surveys occurred from October 2003 through May 2004 when personal interviews and computer-assisted personal interviews were conducted. Inmates were asked about their current offense and sentence, criminal history, family and personal background, gun possession and use, prior alcohol and other use and treatment, and educational programs and other services provided while in prison. The 1991 survey was the first time the federal Bureau of Prisons, using a questionnaire developed by BJS, interviewed inmates in their population at the same time that the *Survey of Inmates in State Correctional Facilities* was conducted.

For the 1991 surveys, a total of 6,572 interviews were completed for the federal survey and 13,986 for the state survey, for overall response rates of 93.4 percent in the federal survey and 93.7 percent in the state survey. A total of 14,499 state prison inmates and 3,686 federal prison inmates completed the interview in the 2004 surveys. The overall response rates for state and federal inmates were 89.1 percent and 84.6 percent, respectively.

Based on the completed interviews, estimates for the entire population were developed using weighting factors derived from the original probability of selection in the sample. These factors were adjusted for variable rates of non-response across strata and inmates' characteristics. The sample from the federal facilities was weighted to the total known sentenced population at midyear 1991 and 2004.

* The final weight is the product of the basic weight (which for each sampled inmate is the inverse of the probability of selection) adjusted for drug sub-sampling, facility populations, duplicate sampling in very small facilities, failed interviews and control count ratio.

Survey of Inmates in Local Jails, 1989 and 2002

The 1989 and 2002 *Survey of Inmates in Local Jails* were conducted for the Bureau of Justice Statistics by the U.S. Census Bureau. This survey, conducted every five to six years, provides nationally representative data on persons held prior to trial and on those convicted offenders serving sentences in local jails or awaiting transfer to prison. Similar surveys of jail inmates were conducted in 1972, 1978, 1983, 1989 and 1996.

The sample design was a stratified two-stage selection, in which jails were selected in the first stages and inmates to be interviewed were selected in the second stage. Weights for estimating populations were included with the data.*

For the 1989 survey, personal interviews were conducted during July, August and September of 1989. For the 2002 survey, personal interviews were conducted from January through April 2002. Census Bureau interviewers collected data on individual characteristics of jail inmates, current offenses, sentences and time served, criminal histories, jail activities, conditions and programs, prior drug and alcohol use and treatment, medical and mental health conditions and health care services provided while in jail. The 1989 survey included a total of 5,675 interviews, yielding an overall response rate of 92.3 percent. The overall response rate for the 2002 survey included a final sample of 6,982 local jail inmates; the response rate was 84.1 percent.

Based on the completed interviews, estimates for the entire population were developed using weighting factors derived from the original probability of selection in the sample. These factors were adjusted for variable rates of non-response across strata and inmate characteristics.

Bureau of Justice Statistics Prisoners in 1996 and 2006

CASA consulted the federal Bureau of Justice Statistics to find the most accurate estimates of prison populations in 1996 and 2006. In 1996, the Bureau of Justice Statistics reports 105,544 federal inmates, 1,076,625 state inmates and 518,492 local inmates for a total incarcerated population of 1,700,661. In 2006, the Bureau of Justice Statistics reports 190,844 federal inmates, 1,302,129 state inmates and 766,010 local inmates for a total incarcerated population of 2,258,983.

These reports were used to estimate the number of inmates with a determined characteristic.

Methodological Differences Between CASA's *Behind Bars* Report in 1998 and this Report

In this report, CASA made the following changes in analysis from CASA's first release of *Behind Bars* (1998):

- *Inclusion of all inmates in local jails.* CASA's 1998 report focused on those convicted of a crime. Because more than half of the local jail population was unconvicted inmates who were being held for probation/parole violation hearings, awaiting arraignment or waiting to stand trial, the local jail analysis was restricted to those inmates who had been convicted of a crime (48.1 percent of local jail inmates). The federal and state datasets were not similarly restricted since they included only 0.6 percent of federal inmates and 1.4 percent of state inmates who were being held for trial. This expansion helps us understand the range of substance use problems of all offenders held in local jails.

