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A Report of the Findings

of a Survey of the Nation's Jails

Regarding Jail Drug Treatment Programs

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INTRODUCTION

In June, 1987, the American Jail Association made application to the Bureau of Justice Assistance to obtain funding for a program to reduce drug abuse, criminality and jail crowding by establishing jail drug treatment demonstration projects in several metropolitan jails.

In September, 1987, the Bureau of Justice Assistance awarded $300,000 demonstration grants to the Hillsborough County Sheriff's Office in Tampa, Florida, the Pima County Sheriff's Department in Tucson, Arizona, and later to the Cook County Department of Corrections in Chicago, Illinois, to establish model drug treatment programs. Additionally, the American Jail Association was awarded $290,793 to meet the following program objectives:

* Survey the nations jails regarding the presence of drug treatment programs;

* Develop the three pilot projects incorporating a comprehensive model for jail and community treatment of drug involved offenders;

* Transfer components of the models to other metropolitan jails; and

* Conduct preliminary research into the success of reducing drug abuse and recidivism through a combination of institutional and community treatment.

This report contains the results of the first objective of this project, the survey of our nation's jails. The information that follows is the result of hundreds of hours of envelope stuffing, labeling, mailing and telephone calling to the approximately 3,296 jails in the United States. This report would not have been possible if it were not for the help of the many Sheriffs, Jail Administrators, and other jail professionals that took the time to complete the survey.

We are hopeful that the results of this report will be useful in future planning of criminal justice budgets and programs at the federal, state and local level. The implementation of effective jail drug treatment programs in more jails could make a considerable contribution to the fight against drug abuse.

The American Jail Association is extremely grateful to the more than 70,000 people who work in our jails for their dedication and commitment to the professionalization of our nation's jails.

Overview

Federal, state, and local correctional populations have grown substantially in the past five years, due in large part to a significant influx of drug abusers within the criminal justice system. Recent survey findings (Frohling, 1989) indicate that 62% of state and federal prisoners used drugs regularly prior to incarceration. The proportion of drug-dependent jail inmates has also risen steadily. Information from the Drug Use Forecasting (DUF) system reveals that over 70% of arrestees in many metropolitan areas test positive for drugs (U.S. Department of Justice, 1989). Over a recent six-month period, 60% of metropolitan areas sampled showed large increases (of from 4 - 14%) in arrestees testing positive for drugs (National Institute of Justice, 1988).

The need for drug treatment in jail and prison settings is also substantial. State correctional administrators report that from 70-80% of inmates are currently in need of drug treatment (Frohling, 1989). An anonymous survey of new arrestees admitted to metropolitan jails reveals that up to 41% of males and 43% of females report the need for treatment (National Institute of Justice, 1989). Treatment in a jail or prison setting provides an important opportunity to engage offenders in a therapeutic environment with others who are experiencing similar difficulties. Many drug-involved offenders are unlikely to seek treatment on a voluntary basis and have a poor record of treatment participation. Incarceration is frequently the first lengthy period of abstention from drugs since initiation of regular drug use. Correctional treatment provides the opportunity to confront the inmate with the clear and unavoidable consequences of past drug use, to reduce denial that often undermines involvement in treatment, and to develop life skills and drug coping skills in a structured and supportive milieu.

Effectiveness of Drug Treatment

Drug treatment provides an effective vehicle for preventing offenders from returning to chronic patterns of drug abuse and crime. Evidence from several longitudinal studies indicates consistently favorable results associated with drug treatment. Findings from the Drug Abuse Reporting Program (DARP; Simpson, Joe, & Bracy, 1982) reveal that 63% of the research sample remained abstinent for a period of at least three years, during a twelve-year follow up. Each successive return to drug treatment was found to produce increasingly favorable outcomes. Available research evidence from prison-based drug treatment programs indicates a potential for favorable outcomes in reducing recidivism. Findings from a follow up of 376 offenders participating in the Stay-N-Out Program in New York (Wexler, Falkin, & Lipton, 1990) indicate that 80% of inmates completing nine months of treatment had no subsequent parole violations, compared with a 50% parole violation rate for inmates who dropped out before completing three months of treatment, and up to a 56% parole violation rate for inmates involved in other less intensive treatment programs.

