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Estimating drug treatment needs among state prison inmates

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Abstract

Growing prison populations in the U.S. are largely due to drug-related crime and drug abuse. Yet, relatively few inmates receive treatment, existing interventions tend to be short-term or non-clinical, and better methods are needed to match drug-involved inmates to level of care. Using data from the 1997 Survey of Inmates in State Correctional Facilities, a nationally representative sample of 14,285 inmates from 275 state prisons, we present a framework for estimating their levels of treatment need. The framework is drawn partly from the American Society of Addiction Medicine Patient Placement Criteria and other client matching protocols, incorporating drug use severity, drug-related behavioral consequences, and other social and health problems. The results indicate high levels of drug involvement, but considerable variation in severity/recency of use and health and social consequences. We estimate that one-third of male and half of female inmates need residential treatment, but that half of male and one-third of female inmates may need no treatment or short-term interventions. Treatment capacity in state prisons is quite inadequate relative to need, and improvements in assessment, treatment matching, and inmate incentives are needed to conserve scarce treatment resources and facilitate inmate access to different levels of care.

Keywords: Drug treatment; Offenders; Level of treatment need; Placement criteria

1. Introduction

America's prison and jail populations have grown substantially over the past 20 years. Between 1980 and 2002, the total number of inmates in the United States quadrupled from 501,886 to 2,033,331 (Harrison and Beck, 2003). The state prison population (housing inmates convicted of state crimes, usually felonies, who are serving sentences of more than a year) increased by 309% to 1,209,640, the federal prison population (housing inmates convicted of violating federal laws) increased by 538% to 151,618, and the local jail population (inmates convicted of violating state laws, generally misdemeanors, who are serving sentences of less than a year, or those held in custody while awaiting trial in state courts) increased by 265% to 665,475 (Harrison and Beck, 2003). These increases have been fueled mainly by drug-related crime, and the consequent high rates of substance abuse or dependence among inmates (Belenko and Peugh, 1998; Blumstein and Beck, 1999).

Despite this large and growing number of drug-involved inmates, relatively few receive treatment while incarcerated (Belenko and Peugh, 1999), and the available treatment opportunities often are a choice between interventions that may be too limited and short-term for many substance-involved inmates (12-step programs or drug education classes), or those that are overly intensive and expensive (long-term residential treatment). Although data are lacking on the effectiveness of short-term or "outpatient" correctional treatment, a number of studies have found that participation in residential treatment during incarceration, followed by continuing care in the community, yields reductions in recidivism and relapse to drug use (e.g. Knight et al., 1999; Martin et al., 1999).

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However, long-term residential treatment beds are limited in correctional systems, and such treatment is not an option for inmates facing relatively short incarceration terms, such as jail inmates or parole violators (Deitch et al., 2002). This is unfortunate because many of the large numbers of inmates who are reincarcerated for drug-related parole violations do not receive the treatment they need and are simply returned to community, with a high likelihood of relapse.

Little is known about the number of inmates who need different amounts or types of treatment, in part because of the absence of standardized and validated clinical screening and assessment in correctional facilities (Knight et al., 2002). Coupled with limited resources and treatment space, correctional systems face difficult problems in allocating scarce treatment resources and matching the level of care to the treatment need. Given the high rates of relapse and recidivism among released inmates, however (Marlowe, 2003, Petersilia, 1999), it is important to improve systems for linking drug-involved inmates to the most appropriate levels of care.

Creating procedures and guidelines for more effectively matching drug-involved inmates to different levels of treatment can be informed by the literature on treatment matching in the general substance-involved population. Awareness of the benefits of matching patient to treatment levels and modalities dates back some 15 years and was originally driven largely by efforts to contain costs in the wake of managed care (Gastfriend and McLellan, 1997) and limits in treatment capacity (Hser et al., 1999), issues that remain salient today. The Institute of Medicine reports on treating alcohol and drug problems (Institute of Medicine, 1990a, 1990b) recognized that the different levels of severity and types of drug and alcohol problems suggested the importance of matching client needs to treatment type and intensity.

