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Federal Drug Aftercare: Its Evolution and Current State

BY PHILIP J. BIGGER

Deputy Chief U.S. Probation Officer, Eastern District of New York

There are three judicial methods of disposition of an addict case: First, the addict may be sentenced for a definite period and his treatment left in the hands of the Attorney General; Second, he may be placed on probation and returned to the community subject to the supervision of a probation officer; or Third, he may have the imposition of sentence suspended and be placed on probation upon condition that he go to a Public Health Service hospital until pronounced cured.

—The Hon. George H. Moore
Eastern District of Missouri¹

ALMOST HALF a century has now passed since Judge Moore's essay on the judicial and treatment options available in 1945 for the proper disposition of Federal offenders who were also substance abusers. It was clear then that two major organizational entities were given the responsibility for providing treatment and supervision to addicts: the Federal Bureau of Prisons and the United States Probation Service. Even if a person was actually in the care of the Public Health Service, Judge Moore noted that probation officers were still responsible for the patient's supervision, especially when discharged to aftercare. Throughout the years, to the present, these two organizations have continued their parallel and similar goals, with the United States Board of Parole, later the Parole Commission, acting as a unifying impetus by assuring a continuation of treatment in the community following treatment in custody through the imposition of special conditions of release.

Most of the many changes which have occurred between 1945 and the present have not disturbed this tripartite relationship, but rather were important experiments in finding the most effective treatment solutions for substance abuses in custody and in the community. For example, 25 years ago, Congress passed the ambitious Narcotic Addict Rehabilitation Act of 1966 (NARA). Under this legislation, a judge could commit an offender to the custody of the Bureau of Prisons for a period of 30 to 90 days to determine whether or not the individual was addicted and, if so, whether or not the offender was likely to be rehabilitated through participation in special treatment programs of the Bureau of Prisons. This would be followed by treatment in aftercare provided by contract with the Bureau but with the offender under the supervision of the Probation Service.

Following the passage of NARA, a variety of

treatment programs were developed within correctional institutions including group counseling, therapeutic community groups, and individual sessions. Contracts were established with community aftercare agencies for treatment after release. By 1972, the need to expand the original NARA was recognized, and eligibility to participate in NARA programs was enlarged to include not only abusers of narcotics but other controlled substances as well.² Treatment availability was also extended to probationers and other non-NARA releasees from Federal prisons.

A significant administrative change in drug treatment occurred when then President Jimmy Carter signed the Contract Services for Drug Dependent Federal Offenders Act of 1978³ which took effect on October 1, 1979. Pursuant to the act, responsibility for operating aftercare programs was transferred from the Attorney General and the Bureau of Prisons to the Director of the Administrative Office of the U. S. Courts. The Probation Division of the Administrative Office was given the authority to administer the overall program while individual chief probation officers of the Federal districts were provided with the authority to enter into contracts, with the approval of the Administrative Office, with community aftercare agencies. Thereafter, the Bureau of Prisons continued to pursue the development of its institutional programs, and the Probation Service followed a similar course in the community. And for many years, the Parole Commission continued to act as a catalyst for the treatment continuum from prison to home for inmates under its jurisdiction.

The Probation Service and Drug Aftercare

The Contract Services for Drug Dependent Federal Offenders Act of 1978 did not simply transfer

the administrative device of contracting from one branch of government to another. It also inspired the development of a uniform, national approach to the drug treatment needs of a variety of offenders in the community. A structure was created, in the development and publication of Chapter X of the Probation Manual contained within the Administrative Office's *Guide to Judiciary Policies and Procedures*, which envisioned the probation officer as the focal point of treatment, providing it directly, or through free community resources or by contract with private agencies. Regardless of the source, the services provided were to include counseling, urinalysis, vocational testing, training and placement, physical examinations, psychiatric and psychological evaluations, psychotherapy, ambulatory detoxification, residential treatment centers, temporary housing, emergency transportation, financial assistance, and travel by contract staff. In 1979-80, the first year of drug aftercare under the auspices of the Administrative Office, 157 contracts were in place for 2,500 substance abusers. An additional 2,300 abusers were in non-contract treatment for a total of 4,800 clients. The budget for that year was \$3.5 million.⁴ At least in part through the nationwide training of officers in the detection of substance abuse the numbers of individuals identified as using drugs substantially increased over the years.

