The Correctional Association of New York
FOUNDED 1844
2090 ADAM CLAYTON POWELL, JR. BLVD. • SUITE 200 • NEW YORK, NY 10027
TEL. (212) 254-5700 • FAX (212) 473-2807 • www.correctionalassociation.org

# TREATMENT BEHIND BARS: SUBSTANCE ABUSE TREATMENT IN NEW YORK PRISONS 2007–2010

## EXECUTIVE SUMMARY

*A Report by the*
*Correctional Association of New York*

**FEBRUARY 2011**

**The Correctional Association of New York (CA)** was formed in 1844 by citizens concerned about prison conditions and the lack of services for inmates returning to their communities. In 1846, the New York State Legislature granted the CA authority to inspect prisons and report on its findings. Through four projects — Juvenile Justice, Prison Visiting, Public Policy/Drug Law Repeal, and Women in Prison — the CA advocates for a more humane prison system and a more safe and just society.

The **Prison Visiting Project (PVP)** is the arm of the Correctional Association that carries out this unique legislative authority for the male prisons. PVP visits seven to ten of New York's 67 state correctional facilities each year and issues facility specific reports on prison conditions to both policymakers and the public. In addition to its general prison monitoring, PVP conducts in-depth studies on specific corrections issues and publishes comprehensive reports of findings and recommendations. Current in-depth research areas include: healthcare, mental health care and substance abuse treatment. PVP produces reports, presents at forums, and engages in activities aimed at educating the public about prison conditions, the high cost of incarceration and the need for alternatives. The Project also works with legislators, corrections officials, former prisoners, service providers and community organizations to develop more humane prison policies. All the prison reports prepared by the Project since 2004 are available on the Correctional Association web page.

*For more information about the Prison Visiting Project, please call 212-254-5700 or visit* http://www.correctionalassociation.org/PVP/index.htm

*Treatment Behind Bars: Substance Abuse Treatment in New York Prisons*
Copyright © 2011, The Correctional Association of New York
All Rights Reserved

The Correctional Association of New York
2090 Adam Clayton Powell, Jr. Blvd
Suite 200
New York, New York 10027
(212) 254-5700
(212) 473-2807 (Fax)

# 1. INTRODUCTION

Substance abuse is a daunting problem for the majority of prison inmates nationally and more than three-quarters of those in New York State. The devastation that often accompanies substance abuse places notoriously heavy demands on the criminal justice, correctional and substance abuse treatment systems, as well as on inmates, their families and their communities. The prison system has the unique potential to provide effective drug treatment to this captive population, addressing not only the individual needs of inmates but public health and public safety as well. Not only is the prison system in a unique position to provide drug treatment, but a substantial body of research documents that treatment is, on the whole, more effective than incarceration alone in reducing drug abuse and criminal behavior among substance abusers and in increasing the likelihood that they will remain drug- and crime-free.[1]

The need to provide more comprehensive substance abuse treatment services in New York State prisons, similar to the increasing need to provide mental health services in prisons as a result of deinstitutionalization of mental hospital patients, has directly been impacted by the Rockefeller drug laws. With their rigid requirements of mandatory minimum sentencing, the Rockefeller drug laws of 1973 radically restricted judicial discretion in utilizing alternatives to incarceration as a response to drug offenses. The result: 11% of the total prison population in 1980 were individuals incarcerated for drug-related offenses; as of January, 2008, that figure was 33%. Though this past year brought significant reform to the Rockefeller Drug Laws, several mandatory minimum sentences are still on the books and a large number of individuals remain ineligible for alternative to incarceration programs. The considerable increase in this population illustrates one of the many factors that make provision of prison-based substance abuse treatment paramount, as the majority of incarcerated individuals will participate in treatment due to the nature of their offense.

As of April 2010, the New York State Department of Correctional Services (DOCS) operated 68 facilities, with 57,650 inmates under custody. Eighty-three percent of inmates were designated by DOCS as "in need of substance abuse treatment."[2] To address their needs, DOCS operates 119 substance abuse treatment programs in 60 of its facilities. As of April l, 2009, two of those programs were licensed as treatment programs by the State's Office of Alcoholism and Substance Abuse Services (OASAS); the remainder are operated solely under the aegis and oversight of DOCS. The 2009 reforms to the Rockefeller drug laws call for change, however, requiring OASAS to guide, monitor and report on DOCS substance abuse treatment programs.

In 2007, the Correctional Association launched a project to evaluate the needs of inmates with substance abuse problems and the State's response to their needs. The information presented in this report is a result of this effort and presents our findings and recommendations based on visits to 23 facilities, interviews with experts, prison officials and correction officers, more than 2,300 inmate surveys and systemwide data provided by the Department of Correctional Services.

---

[1] Fletcher and Chandler, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.

[2] This is the number of inmates DOCS has identified with its screening process, not the number of inmates in New York State prisons with a diagnosis of substance/alcohol abuse or dependence.

# 2. EXECUTIVE SUMMARY

The majority of individuals incarcerated in New York prisons come from urban communities characterized by poverty, unemployment, crime and substance use. These conditions, coupled with the State's law enforcement approach to drug use and sale, inevitably leads to large numbers of individuals with some history of substance use being confined in our prisons. Along with this confinement, however, comes the concomitant obligation that the State should provide services to address the significant substance abuse treatment needs of this population.

A substantial body of evidence has established that effective prison-based substance abuse treatment reduces the likelihood of relapse and recidivism for participants.[3] Moreover, the benefits of successful treatment go beyond the recovery of participants to enhancing the quality of life within the prison itself and heightening public health and safety in the greater community. Successful substance abuse treatment programs can lead to increased safety for inmates and prison staff by decreasing prison violence associated with inmate drug use and trafficking, and can foster positive attitudes and behaviors that frequently result in increased participation in educational, vocational and other prison-based programming. Additionally, successful prison-based treatment reduces drug use by formerly incarcerated individuals on the outside, leading to reductions in crime and more productive and healthy lives for the individuals involved, their families and other members of their community.

The New York State Department of Correctional Services (DOCS) reports that 83% of the State's prison population, or approximately 47,850 of the 57,650 [4] current inmates, are in need of substance abuse treatment.[5] Many inmates have struggled with addiction for years prior to their incarceration, and many have participated in prison- and community-based treatment programs before their current sentence. Sixty of New York State's 68 correctional facilities operate 119 substance abuse treatment programs, making DOCS the single largest provider of substance abuse treatment in the State. Developed and monitored by the DOCS Office of Substance Abuse Treatment Services, these programs comprise approximately 10,000 treatment slots; about 34,000 inmates are enrolled in these programs annually. Each year, 27,000 individuals—nearly 40% of the prison population—return home. How well inmates with substance abuse histories are prepared for their reentry into society has a significant impact on their overall success on the outside and on quality of life in their communities.