* The weighting procedure consisted of a base weight for each inmate and four adjustment factors that produced the final weight for the survey. These adjustments were: the jail non-interview adjustment, the inmate non-interview adjustment, the 1999 national jail census ratio adjustment and the 2001 *Sample Survey of Jails* ratio adjustment.

- *Expansion of the definition of "alcohol-involved offender."* In our original report, the definition used for "alcohol-involved offender" was an inmate who was under the influence of alcohol at the time of the offense or was incarcerated for drunk driving and no other offense, and who never used drugs regularly. For this update and our revised 1996 analysis, we expanded the definition of "alcohol-involved offender" to include an inmate who violated any alcohol law, was under the influence of alcohol at the time of offense or had a history of alcohol abuse.

  These two changes resulted in a slight overall decrease in the percent of offenders who were substance involved in 1996--79 percent vs. 80 percent. The percent of substance-involved federal (80 percent) and state (81 percent) remained the same. The difference was in the percent of substance-involved local jail inmates (73 percent vs. 77 percent).

- *Inclusion of all inmates who have a medical diagnosis of substance abuse or dependence.* The 2002 *Survey of Inmates in Local Jails* and the *2004 Survey of Inmates in State and Federal Correctional Facilities* included variables identifying medically diagnosed abuse of or dependence on alcohol or other drugs that were not available at the time of the 1998 CASA report. The *National Survey on Drug Use and Health* (NSDUH), *2006* contained comparable variables and thus allowed for a consistent comparison variable across those datasets.

  This change involved adding a category of 'had a substance use disorder' (i.e. met the appropriate DSM criteria for abuse or dependence to alcohol, prescription drugs, or other illicit drugs) to our criteria for substance-involved inmates. While most inmates with substance use disorders also met criteria for one or more other categories of substance-involved inmates, a total 60,907 inmates only met criteria for substance use disorders and did not fit into any of the other categories. CASA included these inmates in its 2006 analysis, but to better understand the impact of the addition of these 60,907 inmates to the analysis, we also estimated the change between 1996 and 2006 *without* the inclusion of these offenders. The results are presented in the tables below.

Substance-Involved Federal, State and Local Inmates *without* the Inclusion of Inmates who Only Meet Criteria for Having a Substance Use Disorder (n=60,907)

	1996		2006	
	Number	**Percent**	**Number**	**Percent**
Federal Prison	84,787	80.3	160,773	84.2
State Prison	871,636	81.0	1,071,131	82.3
Local Jail	380,677	73.4	622,153	81.2
Total Substance-Involved Inmates	**1,337,099**	**78.6**	**1,854,057**	**82.1**

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (1991 and 2004), *Survey of Inmates in State Correctional Facilities* (1991 and 2004), *Survey of Inmates in Local Jails* (1989 and 2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in* (1996 and 2006).

Number of Inmates Who Are Substance Involved, by Type *without* the Inclusion of Inmates who Only Meet Criteria for Having a Substance Use Disorder (n=60,907)

	1996	2006	Increase 1996-2006	Percent Increase
Used illicit drugs regularly	1,201,158	1,527,506	326,348	27.2
Under the influence of alcohol or other drugs at the time of crime	703,788	967,046	263,258	37.4
History of alcohol abuse	403,384	586,490	183,106	45.4
Drug law violation	357,734	567,366	209,632	58.6
Committed crime for money to buy drugs	225,623	319,479	93,856	41.6
Alcohol law violation	53,950	99,955	46,006	85.3
Substance-Involved Inmates	**1,337,099**	**1,854,057**	**516,958**	**38.7**

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (1991 and 2004), *Survey of Inmates in State Correctional Facilities* (1991 and 2004), *Survey of Inmates in Local Jails* (1989 and 2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in* (1996 and 2006).