Results from several other correctional drug treatment programs also provide support for the effectiveness of such programs. After two years of discharge from the Wisconsin Department of Corrections Drug Abuse Treatment Unit (DATU), only 6% of program participants returned to state prison, compared to 33% of untreated inmates (Vigdal, in press). A follow up evaluation of graduates from the Cornerstone Program in Oregon (Field, 1989) found that over a three-year post-release period only 29% of offenders were rearrested, compared to a 37% rearrest rate for untreated parolees, and a 74% rearrest rate for inmates who dropped out of the program after completing less than 30 days of treatment.

There is considerable evidence that the demand for correctional drug treatment programs exceeds the number of program slots currently available. Much of this evidence is based on self-report information gathered from jail and prison inmates. Despite evidence that enrollment in state correctional drug treatment programs is increasing (Chaiken, 1989), only 30% of prison inmates report prior involvement in substance abuse treatment (U.S. Department of Justice, 1986). Recent evidence indicates that only 11% of jail inmates referred for drug treatment reported past involvement in alcohol treatment, and only 31% received prior drug treatment (Peters & Dolente, 1989). The absence of in-jail drug treatment programs presents a significant problem, particularly for the large number of drug-involved inmates who have a history of repeated contact with juvenile detention facilities (Chaiken, 1989), and who are likely to commit numerous offenses for each year they are free in the community and are using drugs. Because only a small number of drug-involved felony offenders are convicted and sent to state prison, the absence of in-jail treatment programs, or linkage to community treatment agencies following release from jail means that the vast majority of serious drug abusers will

return to the streets without gaining additional skills to prevent drug relapse. With multiple untreated problems associated with drug dependency, these individuals are extremely likely to reoffend and to return to jails and prisons (Wexler, Lipton, & Johnson, 1988).

Results of Previous Jail Surveys

Although there are many reports documenting the extremely high prevalence of drug abuse among jail inmates and the high proportion of inmates who have not previously received treatment, program-level survey data addressing the quantity and quality (e.g. content) of in-jail drug treatment programs has not been systematically collected. Several studies have examined the prevalence of mental illness in jails (Swank & Winer, 1976; Teplin, 1983), and the extent of mental health programs in jails (Steadman, McCarty, & Morrissey, 1986). The latter study is worth reviewing in some detail because it has examined the presence of substance abuse services in the larger context of mental health programs.

A nationwide sample of 43 jails with a demonstrated interest in mental health programming was selected for the study. This sample was likely to include a disproportionate number of moderate to large-sized jails, jails with pre-existing mental health and substance programs, and jails with an administrative philosophy supporting the development of inmate programs. Despite evidence of sampling bias, findings suggested that in-jail substance abuse programs were often neglected, and received fewer staff resources than in-jail mental health programs. Site visits and survey questionnaires revealed that 26 of 43 jails (60%) provided substance abuse services. Only 16 of the respondents (37%) indicated that case management services were provided to substance abusers at the time of release from jail. The primary mode of treatment for most jails appeared to be Alcoholics Anonymous (AA) groups. For several jails there was no evidence of substance abuse treatment planning or coordination. Instead, it appeared that community AA groups were expected to develop and organize a program. In at least one case, staff from a mental health center had identified the need for developing a substance abuse program in the jail setting but had failed to receive support from the jail administrator to fund the program.

For several jails surveyed, outreach counselors were assigned to work with drug-involved inmates. The most comprehensive substance abuse program described had two full-time and three part-time counselors. Group, individual and marital counseling was available through the mental health program of one jail, although it is unclear whether these services were available to drug-involved inmates. For one of the allegedly more comprehensive substance abuse programs, few treatment activities were provided other than assessment of pre-trial inmates for diversion to community drug treatment programs. This limited survey of mental health services in jails provides an initial indication of the paucity of substance abuse programs provided in this setting. Among the 43 jails surveyed, the relative status of substance abuse programs as compared to other rehabilitative activities was clearly quite low, with relatively few funds allocated for direct treatment activities.

The American Jail Association Drug Treatment Program Survey

The present evaluation study provides the first comprehensive survey of drug treatment programs in American jails. The Drug Treatment Program Survey was conducted as part of a larger program funded by the U.S. Department of Justice, Bureau of Justice Assistance (BJA), entitled "Drug Treatment in the Jail Setting: A National Demonstration Program". The American Jail Association was awarded a grant from BJA to administer the program. In addition to developing three demonstration in-jail treatment projects, one of the primary objectives of the program was to survey the nation's jails for existing drug treatment programs. This approach was developed to provide a thorough sampling of jails for innovative drug treatment projects that might already have been implemented, and that might serve as additional models for jails interested in establishing similar programs.