Given the inmate population's considerable need for treatment and the large number of inmates participating in treatment programs, it is crucial that these programs be effective. Successful prison-based treatment is realized only when that treatment is based upon sound strategies carefully matched to the needs and strengths of program participants, and delivered by competent, committed staff. Prison-based treatment can also provide an opportunity to address the unhealthy behaviors that often lead to involvement with the criminal justice system in the first place. Providing appropriate education about substance abuse and clinical treatment

---

[3] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf.*
[4] As of April 1, 2010.
[5] NYS Department of Correctional Services, *Identified Substance Abusers 2007*.

services makes it more likely that these individuals can better manage their behavior and take care of themselves, their health and their communities. An additional ancillary benefit to providing substance abuse treatment in prisons is not only the reduction in drug use and crime, but the decrease in the spread of many injection-related chronic health conditions such as HIV and hepatitis C.

The Department's substance abuse treatment programming has been subject to little analysis or outside monitoring. Consequently, in 2007 the Correctional Association of New York's Prison Visiting Project (PVP) undertook a multiyear study to evaluate the substance abuse treatment programs in New York State's prisons. PVP visited 23 correctional facilities that included more than half of the Department's treatment slots. PVP staff met with DOCS treatment staff and facility management, interviewed treatment participants, observed treatment sessions, visited housing units set aside for treatment participants and reviewed treatment case records. We collected more than 2,300 surveys from inmates in prison treatment programs and those waiting to enroll in such programs.

The information gathered by PVP shows that though most of DOCS treatment programs use the same program curriculum, the implementation of these programs demonstrates wide variation in the content and quality of prison substance abuse treatment, revealing some programs that exhibit good practices run by dedicated and skilled staff and others that need significant improvement. Of the 23 programs visited, there was considerable variation among programs in content, structure and satisfaction. The variations were apparent in all aspects of the programs: clinical content, staffing patterns and qualifications, participant satisfaction, treatment strategies, program structure and program oversight. We visited programs where the vast majority of participants (96%) were satisfied with their treatment, and other programs where two-thirds of the participants were dissatisfied.

Our review of programs at individual facilities resulted in a number of findings that apply to the overall treatment approach Department-wide. First, DOCS's broad standards for designating inmates as "in need of substance abuse treatment" result in considerable variation among treatment participants with regard to the severity of their substance abuse and motivation to complete treatment. Second, despite this variability, most programs adhere to a single design, a six-month residential program of daily half-day sessions with groups of 20 to 50 participants. Some programs better support participants in gaining insight and make meaningful progress in addressing their addiction, but other programs are much less successful in engaging and assisting the participants. Third, although some treatment staff have frequent and meaningful one-on-one meetings with program participants, the individual counseling sessions in many programs are brief and only occur monthly. Fourth, the Department does not have a detailed curriculum, and therefore there is limited standardization of program content or materials. As a result, some facilities use best practices and up-to-date materials while others rely on outdated materials and conduct poorly designed treatment sessions. Fifth, the experiences, training and overall competence of the treatment staff vary greatly, and there is little clinical guidance and oversight. Finally, discharge planning is limited, with little coordination between in-prison treatment programs and community-based treatment providers. Some DOCS treatment providers attempt to assist soon-to-be-released inmates in identifying aftercare programs, but in most programs, treatment staff do not help the participants develop effective aftercare plans. Instead, inmates are

often left to identify their own post-release care or to rely on parole officers, who have little knowledge of individuals' treatment needs or community resources.

After reviewing practices in New York State's prisons, researching current standards in the field, and identifying the most up-to-date evidence-based practices, we identified several concrete steps the State can take to improve its treatment programs. (See **Section 18, Recommendations**, for more detailed descriptions.) We urge State officials and DOCS to consider implementing five critical changes that could have the greatest positive impact. First, the Department should implement a comprehensive system of screening and assessment to identify the severity of each inmate's substance abuse and corresponding treatment needs. Second, the Department should develop a continuum of treatment options, from education to intensive residential treatment. Third, the Department should place each inmate in the program that best addresses his/her needs. Fourth, DOCS and other State agencies should enhance and coordinate discharge planning that connects inmates with appropriate community-based treatment and other support services upon release. Finally, the Department should collaborate with the Office of Alcoholism and Substance Abuse Services (OASAS) to develop a more comprehensive curriculum for each program and implement an effective system of monitoring and oversight of programs and staff. Implementing these recommendations would not only greatly increase the likelihood that formerly incarcerated individuals with substance abuse histories can avoid both relapse and reincarceration, but also significantly benefit general public health and the safety of all communities.

# Major Findings

**Screening/Assessment**

- **DOCS assesses inmates at reception to determine their need for substance abuse treatment using five methods and a broad definition for what constitutes need for treatment. Many inmates object to the Department's determination that they need treatment.** Corrections staff use two nationally recognized screening instruments, the Michigan Alcohol Screening Test (MAST) and the Simple Screening Instrument (SSI), to assess need for treatment, but the scores used to make this evaluation are set at a low threshold so that inmates with a limited history of substance use are designated to need treatment. For example, a score of 5 to 8 is specified by the MAST to be indicative of alcohol abuse, but a score of 4 is used by DOCS to designate an individual as in need of treatment; thus many individuals are inappropriately screened into treatment programs, resulting in a high rate of false positives, which in turn overwhelms the treatment resources and leaves programs with high numbers of individuals not in need of treatment diluting the treatment resources for those with more severe need. These instruments were designed only to screen inmates for a potential substance abuse problem and to determine who should be further evaluated for potential treatment. A determination of an individual's diagnosis and actual treatment needs should be made only after a more comprehensive assessment by a qualified substance abuse professional who can distinguish between substance abuse and substance dependence, a procedure recommended by the Substance Abuse and Mental Health Services Administration

(SAMHSA).[6] The Department does not follow this process, as individuals with positive scores on the screening tests will have substance abuse treatment added to their required program list.[7] In addition, individuals may be designated to need treatment as a result of self-reporting during reception or based upon information included in his/her pre-sentence report. For example, if an individual has been convicted of a drug-related offense such as possession, use or sale, he/she would generally be designated as needing substance abuse treatment. The exact criteria for who will have treatment added to their required program list are unclear, and the process for making this assessment is not well defined, resulting in numerous reviews by DOCS staff of the same information without a clearly designated person responsible for making the final determination of treatment need. Finally, there is no Department training or requirement for specific experience in treatment assessment for the staff involved in the process, resulting in inconsistent application of the standards for who is required to enter a program.