Percent of Inmates Who Are Substance Involved, by Type *without* the Inclusion of Inmates who Only Meet Criteria for Having a Substance Use Disorder (n=60,907)

	1996	2006	Percent Change 1996-2006
Used illicit drugs regularly	70.6	67.6	-4.3
Under the influence of alcohol or other drugs at the time of crime	41.4	42.8	+3.5
History of alcohol abuse	23.7	26.0	+9.5
Drug law violation	21.0	25.1	+19.4
Committed crime for money to buy drugs	13.3	14.1	+6.6
Alcohol law violation	3.2	4.4	+39.5
Substance-Involved Inmates	**78.6**	**82.1**	**+4.4**

Source: CASA analysis of the *Survey of Inmates in Federal Correctional Facilities* (1991 and 2004), *Survey of Inmates in State Correctional Facilities* (1991 and 2004), *Survey of Inmates in Local Jails* (1989 and 2002) [Data files], and U.S. Bureau of Justice Statistics Reports, *Prisoners in* (1996 and 2006).

Analysis of Arrests, Convictions and Sentences

For the analysis of federal arrests, CASA used the *Federal Justice Statistics Program Website* to obtain the most updated and comparable data for 1998 and 2004. To analyze federal arrest data, CASA separated federal arrests for crimes into four basic types of offense: drug, violent, property and other offenses. CASA obtained the number of drug, violent, property, and total arrests directly from the source. Since the *Federal Justice Statistics Program Website* listed more categories of crime offenses than needed for the information in the report, CASA subtracted the combined total number of drug, violent and property arrests from total arrests to arrive at the number for other offenses.

CASA used the Federal Bureau Investigation (FBI) *Crime in the United States, 1998 and 2004*, to examine state and local arrest trends. CASA separated state and local arrest categories for crime into five basic types of offense: drug, alcohol, violent, property and other offenses. CASA obtained the numbers for drug, alcohol, violent, property and other offenses directly from both sources (Table 29). Since the FBI reports listed more categories of crime offenses than needed for the information in the report, CASA subtracted the combined total number of drug, alcohol, violent and property arrests from total arrests to arrive at the number for other offenses.

In cases where CASA had access to the number and not the percentages, CASA obtained the percentage of each category of arrest crimes by dividing the number of arrests in each category by total arrests. CASA calculated the percent change in number of arrests for each category of arrest crimes, by subtracting the difference

between the number of arrests between the years of 1998 and 2004 and then dividing the difference by the number of arrests in 1998 in that category.

For the analysis of federal and state convictions and sentences, CASA used BJS *Felony Sentences in State Courts, 1998 and 2004* and the *State Court Sentencing of Convicted Felons, 2004-Statistical Tables* to obtain numbers and percentages found in the text. Where such numbers and percentages needed for the report were not available directly from the source itself, CASA calculated them in the same manner as described above for arrest data.

Analysis of Released Offenders

There is no national data set that provides information on the characteristics and treatment needs of all released offenders. The closest proxy is the 2006 *National Survey on Drug Use and Health* (NSDUH) which identifies the non-institutionalized population ages 12 and older who have been conditionally released from prison--on parole, supervised release or other restricted release--at any time during the 12 months prior to the survey. No data are available on those released unconditionally from prisons or those released from local jails. CASA used the *Treatment Episode Data Set* (TEDS) to examine differences in the receipt of treatment among those referred by criminal justice agencies and those referred by other sources.

CASA restricted the analysis of the NSDUH to those respondents 18 and older and the analysis of TEDS to admissions of 18-year old clients and older. This was done to insure the exclusion of juvenile facility conditionally released offenders.