Survey Development

Development of the Drug Treatment Program Survey Instrument (Appendix A) began in November of 1987. The survey was broken into three separate categories: 1) Background Data 2) Statistical Data, and 3) Drug Treatment Program Data. With the desire to become a national clearinghouse of information on drug treatment in jails, it was important to gain as much information from the jails as possible. The background data provided basic information on the jails. For instance, the names of the jails, addresses,

telephone numbers, jail administrators, rated capacities, etc. The statistical data provided information on the average daily populations, ethnic breakdowns, numbers of personnel employed, etc. The drug treatment data provided the information pertaining to any aspect of drug rehabilitation that the jails were involved in, including volunteer organizations such as Narcotics Anonymous.

The survey was pilot tested in several jails. On-site, we visited the Montgomery County Department of Correction & Rehabilitation, the Prince William-Manassas Regional Adult Detention Center, and the Alexandria Detention Center. We also utilized the services of Carter Goble Associates. In addition, we spoke with several jail personnel from around the country who agreed to help pilot test the survey over the telephone. After several revisions, a final copy was designed and printed.

The information derived in each of the three categories provides a valuable resource to jails that are interested in starting or improving their current treatment programs. If a jail is interested in starting a program, we can locate a facility that currently has a program and which has similar attributes. For example, we can match locations, rated capacities, average daily populations, personnel numbers, etc. In this respect, we can see what works best in similar surroundings and situations.

In March 1988, the survey was first mailed to approximately 3,400 jails. The mailing list was developed from the ACA Adult Detention Directory and the National Sheriffs' Association's Sheriff's Directory as well as the files of the American Jail Association.

During the next eight months, three more mailings were done to jails that had not originally responded and by March of 1989, approximately 10,000 surveys had been mailed out and 1,200 had been returned.

During the next several months, American Jail Association staff telephoned approximately 2,400 jails to obtain correct mailing addresses and the names and titles of the persons who would be best able to complete the survey. As a result of this time consuming effort, another 600 surveys were received. A random sampling of the non-responding jails is now being conducted. It is suspected that many of the 1,559 jails that have not responded are the very small jails that would most likely not have any inmate programs and therefore did not complete the survey. As of April 10, 1990 AJA had received 1,737 surveys. Many jails on the original mailing list had been closed and new ones opened, including several regional jails.

In the spring of 1987, the SPI Law Enforcement Computer Group in Ashtabula, Ohio volunteered their services to develop the software which would enable AJA grant staff to enter the information from the returned surveys and later to analyze that data. AJA staff spent approximately 348 hours (10 weeks) entering the survey data into the computer program developed by SPI.

Finally, in April of 1990, AJA obtained the services of the Florida Mental Health Institute to conduct the actual analysis of the data according to the parameters set by the American Jail Association.

Survey Respondents

The following survey results are based on a total of 1,737 respondents to the survey. As few as 85% of respondents answered several survey questions, although the typical response rate per item was about 96%. The location of respondent jail facilities is described in Appendix B. Surveys were returned from 48 states, and the District of Columbia. No surveys were received from the states of Hawaii or Vermont. In all, survey responses were received from 57% of all jails in the country.

Each geographical region of the country was adequately represented in the survey. Respondents were about evenly split between eastern and western states. The largest group of respondents (by region) was from the Southeast, representing 15% of all surveys. Fourteen percent of respondents were from (both) the Northeast-Great Lakes region, and from the Midwest. Another 13% were from the Northeast-Atlantic region, and from the South-central region. Rocky Mountain and Western states totalled 14% of the sample. Within-state response rates to the survey range from extremely high; in the state of Nebraska (62 of 66 surveys returned) and Oregon (24 of 29 surveys returned), to quite low; in the state of Arkansas (20 of 87 surveys returned) and Mississippi (22 of 96 surveys returned).

Survey Results

Characteristics of Jails Sampled

The majority of jails responding to the survey reported fewer than 50 inmates. Respondents were categorized into six groups according to their average daily (peak) population, for purposes of evaluating programmatic differences among jails of varying size. The number of survey respondents according to the size of the jail facility were as follows: (1) under 50 inmates (n = 1031), (2) 50 - 249 inmates (n = 447), (3) 250 - 499 inmates (n = 104), (4) 500 - 999 inmates (n = 57), (5) 1,000 - 2,000 inmates (n = 33), and over

2000 inmates (n = 15). The average designed capacity of jails surveyed was 127 inmates (standard deviation: SD = 437; median = 41). About 10% of respondents (n = 179) indicated that their jail system included multiple jails. For those operating more than one jail (48%), the median was three jails.