The notion of matching stems from the idea that no treatment is effective for all clients, but that all treatment is effective for some clients (Gastfriend and McLellan, 1997); determining which clients will do better in which settings is the challenge of matching. One of the earliest widely disseminated matching schema was known as the Cleveland Criteria, developed in the late 1980s (Gastfriend and McLellan, 1997) through a multi-agency consensus process. Spurred by the popularity of the Cleveland Criteria, the National Association of Addiction Treatment Providers, and the American Society of Addiction Medicine (ASAM) worked together to develop the first ASAM Patient Placement Criteria (Hoffmann et al., 1991). The ASAM criteria provide guidelines for placement of patients in a hierarchy of five treatment settings ranging from early intervention through intensive inpatient treatment (Mee-Lee et al., 2001). Despite the ensuing promulgation and popularity of the ASAM and other matching protocols, evidence of their predictive validity in terms of treatment outcomes is still limited (Gastfriend and McLellan, 1997; Melnick et al., 2001; Thornton et al., 1998; Turner et al., 1999).

There are two key dimensions to the matching problem: the severity of drug use and the other service needs. Evidence that clients with a higher severity of drug use have better outcomes in residential/inpatient or more intensive or highly structured treatment comes from the DATOS study (Simpson et al., 1999), studies in therapeutic communities (Melnick et al., 2001), outpatient settings (Rychtarik et al., 2000; Thornton et al., 1998), and Project MATCH for alcohol patients (Project MATCH, 1998). Mattson et al. (1994) reviewed 31 studies that supported the notion of treatment matching.

In addition, a number of studies in different treatment settings have found that matching services to specific client needs (e.g. psychological services, housing, employment, etc.) improves treatment outcomes (Gastfriend and McLellan, 1997; Hser et al., 1999; McLellan et al., 1983, 1993; Mattson et al., 1994; Moos and Finney, 1995). However, in many treatment programs, specific client service needs are not being adequately met (Etheridge et al., 1995; Hser et al., 1999). The Client Matching Protocol recently developed for therapeutic community clients by Melnick et al. (2001) combines dimensions of prior drug use pattern and severity, social factors, and education and work skills in an algorithm designed to determine whether a patient should be place in outpatient or residential treatment.

This experience suggests that determining treatment need for inmates is not a matter of simply assessing for drug abuse or dependence. Many inmates present with an array of health and social problems that accompany their substance abuse (Belenko and Peugh, 1999; Hammett et al., 1998). Poor education, lack of employment, physical and mental health problems, lack of housing, and family instability are common among inmates and can undermine treatment and recovery (Beck and Maruschak, 2001; Belenko et al., 2003; Ditton, 1999; Finn, 1999; Taxman, 1999).

For example, given the connections among crime, poverty, and poor health, it is not surprising that many inmates enter prison in need of medical services (Anno, 1991; Hammett et al., 1999; Marquart et al., 1997). Health services of particular relevance for drug-involved inmates include mental health services and services for the treatment of HIV and other infectious diseases (Hammett et al., 1998). For drug-using women offenders, sexually transmitted disease treatment services and pre- and post-natal care are often needed (Peugh and Belenko, 1999). A number of studies have found high rates of co-morbid substance abuse and mental health conditions among inmates and other offenders (Belenko et al., 2003; Ditton, 1999; Lamb and Weinberger, 1998; Teplin, 1994; Teplin et al., 1996).

Drug-involved inmates frequently have educational deficits and sporadic work histories, which can affect long-term recovery and complicate the transition back to the community (Finn, 1999; Travis et al., 2001). Once released from prison, an inmate who has few marketable skills and limited opportunities for employment may be more susceptible to relapse into drug and alcohol abuse and resumption of illegal activity (Laub and Sampson, 2001; Platt, 1995). A further complication is that for many inmates their physical