- **The Department's definition of substance abuse issues that justify treatment is very broad and includes any individual who is at moderate risk of substance abuse, has any history of substance use or has been involved in drug sales in any capacity.** As a result, the Department estimates that approximately 83% of the inmate population has a "substance abuse problem" and, therefore, would benefit from treatment.[8] In determining the need for treatment, the Department lacks guidelines instructing correction counselors to consider how recently an individual used an illegal substance when assessing treatment need, nor is there a threshold for frequency or consequences of substance abuse before a determination of need is made.

- **Many inmates we interviewed questioned their designation as in need of treatment by DOCS because they believed they did not have a substance abuse problem.** This group includes inmates who were convicted of selling drugs, or whose pre-sentence reports indicated involvement in drug sales, but who asserted they did not use drugs. Department officials suggest that the individuals are appropriate candidates for treatment because, despite assertions to the contrary, many of them are in fact substance users, and the others can still benefit from treatment that addresses the issues of individual responsibility, life skills, addiction behavior and criminal thinking. Other inmates who complained about their designation reported using only marijuana on occasion or stated that their substance use occurred many years prior to their current incarceration. In 2007, DOCS reported that the most serious drug used by 36% of the male identified substance abusers was marijuana, a percentage significantly greater than alcohol only (23%) or the other identified substances (all under 18%).

---

[6] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf.*

[7] Though substance abuse treatment is not mandated, if an inmate refuses to participate in a program on his/her required program list, the consequences are extremely negative and can result in a loss of good time or merit time and being denied early release by Parole. Many inmates expressed feeling forced to complete a treatment program or face spending more time in prison.

[8] NYS Department of Correctional Services, *Hub System: Profile of Inmate Population Under Custody on January 1, 2008.*

- **The screening process used by DOCS to determine whether an inmate needs substance abuse treatment while incarcerated does not provide an assessment of the severity of the individual's substance abuse problem and criminal risk or a recommendation for the type of program most beneficial to the inmate. Even if such recommendations are made, only a limited number of types of programs are available for individuals who have been designated as needing substance abuse treatment.** Substance abuse treatment programs offered by the Department are primarily a "one size fits all" approach. Although there are programs for some special populations,[9] representing approximately 16% of all treatment slots, these programs follow similar curricula as the general Alcohol and Substance Abuse Treatment (ASAT) program with additional topics being discussed (mental health, for example) and an extended length of time spent to complete the curriculum in order to accommodate different learning abilities. Other DOCS substance abuse treatment programs such as the four Shock programs, the Willard Drug Treatment Campus and Edgecombe Correctional Facility accept individuals based not necessarily on treatment needs, but on sentence and other factors. Treatment matching requires that different types of individuals are assigned to the most appropriate kind of treatment to achieve different types of treatment goals. Most experts consider this kind of precise approach not only to be cost effective, as individuals are matched to the level of services most appropriate to their need, but to improve the effectiveness and quality of services offered.[10] This type of treatment matching generally does not occur in DOCS.

- **Largely due to the over-inclusive screening process and the failure to institute a more comprehensive assessment of need, significant variation exists among treatment participants regarding their substance abuse histories and needs.** Mixed together in the sessions that we observed were inmates with active substance abuse histories with substances such as heroin or crack, inmates who reported only using marijuana occasionally, inmates who had previously had substance abuse problems but had been abstinent for many years and inmates who were drug dealers but who asserted they never used drugs themselves. For example, 15% of individuals we surveyed not in treatment at the time of our visit, but who had previously completed prison-based treatment, reported only occasional marijuana use and limited alcohol use, and said they had no or only a slight substance abuse problem. Common criticisms from inmates included that they often could not relate to some of their fellow participants and felt pressure from their peers and the treatment staff to admit to more drug use then they had actually done. They also reported that some of the subjects covered in group sessions were either not specific or comprehensive enough to address their needs or were about topics that were not applicable to them.

[9] Programs for special populations include: two DWI programs, four CASAT programs, 13 programs for individuals with co-occurring disorders, three programs for the special needs or sensorially disabled population and four programs for inmates residing in regional medical units.
[10] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf.*

- **Most treatment programs we visited prioritize admission to the program based on the inmate's proximity to his/her earliest release date. Treatment programs generally do not give priority to inmates who have current substance abuse problems.** Because it is DOCS policy to prioritize individuals for treatment based upon the proximity to their release dates, inmates facing lengthy incarcerations will not receive any treatment for many years, regardless of demonstrated need. At many prisons, inmates must be within one year of their potential release dates before they are offered treatment. We understand the challenges associated with completing a substance abuse treatment program soon after beginning one's incarceration. For example, the inmates would then have to return to general population to complete their sentence, where continued recovery support is limited and the chance of relapse is high, also negatively impacting on prison management and safety. Moreover, at the beginning of one's prison term, it is more difficult to plan appropriate continuity of care for eventual discharge to one's community. Inmates definitely need treatment support toward the end of their incarceration to prepare them for returning to the community. But we also observed during our visits a portion of the inmate population with a significant need for treatment earlier in their incarceration. Many inmates entering prison with a history of substance abuse end up using drugs in prison and thus becoming subject to considerable disciplinary sanctions. Inmates found possessing or using drugs or alcohol are routinely given disciplinary sentences of several months to a year or more and are placed in a Special Housing Unit (SHU) where they spend 23 hours of their day in lockdown and are denied programming. In addition to being disciplined, inmates using drugs are simultaneously moved to the back of the waiting list for substance abuse treatment and will still have to wait for treatment until one to two years before their release.

**Treatment Programs, Processes, Content and Structure**

- **Though many of the treatment programs we visited had some type of modified hierarchy structure in place, the hierarchy roles were not generally associated with an increase in privileges nor were all members of the community given a role in the hierarchy structure.** In a therapeutic community program, the treatment model for the majority of DOCS treatment programs, hierarchy is defined as a system that allows for positions of increasing responsibility and associated privileges through commitment to and mastery of therapeutic community and counseling concepts. Sanctions and incentives serve an equally important function. Many treatment programs we observed punished individuals for failure to conform to the rules. However, we did not witness or learn about many incidents in which individuals were rewarded for their progress. Incentives are a principal function of a structured hierarchy and can help build self-esteem, model appropriate behavior and develop important social skills. In most cases we observed and heard about from inmates, it seemed that occupying one of the multiple hierarchy positions was often based on staff preferences or inmate volunteerism rather than upon actual progress in the program.