In 1990, 817 contracts were in place for 9,607 substance abusers. With 10,175 abusers in non-contract treatment there was a total of 19,782 clients in treatment and a budget of \$21 million. In order to assist the districts with both administering contracts as well as providing treatment, the Probation Division created the senior officer position of Drug Abuse Treatment Specialist (DATS) in 1982. Today the number of these specialists is substantial.

Four years after the creation of the first drug abuse treatment specialist positions, another milestone was achieved with congressional authorization permitting contracting for alcohol treatment in 1986.⁵ Prior to this time officers had to rely on a limited number of free community services with limited ability to monitor treatment progress by virtue of the anonymous nature of some programs. Occasionally, in the case of multiple addictions, the client with drug and alcohol problems could be in contract treatment based on drug use with the goal of resolving an alcohol addiction as well. But these were fortuitous circumstances which did not directly confront the obvious treatment needs of alcohol dependent clients. Having

obtained the support of Congress, alcohol treatment is now available, and in 1990, 3,612 Federal offenders were in a variety of treatment programs.⁶

As the year 1990 ended, the services available by contract for all substance abusers included individual, group, and family counseling; intake assessment; intensive outpatient counseling (daily treatment); vocational testing, training, and placement (including testing and work skills evaluation, pre-employment training, on-the-job training, and classroom); physical examinations; psychological and psychiatric evaluations; psychotherapy; outpatient detoxification; antagonist treatment; inpatient detoxification; methadone maintenance; and urinalysis.⁷

Urinalysis

While there are numerous subjective and historical methods for identifying drug use, urinalysis still remains as the single most important scientific and objective procedure. Many of the human and legal issues concerning urinalysis as well as the several methodologies employed, client subterfuges, interpretations of laboratory results, and the quality control of laboratories have been discussed elsewhere.⁸ However, since 1979 when the Probation Division became involved in contracting for urinalysis services, the qualitative demands for excellence have increased significantly. For example, in the beginning, when laboratories competed for contracts, the laboratories, themselves, offered their own detection limits (i.e., the smallest amount of a drug in the biological sample which they could identify) and their own methods of confirming an initial positive result. As the Probation Division (now the Probation and Pretrial Services Division) gained experience, however, it was and continues to be the Division which sets the standards for detection and confirmation procedures, as well as directing which tests will be employed for particular drugs.

At present, every urine sample submitted to the contract laboratory is routinely tested for the following drugs using a highly sensitive procedure known as Enzyme Multiplied Immunoassay Technique (EMIT): The opiates class (including morphine, codeine, and Dilaudid), benzococaine (a metabolite of cocaine), phencyclidine (PCP), amphetamines, barbiturates, the diazepam class (e.g., Valium, Librium, etc.), and methadone. Upon request, the laboratory will also screen for a variety of drugs in one procedure, Thin Layer Chromatography (TLC), which has the capacity to identify many drugs at once, although not with

the same sensitivity as EMIT. This screening procedure includes amitriptyline (Elavil), doxepin (Adapin), glutethemide (Doriden), hydroxyzine (Doriden), imipramine (Tofranil), meperidine (Demerol), chlorpromazine (Thyroxine, etc.), phenytoin (Dilantin), propoxyphine (Darvon), promethazine (Phenergan), phenmetrazine (Preludin), levo-alpha-acetylmethadol (LAAM, a long-acting form of methadone), pentazocine (Talwin), and oxycodone (Percodan). Individual specialized tests are also available for alcohol, cannabinoids, ethchlorvynol (Placidyl), methaqualone (Quaalude), methylphenidate (Ritalin), phenylpropanolamine (PPA), quinine, and lysergic acid diethylamide (LSD). A specific gravity test is also available in order to determine the degree of water in a specimen. (The specific gravity of water is 1.000. The lower range of the specific gravity of urine is 1.005. Therefore, a specimen whose specific gravity is between 1.000 and 1.005 suggests that a person might be attempting to dilute the specimen through drinking an excessive amount of water, a common subterfuge known as "flushing.") All positive results for the drugs noted above are confirmed by a separate and distinct methodology including Gas Chromatography (GC), High Performance Liquid Chromatography (HPLC), or Gas Chromatography/Mass Spectrometry (GC/MS). Complementing the development of qualitative test requirements has been the simultaneous enhancement of chain-of-custody protection procedures, including new sealing and initiating steps and the use of a bar graph identification for each specimen. Thus, the possibility of misidentification of a specimen or test result has been greatly reduced.