National Survey on Drug Use and Health (NSDUH), 2006

To compare the demographic characteristics and substance use patterns of those conditionally released in the past year to the general population, CASA analyzed the data set, the *National Survey on Drug Use and Health, 2006*. NSDUH 2006 is the 26th in a series, the primary purpose of which is to measure the prevalence and correlates of drug use in the United States. This survey provides data on the use and abuse of tobacco, alcohol and other drugs among members of the non-institutionalized U.S. civilian population aged 12 or older. Each NSDUH respondent was given an incentive payment of $30. The survey captures prevalence estimates of drug use that would not ordinarily come to the attention of administrative, medical, or correctional authorities. In-person interviews with a large national probability sample seem to be the best way to estimate drug use in virtually the entire population of the United States.

The 2006 NSDUH is the second survey in a coordinated five-year sample design. The coordinated design for 2005 through 2009 facilitated a 50 percent overlap in second-stage units between each two successive years from 2005 through 2009. This design was intended to increase the precision of estimates in year-to-year trend analyses because of the expected positive correlation resulting from the overlapping sample between successive survey years. The 2006 design allows for computation of estimates by state in all 50 states plus the District of Columbia. The sample is weighted to reflect the United States population in the year 2006 by the variable, analwt_c.

Treatment Episode Data Set (TEDS), 2006

To investigate the levels and types of treatment for substance use disorders obtained by those individuals who have been referred to treatment by correctional agencies, CASA analyzed admissions data from the *Treatment Episode Data Set* (TEDS), 2006. TEDS is an administrative data system providing descriptive information about the national flow of admissions to specialty providers of treatment for substance use disorders. The unit of analysis is treatment admissions to substance treatment units receiving federal funding. TEDS is designed to provide annual data on the number and characteristics of persons admitted to public and private nonprofit substance treatment programs. TEDS is part of a larger data

collection effort, the *Drug and Alcohol Services Information System* (DASIS). TEDS is a continuation of the former *Client Data System* (CDS) and, for 1997, covered an estimated 85 percent of admissions to TEDS-eligible providers, which is 58 percent of admissions to all known substance treatment providers. These are the most recent TEDS inclusion rates available. Missing from TEDS are most admissions to providers receiving no public funds or providers reporting to other federal agencies, such as the Bureau of Prisons, Department of Defense, Veterans Administration, and the Indian Health Service.

Analysis of the Costs and Benefits of Treatment

To calculate the direct costs of incarceration, CASA used the following sources. If the most recent data available were prior to 2006, the federal Bureau of Labor Statistics (BLS) inflation calculator was used to adjust costs to 2006 dollars.

For federal expenditures, CASA used data from *The Corrections Yearbook: Adult Corrections 2002*:

- Total reported federal costs in 2002: $4.6 billion, BLS Inflation Calculator to 2006 dollars = $5.2 billion.
- Annual costs per federal inmate: $5.2 billion / 190,844 = $27,247.
- Annual costs for all federal substance-involved inmates: $27,247 * 164,521 = $4.48 billion.

For state expenditures, CASA used data from *The Corrections Yearbook: Adult Corrections 2002*:

- Total reported state costs in 2002: $31.8 billion, BLS Inflation Calculator to 2006 dollars = $35.6 billion.
- Annual costs per state inmate: $35.6 billion / 1,302,129 = $27,370.
- Annual costs for all state substance-involved inmates: $27,370 * 1,101,779 = $30.16 billion.

There was no single source of current expenditures for local jails and the cost estimates varied widely. To arrive at an estimate, CASA averaged estimates from studies that either provided multi-state assessments of jail costs or provided a comprehensive assessment of within state jail costs. Two studies met such criteria.

- *Jails and Jail Inmates 1993-94: Census of Jails and Survey of Jails, 1995*,[12] which reported daily 1993 costs as $40.18 per day per inmate. Applying the BLS Inflation Calculator to the 1993 costs yields a $56.06 per day estimate for 2006.
- A census of jail costs in 2003[13] in Virginia found that daily costs were $52.69. Using the BLS Inflation Calculator to 2006 dollars in an estimate of $57.73 per day.