- **The role of inmates in the treatment programs varied significantly. At some programs, inmate-participants facilitated a significant portion of the group sessions, while at other prisons staff took a more direct role.** At many facilities, inmate

hierarchy members facilitated all or most community meetings. At other facilities, inmates with hierarchy positions such as coordinator or assistant coordinator played a central role in group sessions ranging from facilitating the entire session, to assisting in engaging fellow participants, to assisting staff with materials or other assignments. Though treatment staff were often present as inmates facilitated part or all of some sessions, at some facilities the treatment staff would leave the group and allow the inmate to facilitate on his/her own. This was also reported to us by treatment participants at some facilities. While it is important that inmates take a leadership role in treatment programs, appropriate supervision by treatment staff is key. Many inmates have a significant amount to offer to other participants regarding their own experiences with substance abuse and recovery, but they rarely possess the clinical background, training or expertise necessary to provide a full range of treatment services. Being a facilitator can be an important learning experience for the inmate and a meaningful opportunity to model behavior and develop self-esteem. This type of development can only be accomplished with the assistance and supervision of qualified treatment staff.

- **Program structure varied a great deal from program to program.** Group sizes in most treatment programs ranged from 15 to 60 inmates, with typical groups of 25 to 30 participants. This group size is more appropriate for educational or informational lectures and generally considered too large by experts for effective group therapy. In a significant number of the programs we visited, groups rarely divided up to work in smaller groups. Treatment participants also said they spent a considerable amount of the program listening to educational presentations or watching informational videos and much less time talking about their own substance abuse issues. As most programs use some type of modified therapeutic community, they had some type of community meeting, but again these sessions differed in length, frequency and format, with the typical program having group meetings once a week. The variability from program to program and within programs did not appear to reflect any differences in the population or program design, but rather the style and preference of the individual treatment staff.

- **Most of DOCS treatment programs are designed as modified therapeutic communities. The DOCS ASAT Manual does not provide detailed guidance as to clinical content or treatment modalities, and loosely states that programs can utilize various techniques, such as cognitive-behavioral therapy, within their programs. Consequently, significant variations are present in program content and treatment modality within and among the prison treatment programs.**

***Program Content***

- **The lack of a detailed curriculum with supporting documents in the treatment manual leaves program staff without adequate direction concerning the daily content of the program.** The amount of skills training in areas such as anger management, stress management and communication skills varied amongst programs. For example, 83% of treatment participants at Greene Correctional Facility reported receiving communication skills training, compared with 29% at Oneida. We observed some effective presentations and program sessions, but also saw sessions that were

poorly planned and lacking coherent content. Each prison, and often each staff member within a prison, collects and maintains different handouts, worksheets and other tools. Some of these materials are inaccurate and/or outdated, resulting in treatment programs that are very inconsistent.

***Treatment Modality***

- **Though most DOCS treatment programs utilize some components of a therapeutic community, cognitive-behavioral and 12-step approach, the degree to which these are utilized varied among facilities.** Inmates voiced differing perceptions of the importance of these treatment modalities among the programs, rating cognitive behavior as both the most important component (77%) and the modality which provided them higher levels of satisfaction (77%). Survey participants next expressed the importance of and satisfaction with therapeutic community (63% importance of and 67% satisfaction with) and 12-step elements (53% importance of and 60% satisfaction with).

- **Individual counseling is limited, with wide variations among programs.** There is no clear requirement for significant one-on-one counseling beyond monthly meetings that serve as the basis for the monthly evaluations. Some of these monthly meetings last only a few minutes or less per inmate. Some treatment staff reported, however, that they have frequent informal individual meetings with program participants who request them. It does not appear that these sessions are documented in participants' treatment records.

- **The written materials and handouts used in the treatment programs varied significantly, at times were outdated and were made up of individual documents brought in by treatment staff with limited to no guidance from DOCS Central Office.** Both treatment staff and inmates voiced concerns about the lack of up-to-date materials, written and video, available for use in the treatment programs. They expressed frustration with the limited amount of resources available to update these materials. It is challenging to find innovative ways to engage a population that is oftentimes resistant to treatment, and using videos and handouts that do not reflect current trends or evidence-based practice make this task even more difficult. Facilities such as Bare Hill, Franklin, Five Points, Oneida, Shawangunk and Taconic added supplemental materials from outside sources, though these were not always consistently up to date.

- **Individual treatment records vary in content from program to program and the documents in the records provide no real indication or detail about an individual's treatment needs, substance abuse history, or treatment objectives**. We received substance abuse treatment records from some facilities that did not represent an adequate or holistic view of the individual and the many factors that will impact his/her current treatment, including information about the individual's previous treatment history, results of his/her initial screening by DOCS, medical history, educational/vocational needs or social support assessment. We also were unable to find any results of individuals being tested for drug use while incarcerated. In many records, treatment objectives or other important questions were left blank or filled in with one word answers. In addition, the monthly evaluations and discharge assessments contained limited substantive feedback

and few, if any, notes indicated the content of individual counseling sessions. Overall, the treatment records were not sufficiently individualized. Also, it appears that no clinical supervisors ever reviewed the charts.

## Program Climate

- **Treatment participants' views on staff support, communication within the program and engagement in the program varied considerably from facility to facility.** The program environment can either assist a program's effectiveness and improve outcomes for the participants, or hinder them. We observed both the positive and negative impacts that program climate can have on programs during our visits.

  ***Staff Support***

  We observed variation among treatment staff in their commitment to inmates, including some treatment staff who seemed to possess a negative attitude toward inmates, viewing the role of prisons as containment rather than rehabilitation. In contrast, 32% of all treatment participants we surveyed reported that it was *mostly* or *very true* that staff believed in them and 30% stated it was *mostly* or *very true* that staff were interested in helping them. In some programs, such as Taconic (63% and 48%, respectively) and Lakeview Female (64% and 68%, respectively), survey respondents reported significantly higher positive responses to the above questions, and we were able to observe some staff who appeared sincere and dedicated to the work and the population.

  ***Communication***

  For individuals to gain the most from a treatment program and their community of peers, it is important that they feel the program is a safe space for sharing personal information and viewpoints. We observed some programs that clearly had created a safe environment conducive to honest and open discussion and others where levels of tension appeared high and participation was lower. For example, survey respondents from Lakeview Female (71%), Oneida (59%), Bare Hill (60%) and Washington (56%) reported it was *mostly* or *very true* that participants were afraid to speak up for fear of ridicule or retaliation, whereas survey respondents at other prisons expressed much less fear about participating in a discussion (Shawangunk (27% *mostly* or *very true* afraid to speak), Eastern (28%), Taconic (33%) and Hale Creek (32%)).