Other Detection Procedures

Except for those districts which conduct *in vivo* urine testing with an EMIT machine on site, the possibility of achieving an immediate drug test result for use in treatment and prompt intervention is limited. However, many district offices now employ breathalyzers which provide results of alcohol levels in clients within seconds. In order to detect drug use among clients who inject drugs, several districts employ a skin detection technique using a magnifying glass. The advantage of this procedure is the fact that both current and past drug usage can be detected by an experienced observer.

Finally, at least one court has accepted hair analysis as a legitimate scientific procedure to determine drug use.⁹ Although the body excretes all of the drug or drugs which a person injects

over time, it retains an historical record in hair. If a length of hair is analyzed, it will reveal the use of particular drugs over time, subject only to the length of the hair sample.

Contracting and Quality Control

The accuracy of urinalysis is governed by two systems: One concerns the taking of the specimen and the other with the actual analysis of the biological sample. Each system complements the other, and the overall process is only as strong as the weaker component. The qualitative standards adapted in the procurement of urinalysis services must be at least equal to the standards used in the taking of the specimens and the interpretation of laboratory results. Otherwise, the tool of urinalysis becomes valueless. A full presentation of the guidelines developed by the Probation and Pretrial Services Division to select and monitor the proficiency of toxicology laboratories is beyond the scope of this article. However, not long after being given the responsibility to contract with laboratories, the Division had to confront a significant national problem concerning the maintenance of quality in laboratory performance, a problem created by the cessation of congressional funding.

Briefly, in 1967, The Clinical Laboratories Improvement Act (CLIA) was enacted.¹⁰ The purpose of this much-needed legislation was to improve the performance of laboratories engaged in the analysis of biological samples to detect drugs of abuse by requiring them to adhere to certain standards established by the Federal Government through a licensing policy. The Centers for Disease Control (CDC) in Atlanta, Georgia, which had already begun a proficiency testing program in 1964, was assigned the task of administering the new national program.¹¹ CLIA required that all laboratories engaged in interstate work (1) maintain an internal quality control program; (2) have on hand sufficient and appropriate testing equipment; (3) maintain adequate records; (4) employ qualified professionals; and (5) participate in a proficiency testing program. The value and effectiveness of the last requirement, that laboratories allow themselves to be tested by an outside, objective agency, has been described by Guerrant and Hall in their 1977 evaluation of the CDC's proficiency testing program.¹² For example, these chemists noted that in 1972 when test samples of urine of known drug content were sent from the CDC to an initial 114 participating laboratories, the results revealed that only between 50 percent and 70 percent of the toxicologi-

cal laboratories were able to identify all the drugs found in the urine specimens. And only 29 percent of hospital laboratories attained a perfect score. With the continuation of testing by the CDC, however, the percent of correct results from laboratories on subsequent tests gradually increased, and this in spite of a more rigorous testing program.

Thus, after 1975, 78 percent of the laboratories participating in the CDC's proficiency testing program attained a perfect score. Despite the impressive record by scientists at the Centers for Disease Control who administered the proficiency testing program, funding for this activity evaporated by the end of 1982 with the Federal budget cuts at that time. And so, in 1983, with an average national error rate among laboratories at about 14 percent,¹³ laboratory service users, such as the Probation and Pretrial Services Division, had to develop even more care in the selecting and monitoring contract laboratories.

The screening process for bidding laboratories is a rigorous one. In addition to the submission of written proposals to meet the standards set by the Division (which are initially reviewed in light of cost, quality of services and experience, business reputation, and responsibility), laboratories in the final competitive range are subject to an on-site visit. The evaluating team presents between 50 and 100 test urine specimens at the start of the evaluation. These are inserted with the regular "run" of specimens that a laboratory handles each day. While these test specimens are being logged in, labeled, and processed, the team has the opportunity to examine several predetermined areas including the laboratory's personnel, testing methodologies, operations, physical plant and safety procedures, and office and billing procedures; Standard Operating Procedures Manual, equipment, maintenance and quality control logs, chain of custody procedures, capacity to handle a large control, and specimen storage facilities.