Eighteen percent of respondents reported that their jail was constructed as a direct supervision facility. However, the direct supervision model of inmate management was used by 33% of respondents. The number of paid staff per facility was highly variable for the jails surveyed. The average number of staff per jail was 45 (SD = 138; n = 1,620) while the median was 12 staff. Similar variability among jails was noted in the total number of male staff (mean = 31; SD = 100; median = 8) and female staff (mean = 12; SD = 40; median = 4). The large discrepancies between the means and medians are attributable to the disproportionate influence of extremely large staffs employed by the fifteen jails with more than 2,000 inmates. In this circumstance, the median is a more accurate indicator of staffing patterns. Fully 442 jails (27%) reported the presence of an employee assistance program.

Respondents (n = 1,480) indicated that 47% of inmates in jails were sentenced offenders. Sentenced offenders were classified into the following subgroups, according to their sentence length: (1) under 3 days (15%), (2) 3 - 30 days (30%), (3) 31 - 90 days (23%), (4) 91 - 180 days (16%), and (5) over 180 days (15%). When queried about length of stay, jails indicated that 30% of inmates were incarcerated for under three days, 25% from three to 30 days, and 19% from 31 to 90 days. Another 13% of inmates were incarcerated for 91 to 180 days and 12% for over 180 days.

Fully 1,607 jails reported information regarding ethnic make-up of inmate populations. The ethnic composition for inmates in the respondent sample was as follows: white (67%), black (21%), Hispanic (8%), native American Indian (3%), and other race or ethnic groups (1%). The majority of jails surveyed indicated that they had no access to information regarding inmate education. Of those who reported access, one third indicated that the data was not readily available. Respondents (n = 1,215) indicated that 28% of jail inmates functioned below the 6th grade level. The average age of the inmate population was 26.6 years (SD = 3.7).

By far the most common funding source for jails was the county (95%), followed by the state (7%) and city (6%). Only 66 jails obtained support from other sources. Eighty-nine percent of jails reported funding from only one source, while 9% reported two sources and 2% reported three sources of funding.

TABLE 1

Drug Treatment Services by Size of Jail for all Survey Respondents

Drug treatment services:	Less than 50	50-250	251-499	500-999	1000-2000	Over 2000	TOTAL
	(N=1014)	(N=440)	(N=103)	(N=57)	(N=32)	(N=15)	(N=1647)
Have drug treatment program*	15%	41%	60%	67%	72%	87%	28%
Group counseling	6%	20%	43%	47%	58%	60%	15%
Transition planning	2%	11%	31%	32%	33%	53%	8%
Drug education	6%	19%	42%	46%	55%	60%	14%
Have comprehensive program**	2%	9%	28%	32%	35	53%	7%
Volunteer services only	6%	15%	13%	18%	9%	27%	10%
Plan program within six months	5%	14%	20%	22%	39%	20%	9%

* Other than detoxification services.

** Program includes group counseling, drug education, transition planning, and referral to outside treatment agencies.

In-Jail Drug Treatment Programs

Only 458 of 1,647 (28%) of jails responding to the survey offer drug treatment services other than detoxification. As indicated by Table 1, jails of less than 50 inmates are particularly underrepresented among facilities with drug treatment programs, with only 15% currently providing such services. The likelihood of a jail having a drug treatment program was significantly greater for larger jails. Of jails with drug treatment programs, 33% of all programs consisted solely of volunteer services, leaving only 307 of 1,641 jails (19%) with funded programs. Smaller jails were more likely to report drug treatment programs based solely on volunteer services, although it is noteworthy that almost a third of the largest jails appear to also rely on volunteer services. An additional 116 (9%) of jails reported plans to implement a drug treatment program within six months. The survey did not attempt to assess the type of drug treatment program that was planned. Only 5% of jails of less than 50 inmates indicated plans to develop a new program, in contrast to over 20% of jails larger than 250 inmates.

For jails without a drug treatment program (n = 1,186), and with no plans to implement a program in the following six months, 65% indicated that a lack of funds prevented development of such services, and 29% reported that there was a lack of need for such programs in their jurisdiction. Jails of less than 250 inmates accounted for 93% of respondents reporting lack of funds for drug treatment services, and 97% of respondents reporting lack of need for drug treatment services. However, it should be noted that more than 20% of respondents in each category of jail size reported that the lack of funds prevented further development of drug treatment services. Less than 1% of jails larger than 250 inmates reported a lack of need for these services.