The average of these two estimates is $56.90 per day for jail inmates, and a total annual cost per inmate of $20,769 in 2006 dollars. The total annual cost for substance-involved jail inmates is: $20,769 * 648,664 = $13.47 billion.

To estimate the cost of offering quality treatment and aftercare to inmates with a substance use disorder in 2006 that are not currently receiving treatment, CASA employed the following methodology:

- Used the methodology for the inmate data analysis described above, to estimate the number the number of federal, state and local inmates with a substance use disorder who are not receiving treatment--1,289,858 million inmates.
- Used the work of McCollister *et al*[14] to arrive at an estimate of the cost per inmate to provide in prison science-based treatment and aftercare; applied the BLS Inflation Calculator to convert to 2006 costs amounting to $9,745 per inmate ($3,778 for

in prison treatment costs and $5,967 for aftercare).

- Multiplied the number of inmates with substance use disorders who are not receiving treatment (1,289,858 inmates) by the average cost for in prison treatment and aftercare ($9,745) to estimate the cost of providing science-based in prison treatment and aftercare to all inmates with substance use disorders who are not receiving treatment ($12,569,666,210).

To estimate the benefit of keeping one inmate substance and crime free and employed and to maintain reasonable comparability with the 1993 cost estimates, CASA used the most recent data available, or updated estimates from prior calculations using inflation calculations if similar data and data sources were not available. CASA used the following sources:

- Gerstein *et al*[15] for avoided crime costs. Using data from over 150,000 participants in California, the study estimated that victim and theft losses were lower after one year of drug treatment by $5,675. While exact components costs are not able to be extracted from the study, it was conservatively assumed that a drug using inmate would have committed 100 crimes per year, with $50 in property and victimization costs per crime; avoiding those crimes would result in $5,000 savings, updated using the BLS Inflation Calculator to $6,100 in 2006 dollars;

- CASA's 1993 estimate of reduced arrest and prosecution costs. CASA estimated these costs by totaling state and local expenditures for arresting, prosecuting, defending and supervising substance-involved offenders and dividing by the total number of arrests, resulting in $3,638 in non-correctional expenditures per arrest; CASA assumed that two arrests would occur per year, resulting in total avoided arrest and prosecution costs of $7,276.[16] CASA updated this estimate using the BLS Inflation Calculator to $9,000 in 2006 dollars;

- CASA's estimate of avoided annual incarceration costs of $25,144 as presented in Chapter VII, Table 7.1;

- CASA's estimate of avoided health care costs in 1993.[17] In this report, CASA used data from the *National Medical Expenditure Survey* to calculate the difference in annual medical costs between those with substance use disorders and those without such disorders to be $4,800 per year. Using the BLS Inflation Calculator, this equals $5,937 in 2006 dollars;

- The BLS[18] data to calculate the annual economic benefit of an employed individual. The BLS estimates that the median income of a high school (no college) graduate is $29,849 in 2004 dollars. CASA then adjusted this amount by the standard economic multiplier of 1.5 and converted to 2006 dollars using the BLS Inflation Calculator. These calculations resulted in an annual economic benefit of $44,772, adjusted by the standard economic multiplier of 1.5, then converted to 2006 dollars.

The benefit of keeping one inmate substance and crime free and employed is therefore $90,953 in savings from expected reduction in crime costs ($6,100), arrest and prosecution costs ($9,000), incarceration costs ($25,144), health care costs ($5,937), and economic benefits ($44,772).

If we treated all 1.3 million inmates with untreated substance use disorders and spent the $12.6 billion necessary to do so, we would break even within a year post release if only 10.7 percent of those treated remained substance and crime free and employed: $12.6 billion / $90,953 = 138,200, 10.7 percent of the 1.3 million who received treatment and aftercare.