Once a laboratory is successful in receiving a contract award, it becomes subject to on-going proficiency testing by the Probation and Pretrial Services Division to assure excellence in its daily performance. The method in use by the Division is a procedure known as the "blind" test. In this method the laboratory receives specimens through one or more probation or pretrial services offices but is unaware that these are not routine specimens. The advantage of such a procedure is that it permits the quality controller to have the opportunity to judge how a laboratory performs under routine conditions—how it performs, in

fact, with most of the specimens that it usually handles. At present, blind testing of the laboratory currently under contract with the Division has reflected 96 percent accuracy in the last calendar quarter of testing in 1990.¹⁴ This is especially significant in view of the fact that the contract laboratory, in 1990 alone, tested approximately 500,000 specimens.

The Future

Despite the high level of treatment and services available within institutions and in aftercare, there still remain several areas of concern which require continued work. These include the perpetuation and enhancement of the treatment continuum for substance abusers from the prison environment to the community; the need to continue to learn about the human immunodeficiency virus and how to work with its victims; and, finally, the need to continue to evaluate the value of both institutional and aftercare programs.

With respect to the reality of AIDS, information concerning the HIV virus itself has been proliferating since 1987. However, the total number of individuals under community supervision who have tested positive for the virus is not known. Policies and procedures for working with these vulnerable individuals have yet to be developed. Plans are under way, however, within the Probation and Pretrial Services Division of the Administrative Office, to produce these needed guidelines in the near future. The continuation of treatment for which substance abusers received in the institution to aftercare in the community seems to have been adversely, albeit inadvertently, affected by the Sentencing Reform Act of 1984. The act, in abolishing parole, removed an important catalytic agent in the form of the Parole Commission. Although the life of the Commission has been extended to 1997 (to ensure parole supervision for the more than 29,000 individuals still in custody for offenses committed prior to the effective date of the Sentencing Reform Act), there are many more individuals in confinement and going into confinement in the future for whom parole does not apply. In parole cases the Commission will require special conditions for substance abuse treatment in appropriate cases, thus alerting field officers to the past that there may have been treatment in the institution as well. Officers can then contact the institution for drug treatment data. However, in determinant sentence cases, individuals are simply released with no prior planning as was necessary in parole cases. In these instances which constitute most

releases and eventually all, it is critical that a communication link be created in order to apprise officers of the aftercare treatment needs of substance abusers who have received therapy within the prison setting.

Without this linkage it is possible that the treatment foundations established while the abuser was institutionalized will erode rather than be supported.

Finally, research. The constant need to review policies, procedures, and practices is always present. The drug aftercare program of the Probation and Pretrial Services Division has already been evaluated as recently as 1986.¹⁵ However, continued evaluations are essential to achieving that highest number of successful treatment outcomes by determining what works and what works best.

NOTES

¹Judge George H. Moore, "The Narcotic Addict Before The Court: A Judge's Viewpoint," *Federal Probation*, 9(4), Oct.-Dec. 1945, pp. 3-8.

²Public Law 92-293.

³Public Law 95-537.

⁴Dan W. Stowers (ed.), *News and Views*, 5(13), June 23,

1980, Probation Division, Administrative Office of the U.S. Courts.

⁵Title 18 U.S. Code, Section 3672.

⁶Administrative Office of the U.S. Courts, *1990 Report of the Director*, Washington, DC (undated).

⁷Chapter 10, Probation Manual, *op cit*.

⁸Philip J. Bigger, "Urinalysis: Issues and Applications," *Federal Probation*, 43(4), Dec. 1979, pp. 23-27.

⁹*U.S. v. Anthony Medina*, 87CR824-3, EDNY, October 22, 1990, Weinstein, J.

¹⁰Public Law 90-174; Title 42 U.S. Code, Section 263.

¹¹Gordon O. Guerrant and Charles T. Hall, "Drug Abuse Proficiency Testing," *Clinical Toxicology*, 10(2), 1977, pp. 209-219.

¹²*Ibid*.

¹³*New York Post*, Mar. 24, 1980, p. 15. See also Hugh L. Hansen, Joseph Boone, and Samuel P. Caudill, "Crisis in Drug Testing: Results of CDC Blind Study," *Journal of the American Medical Association*, 253(16), April 26, 1985.

¹⁴Ronald Dyson, drug program administrator, Probation and Pretrial Services Division, Administrative Office of the U.S. Courts, in an interview with the author.

¹⁵James B. Eaglin, *The Impact of The Federal Drug After-care Program*, Federal Judicial Center, 1986.