  ***Engagement***

  At some treatment sessions we saw programs participants who were actively engaged and demonstrated a clear sense of ownership for the program, while at other facilities, participants appeared bored and disengaged. Of the total number of survey respondents, 34.5% stated that it was *mostly* or *very true* that they enthusiastically participated in the program and 37% reported that it was *mostly* or *very true* that they felt an attachment to and ownership of the program. The survey results also illustrated the variation we observed among programs with facilities such as Lakeview Female (63%), Lakeview

Male (55%), Taconic (52%) and Sing Sing (50%) reporting higher percentages of individuals who found it to be mostly or very true that they felt an attachment and ownership to the program, compared with Gouverneur (15%), Oneida (17%), Willard Drug Treatment Campus Male (21%) and Bare Hill (22%).

- **Treatment participants at many programs reported feeling high levels of anxiety and stress based on their concern that they would be removed from the program for a small infraction, losing their good/merit time and having to spend more time incarcerated.** Many programs appeared punitive in nature, often relying on disciplinary, rather than therapeutic responses, to minor violations. A large focus was placed on keeping areas tidy, and individuals reported receiving sanctions for minor transgressions such as not having their shoes in a straight line under their bed. In contrast, we observed some programs whose staff made a genuine effort to ensure that participants would succeed in the program and who used minor violations as a learning opportunity for the individual.

**Staffing**

- **The staffing ratio at most treatment programs is inadequate to meet the needs of the participants. Most ASAT programs are staffed with only one ASAT correction counselor and two program assistants (PAs) for every 120 program participants, with the PAs facilitating most of the group meetings. We observed significant program staff vacancies at many of the prisons we visited.** The programs are primarily run by PAs and class sessions range from 15 to 60 inmates, with an average size of 25 to 30. At several prisons, we not only found a high number of staff vacancies, but also a high level of staff turnover. It appears that some professionals use the PA position as an entry-level job and then seek promotions once they have met the minimum standards for advancement. Inmate participants often facilitate the classes, sometimes with limited oversight by the PAs. In the current economic environment, most facilities are not being granted the authorization to fill vacancies, resulting in treatment program staff being stretched beyond capacity and inadequate treatment attention often being given to program participants.

- **There was wide variation in staff's commitment to the program.** We observed substance abuse staff that were enthusiastic and engaged with the participants in their classes, evidencing a commitment to the program and the success of its participants. We also observed some substance abuse staff that appeared to be indifferent to the daily activities of the treatment program. These staff members often exhibited a lack of concern about the need for updated materials and innovative approaches for engaging participants in the treatment process. Many survey respondents were highly critical of the staff's efforts and did not believe they were receiving effective support for their recovery. Satisfaction with such key services as providing treatment plans and general counseling varied considerably at some facilities. For example, a minority of survey respondents at Bare Hill (31%), Cayuga (33%), Oneida (33%) and Gouverneur (40%) reported that they were *somewhat* or *very satisfied* with the counseling process, compared with the vast majority of survey respondents voicing satisfaction at Taconic (77%), Hale

Creek (84%), Lakeview Male (84%) and Lakeview Female (96%). We found similar variation with regard to satisfaction with the treatment plan.

- **Wide variations were apparent in competence and skills among DOCS treatment staff.** Some treatment staff had extensive substance abuse training and experience working in community-based treatment programs, while others possessed considerably less experience and training. Very few treatment staff possessed higher level degrees and only 23% of the treatment staff we spoke with reported being credentialed alcoholism and substance abuse counselors (CASACs).

- **Many staff are not actively engaged in continuing professional education and development or engaged in professional organizations that focused on substance abuse treatment. Though all treatment staff participate in the mandatory 40 hours of training required by DOCS, they receive minimal training on substance abuse topics such as new counseling techniques and preparation for working with special populations.** DOCS Office of Substance Abuse Treatment Services provides limited professional training, focused on an average of two or three different topics a year. It appears that training on therapeutic communities is the only topic offered on a more regular basis by this office. We observed some staff actively engaged in professional training programs or professional organizations outside of DOCS. The Office of Alcoholism and Substance Abuse (OASAS) has an extensive training catalog on a variety of topics, but participation in this training is not a requirement for DOCS treatment staff. We observed significant variation in answers among staff when asked if they have participated in OASAS trainings. In addition, when asked about trainings they had participated in during the past two years, a number of staff were unable to recall the topic covered in the training session.

- **Staff/inmate relations varied from facility to facility and were often marked by inmate distrust of staff and frustration with the power many staff held over participants.** Inmates we spoke with often felt that staff were not sincere in their efforts to help them and that they did not appear to be invested in the treatment program. Only 39% of survey respondents said it was *mostly* or *very true* that treatment staff supported their goals and 40% reported as *mostly* or *very true* that treatment staff sincerely wanted to help them. Several inmates also reported that some staff would use their ability to remove them from the program as a means of intimidation. In our conversations and meetings with treatment staff, we observed staff who appeared truly committed to assisting treatment participants and were able to see the individuals holistically. We also observed staff who seemed disengaged and did not express much empathy for them.

### Program Completions and Removals

- **The number of removals and completions among programs varies significantly. The removals policies and procedures in place differ from facility to facility.** Some programs we visited removed nearly as many participants as they graduated, while others had considerably higher graduation rates. Facilities with high removal rates include Five Points, Washington, Greene and Mid-State, whereas Wyoming, Taconic, Wende and

Eastern had much lower removal rates. Treatment staff at some programs we observed worked closely with treatment participants to ensure their successful completion and utilized learning experiences rather than punitive responses to program violations. In contrast, other programs were more likely to remove individuals for repeated relatively minor infractions. Individuals in treatment programs receive a monthly evaluation from staff, and oftentimes, two or more negative monthly evaluations lead to a participant's removal from the program. The various elements that may result in a negative monthly evaluation differ among programs and treatment staff.

**Drug Use and Testing**

- **The frequency of drug use and possession among inmates varies significantly among the DOCS facilities we visited.** Dedicated substance abuse treatment facilities such as Lakeview Shock, Willard DTC and Hale Creek had low occurrences of both drug use and possession. Facilities such as Five Points, Sing Sing and Wende had high rates of both drug use and possession, whereas Gowanda, Greene and Franklin had lower rates. Forty-two percent of survey respondents from all facilities we visited stated that contraband drug use was *very common*, with Sing Sing (73%) reporting the highest percentage and Taconic (25%) the lowest.

- **Inmates who test positive for illicit substances are frequently sent to the Special Housing Unit (SHU), where little to no substance abuse treatment is offered.** Eighty-six percent of survey respondents at the facilities we visited who had received a positive urine test were given a SHU sentence and, if at the time enrolled in a treatment program, were removed from their substance abuse treatment program. Only 14% of the individuals surveyed who received a SHU sentence as a result of drug use or possession were provided with a cell-study workbook on substance abuse treatment during their SHU sentence; no out-of-cell treatment program is offered by the Department for disciplinary inmates.