Appendix B
Proposed Guidelines for Providing Addiction Treatment in Prisons and Jails

American Correctional Association

In 1990, the American Correctional Association (ACA), in cooperation with the Commission on Accreditation for Corrections, published *Standards for Adult Correctional Institutions* (third edition)* recommending policies and procedures for clinical management of inmates with substance use disorders.[1] These recommendations included:

- diagnosis of substance use disorders by a physician;
- determination by a physician as to whether an inmate required non-pharmacologically- or pharmacologically-supported care;
- implementation of individualized treatment plans by a multidisciplinary team; and
- referral to community aftercare upon release when necessary.[2]

National Institute of Corrections

In 1991, the National Institute of Corrections, through its National Task Force on Correctional Substance Abuse Strategies, released the report *Intervening with Substance-Abusing Offenders: A Framework for Action*. Twenty-seven specific recommendations were made in the areas of clinical assessment, program development, linkages between correctional institutions and community-based human service agencies, recruitment and retention of qualified staff, design of safe and favorable environments conducive to behavioral change, and accountability. In addition to the need for standardized assessment and individualized treatment, these guidelines emphasized the reinforcement of inmates' behaviors through

* Updated in 2003.

concrete rewards and sanctions, the linkage between prison-based treatment programs and community-based aftercare services, the need for drug testing and the importance of ensuring treatment integrity and identifying effective therapeutic interventions through process and impact evaluations.[3]

SAMHSA's Center for Substance Abuse Treatment

The Center for Substance Abuse Treatment (CSAT) at the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) first published guidelines for establishing substance treatment programs in prisons in 1993.[4] CSAT's efforts to document standards and guidelines continued into the 2000s with the publication of a series of *Treatment Improvement Protocol* (TIP) reports dealing with criminal justice issues. These best-practice guidelines for the treatment of substance use disorders among offenders draw on the experience and knowledge of nationally known clinical, research and administrative experts and have been distributed to a large number of facilities and individuals across the country. [5]

The most recent and updated TIPs for corrections-based treatment are *TIP 21: Combining Alcohol and Other Drug Abuse Treatment with Diversion for Juveniles in the Justice System*, *TIP 23: Treatment Drug Courts: Integrating Substance Abuse Treatment with Legal Case Processing*, *TIP 30: Continuity of Offender Treatment for Substance Use Disorders From Institution to Community*, and *TIP 44: Substance Abuse Treatment for Adults in the Criminal Justice System*.

By 2005, CSAT had identified 10 critical areas in the design and implementation of criminal justice-based treatment:

1. screening and assessment;
2. triage and placement;
3. treatment planning;
4. clinical strategies;
5. offender populations with special needs;
6. treatment in pretrial and diversion;
7. jail-based treatment;
8. prison-based treatment;
9. treatment for offenders under community supervision; and
10. program development.

CSAT also has offered over 100 recommendations that can be considered standards for treatment and services for substance-involved offenders.[6]

The National Institute on Drug Abuse

In 2006, the National Institute on Drug Abuse (NIDA) joined the enterprise of providing guidance to corrections-based treatment providers and formulated the following research-based principles for the effective treatment of substance-abusing offenders:[7]

- Drug addiction is a brain disease that affects behavior.
- Recovery from drug addiction requires effective treatment, followed by management of the problem over time.
- Treatment must last long enough to produce stable behavioral changes.
- Assessment is the first step in treatment.
- Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.
- Drug use during treatment should be carefully monitored.

- Treatment should target factors that are associated with criminal behavior.

- Criminal justice supervision should incorporate treatment planning for drug-abusing offenders, and treatment providers should be aware of correctional supervision requirements.

- Continuity of care is essential for drug abusers re-entering the community.

- A balance of rewards and sanctions encourages pro-social behavior and treatment participation.

- Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.

- Medications are an important part of treatment for many drug abusing offenders.

- Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, Hepatitis B and C, and tuberculosis.

Chapter I
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