**Reentry/Aftercare**

- **Most treatment programs make little effort to develop specific in-prison and post-release aftercare recommendations for program graduates.** Treatment programs generally do not require or provide assistance to inmates in contacting community-based aftercare programs or developing a concrete plan for continuum of care, even for those participants who are nearing release. In addition, program staff in many prisons make little effort to develop prison-based aftercare programs, and treatment staff frequently do not emphasize the importance of participation in voluntary programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Programs at some facilities, such as those at Lakeview Shock, Sing Sing and Hale Creek, did engage in aftercare planning and support both in prison and in preparing for release. In addition, Mid-State had developed an aftercare dorm for program graduates.

- **Discharge planning is minimal, and many of the staff responsible for this task lack the expertise and resources to execute it effectively. The treatment staff who have worked with the inmates for a minimum of six months and are in the best position to assess an individual's readiness for, and make recommendations to, appropriate community-based treatment programs are not charged with the responsibility of developing a detailed discharge plan. No detailed discharge plan is produced for an inmate in any program, as the responsibility of determining program and housing placement upon release lies with parole. In practice, the treatment staff at most facilities provide little to no support or assistance to inmates who have been graduated from prison-based substance abuse treatment and are being released.** Discharge planning for inmates with substance abuse problems is the responsibility of the DOCS Transitional Services (TS) unit and the New York State Division of Parole. The discharge planning process for inmates with substance abuse problems varies greatly among the prisons we visited. The Transitional Services units are primarily staffed by inmate program assistants, with varying degrees of professional staff oversight. The Division of Parole created a special unit of parole substance abuse counselors called ACCESS that is responsible for interviewing, assessing and referring individuals who are required to participate in community treatment and are being released in New York City. This effort by Parole focuses on New York City, so many inmates discharged in other parts of the state are not provided these important services.

**Clinical Case Records**

- **Substance abuse treatment records we reviewed were often not individualized and did not present a holistic or comprehensive view of the treatment participant or his/her experiences or history.** Many treatment records lacked basic information such as full substance use or treatment histories. They also contained minimal information about other needs or issues that may impact on recovery such as social supports and employment and educational opportunities. In addition many of the long- and short-term goals in the treatment plans were broad and unspecific and were repeated verbatim among various treatment records.

- **The treatment record forms and process outlined in the ASAT manual do not encourage collaboration between inmates and treatment staff in the development of critical treatment elements such as treatment and discharge plans.** The treatment plan and discharge forms did not appear to include space for substantive participant input, nor was there evidence of such input in the treatment staff's comments on the forms themselves. The records we reviewed seemed to contain mostly the views of the treatment staff and less the voice of the participant.

- **No clear process exists for clinical supervisors to regularly review and ensure the quality and content of treatment records.** Only one form in the treatment records included a line for documentation of a clinical supervisor review. Other than annual site visits from Central Office in which some treatment records may be reviewed, there appeared to be no formal process by program supervisors to review treatment records.

This type of review is integral to ensuring appropriateness of content, proper completion of forms and quality and effectiveness of treatment services provided.

**Monitoring/Oversight**

- **Protocols or procedures for prison management oversight of treatment programs do not exist; prison staff responsible for this oversight have little relevant expertise.** On most of our visits, prison administrative staff reported limited experience or expertise in treatment programs. They typically performed no monitoring of the program other than visiting the area and reviewing grievances and complaints from participants. At some facilities, however, the supervising correction counselor, who was directly responsible for the program, had expertise in the area, but even in these situations there was no protocol defining these officials' duties in managing and monitoring the program. There appears to be very little clinical supervision in the daily operations of the treatment program, particularly in terms of observing sessions, case consultations and chart reviews.

- **Only recently has there been any outside monitoring of DOCS substance abuse treatment services.** Language was included in the Rockefeller drug law reforms passed in April 2009 that required the Office of Alcoholism and Substance Abuse Services (OASAS) to monitor prison-based substance abuse treatment programs, develop guidelines for the operation of these programs and release an annual report assessing the effectiveness of such programs. Previously, OASAS certified both the Willard Drug Treatment Campus (Willard DTC) and the treatment program at Edgecombe Correctional Facility. OASAS's involvement with correction, such as the new standards created for Willard DTC in 2009, has helped to reduce the size of group counseling sessions and increase the qualifications necessary for certain treatment staff positions. OASAS' first report on NYS DOCS Addiction Services published in December 2009, lays out plans for 2010 that include site visits to 8-10 facilities (including a reception center and maximum security facility) as well as the development of new basic operating guidelines for both the ASAT and CASAT programs.

**Special Populations**

- **Inmates with both substance abuse problems and mental health needs do not consistently receive appropriate substance abuse treatment.** The State has created only 13 Integrated Dual Diagnosed Treatment (IDDT) programs, designed for individuals with both substance abuse and mental health problems, some of these taking place in general population while most are held in the mental health residential units at Office of Mental Health (OMH) level one facilities. These represent approximately 294 of the nearly 10,000 DOCS treatment beds. No clear policies or criteria exist for including general population inmates with mental health needs in existing treatment programs. We received varying descriptions from the prisons we visited concerning these inmates' participation in general substance abuse treatment programs. Nearly 14% of New York's prison population is on the OMH caseload, representing more than 8,500 inmates, of whom 3,500 to 4,000 have significant mental health needs. The State is not providing an adequate number of treatment slots for this patient population. The majority of

individuals on the OMH caseload are placed in general population, and it is unclear whether they receive treatment geared to their needs. However, the Department has reportedly recently developed a new treatment manual for its IDDT programs, and it appears the Department wants to enhance these services.

- **At most prisons, services for participants with limited English skills are inadequate.** Few DOCS treatment staff are Spanish-English bilingual, and very few treatment activities are conducted in Spanish. Since approximately 6% of the State's inmate population has limited English skills, the needs of many individuals are not adequately being addressed. At many prisons, some materials are available in Spanish. However, for most programs, the inmates must rely on other bilingual inmates to translate for them. The inmate translators have received no training in performing these functions. Moreover, most substance abuse treatment staff cannot read Spanish, so it is unclear to what extent they are able to review the materials prepared by Spanish language–dominant program participants.

- **Gender-appropriate topics and materials for substance abuse treatment programs in DOCS facilities housing women varied significantly.** Approximately 88% of women in New York State prisons are assessed as having an alcohol or substance abuse problem. Eight out of 10 women in prison in New York State experienced severe abuse as children, and nine out of 10 have had incidents of physical or sexual violence in their lifetimes. Compared with nearly 13% of the male inmate population in the State, 42% of women have been diagnosed with a mental illness, and 73% of incarcerated women are mothers. Incarcerated women have specific experiences that will influence their recovery process. These perspectives must be addressed in substance abuse treatment programs serving women in order to ensure effective treatment.

# Major Recommendations

As mentioned above, the Office of Alcoholism and Substance Abuse Services released its first annual report on DOCS treatment services in December 2009. The OASAS report outlined a number of promising developments and future plans for improving DOCS substance abuse treatment programs, including: reviewing the Department's screening/assessment instruments and processes; developing new operating guidelines for the Alcohol and Substance Abuse Treatment (ASAT) and Comprehensive Alcohol and Substance Abuse Treatment (CASAT) programs currently offered by DOCS; providing assistance in identifying additional training opportunities for treatment staff; exploring the use of medication-assisted therapy (MAT) within DOCS facilities; and assisting the Department in monitoring the effectiveness of its programs. These plans are positive and necessary first steps in improving the current substance abuse treatment offered in NYS prisons and the following recommendations build upon and further develop many of these points. We have included a more complete list of recommendations in **Section 18** of this report.

**Screening/Assessment**

- **Develop and implement a more comprehensive and standardized assessment process and an instrument that enable the guidance/reception staff to distinguish among types and severity of need for substance abuse treatment as well as risk of future criminal behavior, and to distinguish between substance use, substance abuse and substance dependence.** The addition of a more comprehensive assessment tool for use for individuals who screened positive for substance abuse and a clear, formal definition of who should receive treatment would reduce the number of individuals being inappropriately placed into treatment programs, would ensure that individuals were being placed into the program that most accurately reflects their level of need, would make the best use of limited staffing and financial resources and would be most effective in reducing risk of relapse and recidivism due to drug use.

- **Require staff conducting assessments regarding substance use to receive training to administer the standardized assessment instrument.** Decisions regarding appropriate placement for substance abuse treatment programs are more effective when done by trained professional staff. A degree of understanding about the different levels of severity of substance abuse, the types of prison-based programs available, and the program that best suits an individual's needs can reduce inappropriate referrals and increase treatment effectiveness. Specialized training covering basic counseling techniques, essential mental health terms, symptoms, relationship building and reflective listening should be offered to counselors administering screening and assessment instruments. Office of Mental Health (OMH) staff should work in coordination with counselors assessing inmates for substance abuse treatment, sharing mental health information as needed and collaborating when necessary to make an appropriate recommendation for substance abuse treatment services for individuals with mental health problems.

- **Develop a variety of treatment and educational programs for individuals with differing needs and match individuals who have been identified as needing some substance abuse treatment to appropriate treatment programs based on their individual needs and severity of substance abuse.** Matching programs to individual needs greatly increases the chances that an individual will be successful in his/her treatment placement. Treatment matching or determining appropriate level of care requires that a continuum of services be available, ranging in levels of intensity, length, treatment modality and location (residential or outpatient). To create a successful therapeutic environment, inmates with similar types and severity of substance abuse issues should be placed together to maximize the effectiveness of the treatment and to make the best use of treatment staff resources. Correctional facilities in Colorado[11] and Maine have had success with treatment matching; these programs could serve as models for a similar approach in New York State.

- **Allow for prioritizing of substance abuse treatment programs according to need and severity of substance abuse problem for inmates demonstrating circumstances such**

[11] https://exdoc.state.co.us/secure/combo2.0.0/userfiles/folder_5/Overview_SA_Treatment_Services_FY08_2.pdf

**as active substance dependence when entering prison and drug use inside prison.** Inmates with a significant need for substance abuse treatment at admission to DOCS or who repeatedly receive disciplinary sanctions for drug use inside prison should be prioritized for substance abuse treatment services regardless of the length of their prison sentence. Though individuals will still be required to participate in a substance abuse treatment program toward the end of their incarceration, the State should explore the creation of a separate voluntary substance abuse treatment program for individuals first entering the prison system who need treatment services more urgently. This option should also be available for inmates who receive a misbehavior report for use or possession of drugs while incarcerated. It is important to note that the Substance Abuse and Mental Health Administration (SAMHSA) also recommends that inmates with significant substance abuse needs and high recidivism risk should be prioritized for initial placement into a substance abuse treatment program.[12]

**Treatment Programs, Processes, Content and Structure**

- **Standardize program content and material using evidence-based workbooks, handouts and videos.** The DOCS Office of Substance Abuse Treatment Services (OSATS) should provide a more detailed curriculum to treatment programs including handouts and videos to be used in the program. Treatment staff with community-based treatment experience should introduce relevant materials that they believe would add value to the program, but such materials should be reviewed by OSATS staff during their routine monitoring of the programs to ensure the appropriateness of such materials and to identify useful materials to distribute to all treatment programs. Centralizing materials and program content can assist in making certain that materials and content are up to date and include new evidence-based practices and approaches.

- **Increase frequency and length of individual counseling sessions.** Individual counseling in a setting with such a diverse population and large group sessions allows inmates to address more sensitive issues that they might hesitate to discuss in a group setting. DOCS should offer individual counseling sessions in substance abuse treatment programs in accordance with OASAS standards for community-based programs. It is also essential that treatment staff ensure the confidentiality of such individual sessions and accurately document their duration and content.

- **Reduce the size of group sessions and increase frequency of use of small group sessions.** Large group sessions are conducive to didactic instruction, but do not create an appropriate environment for open communication, sharing and discussion. Group size should be limited to ensure best clinical effectiveness; groups should routinely break into small groups that can facilitate greater interaction, dialogue and support among peers.

- **Fidelity to therapeutic community and cognitive-behavioral principles should be improved.** Efforts should be taken to ensure that key elements of therapeutic

[12] Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 -- SAMHSA/CSAT Treatment Improvement Protocols -- NCBI Bookshelf*, 148.

communities and a cognitive-behavioral approach are more fully integrated into the program. This approach includes placing a greater focus on role playing and skills development, as well as use of incentives and privileges in the community.

**Staffing**

- **Increase substance abuse treatment staffing numbers.** State policymakers should take action to promptly fill authorized DOCS treatment staff positions. Staff-to-participant ratios should be in accordance with OASAS community regulations

- **Increase qualifications and skills necessary for treatment staff**. Treatment staff should meet the necessary requirements and qualifications as outlined by OASAS, resulting eventually in a substantial portion, if not all, of treatment staff having some type of outside credential or license, such as CASAC.

- **Provide more comprehensive and frequent training for treatment staff covering topics such as evidence-based counseling approaches used in substance abuse treatment, working within the criminal justice setting and working with special populations.** The State should develop additional mandatory ongoing training sessions and encourage greater participation in training by providing monetary support, approved absences and other incentives to enhance the skills of the treatment staff. Training for all DOCS substance abuse treatment programs should be offered by a consistent set of trainers able to inspect treatment plans and observe programs to best identify needed areas for training. The Department should explore creating "model training programs" where all new staff can receive training, prior to placement at a permanent facility.

**Program Completions and Removals**

- **Standardize the removal process for all prison-based substance abuse treatment programs and develop program retention committees at all treatment programs with the aim engaging individuals in treatment and decreasing the number of inmates removed from the program.** Substance abuse and dependence are chronic, reoccurring conditions; relapse, acting out, noncompliance and multiple experiences with treatment programs are typical and expected. Many inmates resist being forced into treatment and may act out in various ways, and it is up to treatment staff to find ways to engage participants in the recovery process. Every substance abuse treatment program in DOCS should develop a program retention committee, which should work resourcefully with individuals who demonstrate problems in the program. These committees should use removals as a last resort.

**Drug Use and Testing**

- **Institute less punitive responses to drug usage inside prison and develop appropriate programs for inmates who use drugs.** We recognize that drug use inside prisons can impact on the safety of inmates and staff and must be regarded seriously. Inmates testing positive for drug use are often in urgent need of intensive treatment services.

Disciplinary responses should be tempered, not eliminated, and efforts should be made to guarantee that individuals placed in disciplinary housing because of a positive urine test are offered treatment preparation or services during this confinement. In addition, once an inmate completes a disciplinary sentence, he/she should be prioritized for intensive treatment services.

**Reentry/Aftercare**

- **Increase aftercare services for inmates completing treatment programs and returning to general population, including possibly an aftercare dorm.** The creation of an aftercare dorm for inmates completing residential substance abuse treatment programs, more formal and diverse aftercare services, and continuity of services from treatment staff are important elements for reducing recidivism and relapse, as well as adding an incentive for inmates to complete the program. In addition, we recommend that the Department allows inmates to run AA and NA programs when volunteers from the outside community are not available.

- **Develop a more comprehensive, coordinated and integrated discharge planning policy, including recommendations from treatment staff on the type of program that would best suit individuals' substance abuse treatment needs in the community.** To promote successful reentry for individuals graduating from prison-based substance abuse treatment programs, the State should develop a prison-based, reentry oriented, integrated process that includes input from, and coordination with, treatment staff, Parole, and community-based organizations. The State should create a comprehensive discharge plan that includes specific recommendations for the type and length of treatment program or services that would most benefit the individual. These programs should range in level of intensity from outpatient services to halfway houses and inpatient treatment programs. In addition, each facility should provide every individual leaving prison with documentation from the treatment staff outlining the treatment services he/she received while incarcerated. This information would enable community-based treatment staff to provide a more effective and appropriate continuity of services.

**Clinical Case Records**

- **Work with the Office of Alcoholism and Substance Abuse Services (OASAS) to design new treatment record forms that are concise, individualized, intuitive and comprehensive.** OASAS has the expertise and experience to assist DOCS in developing forms that more effectively capture the information necessary to offer the highest quality of services to treatment participants. They may also be able to offer training or assistance in developing training for treatment staff on completing these forms in a manner that is both individualized and concrete. DOCS should take advantage of the existing resources and work with OASAS towards improving these forms.

- **Promote better inmate participation in the treatment and discharge planning process.** Treatment staff should be encouraged to involve treatment participants in developing their treatment and discharge plans in order to increase ownership and

investment in the program and their recovery. This collaboration should be documented in the treatment records, and should be viewed as an important learning experience for the participant and an opportunity to engage in important therapeutic conversations.

- **Develop formal process for regular review of treatment records by a clinical supervisor.** Without a process in place to ensure accountability, even the most comprehensive of forms can become ineffective. Proper auditing and supervision of treatment records and their content not only provides this accountability, but allows treatment staff to develop their professional skills while increasing the quality of services beings offered to treatment participants.

**Monitoring/Oversight**

- **Develop and implement written policies and procedures on how individual facilities and DOCS Office of Substance Abuse Treatment Services provide clinical supervision to treatment staff.** A clinical supervisor should regularly monitor all individual treatment plans and records. Clinical supervision should be provided to all treatment staff by a qualified clinical supervisor in accordance with OASAS community standards. If a qualified clinical supervisor is not available at the facility, DOCS should employ a consultant to offer clinical supervision to treatment staff two to four times per month in person or through teleconferencing.

- **Develop written policies and procedures for OASAS oversight and evaluation of DOCS substance abuse treatment programs.** To address the significant variation among programs, the State and OASAS should establish formal policies requiring quality assurance and utilization review plans. In addition, documents should be developed for monitoring purposes to comprehensively rate treatment plans and records, program sessions and participant satisfaction, and to collect outcomes data.

**Special Populations**

- **Increase collaboration with the Office of Mental Health (OMH) to provide support and expertise in substance abuse treatment programs serving inmates with mental health issues.** The Department's efforts to increase the number of substance abuse treatment programs for inmates with mental health needs is commendable, but we are concerned by the lack of mental health training for and expertise of many of the treatment staff. OMH staff should frequently participate in the treatment sessions for IDDT programs for both general population inmates and individuals in residential mental health programs. DOCS should also schedule weekly treatment meetings should be scheduled with OMH and treatment staff working in those programs to address the special needs of this population.

- **Increase the number of Integrated Dual Diagnosed Treatment Programs available in general population.** DOCS and OMH have been able to collaboratively develop what appears to be generally successful integrated treatment programs for individuals with co-occurring mental health and substance abuse problems housed in both disciplinary and

residential mental health programs. Thousands of inmates with mental health disorders, many of them seriously mentally ill, reside in general population and the three current general population IDDT programs are not sufficient to address the needs of this population.

- **Increase resources available for limited English speakers and the number of bilingual treatment staff. Conduct a needs assessment for limited English speakers in need of substance abuse treatment and determine if a Spanish-language substance abuse treatment program should be piloted at one facility.** Treatment staff should be able to provide limited English speakers with information and materials in their native language. All materials and information made available to the group should also be available to limited English speakers, whose treatment services should not be reduced simply because of their inability to speak English. Prison administrators should make a strong effort to recruit more bilingual treatment staff, working with state officials to offer pay differentials where necessary. The Department should explore the possibility of creating at least one Spanish-only treatment program, allowing individuals with limited English skills to participate more fully in their recovery. In addition, if the Department uses inmate translators, it should establish a paid position to adequately trained individuals who are not currently in treatment.

- **Incorporate gender-appropriate topics and curriculum into the substance abuse treatment programs offered in prisons that house women.** Gender-specific programs should address issues of maintaining and developing healthy relationships; trauma; parenting; and health education. The Department should explore the use of gender-specific screening and assessment instruments such as Texas Christian University Drug Screen (TCUDS II) or TWEAK.[13]

[13] Ibid., 38.