Table 2 describes characteristics of drug treatment programs for jails with programs that consist of more than detoxification, and that do not rely exclusively on volunteer services. Only 12% of all in-jail drug treatment programs are housed in a unit that is segregated from the general inmate population. Isolated treatment units are particularly rare in small facilities - fewer than 4% of all programs in jails of less than 250 inmates provide a segregated area. Although drug treatment in facilities of over 500 inmates is more likely to be provided in segregated units, treatment programs are not isolated from the general inmate population in the vast majority (93%) of these larger jails. Seventy-eight percent of all jails with drug treatment programs provide information at the time of intake regarding the availability of the program. Forty-two percent of drug treatment programs are located in jails using the direct supervision model of inmate management. Only 30% of jails without such programs use the direct supervision concept.

Inmate characteristics. Characteristics of inmates enrolled in in-jail drug treatment programs are described in Table 3. The proportion of sentenced inmates in jails with drug treatment programs (48%) did not differ significantly from jails without programs. Jails of over 1,000 inmates that reported drug treatment programs tended to have a larger proportion of sentenced offenders in comparison to other facilities. Although the survey did not examine the proportion of male and female participants in drug treatment programs, recent studies indicate that the rate of growth among drug-involved female offenders may surpass the rate for male offenders (National Institute of Justice, 1989).

The average age of inmates in drug treatment programs was 26, although 67% of respondents indicated that they had estimated the age of participants. For all in-jail programs, 66% of participants are white, 23% black, 8% Hispanic, and 3% are of other ethnic backgrounds. Programs in larger jails tended to have greater numbers of black and Hispanic participants. About half of program participants in jails of over 1,000 inmates were black. The racial composition of in-jail drug treatment programs was comparable to that of jails with no programs. Within jails that had programs, the racial composition of inmates in treatment reflected the general inmate population, with the exception that blacks were slightly overrepresented in programs within jails of 1,000 to 2,000, and were slightly underrepresented in programs within jails of over 2,000. White inmates were slightly overrepresented in programs within jails of over 2,000.

TABLE 2

Characteristics of Drug Treatment Programs* by Size of Jail

Key Program Characteristics:	Less than 50 (N=92)	50-250 (N=113)	251-499 (N=46)	500-999 (N=27)	1000-2000 (N=20)	Over 2000 (N=9)	TOTAL (N=307)
Average Capacity	17	24	48	75	71	171	42
# Hours Per Week	3.4	4.3	6.1	4.9	9.3	13.2	5.0
# Paid Staff	1.8	2.3	4.6	4.5	4.4	6.2	2.9
Staff/ Inmate Ratio**	1/6	1/8	1/10	1/16	1/13	1/25	1/12
# Volunteers	2.9	3.5	7.4	14.1	23.7	13.3	6.5
Program Budget	$13,042	$67,160	$53,450	$59,563	$233,080	$178,400	74,450
Segregated Housing Unit	8%	4%	18%	7%	35%	90%	12%
Treatment Interventions							
Group Counseling	65%	75%	91%	96%	90%	100%	78%
Individual Counseling	65%	75%	91%	96%	90%	100%	78%
Drug Education	63%	74%	89%	93%	85%	100%	76%
Community-Based Volunteers	76%	75%	98%	96%	95%	89%	82%
Transition Planning	26%	40%	65%	63%	50%	89%	44%
Referral To Outside Agencies	79%	83%	87%	93%	80%	100%	84%

* Sample includes jails with drug treatment programs.

** Ratio based on respondents who provided information regarding both the number of paid program staff and program capacity (N = 208).

Program size. A general concern in interpreting the survey data is that much of the information reported regarding program size, inmate characteristics, and the nature of drug treatment services offered may be estimated, and thus is reflects a degree of error. About two-thirds of jail administrators completing the survey indicated that responses regarding inmate age and educational level were estimated. It is unclear to what extent estimates were generated for other more critical areas such as program size, staff, and program budget. Although the survey did not evaluate the extent of estimated responses in these critical areas, it seems likely that administrators would be able to more accurately assess these areas in comparison to inmate age and education.

Jails with drug treatment programs tended to be much larger (average daily non-peak population = 327 inmates) in comparison to jails without programs (average = 68 inmates). The average program size varied considerably according to the size of the jail

TABLE 3

Characteristics of Inmates Participating in Jail Drug Treatment Programs by Size of Jail

Inmate Characteristics-	Less than 50	50-250	251-499	500-999	1000-2000	Over 2000	TOTAL
	(N=92)	(N=113)	(N=46)	(N=27)	(N=20)	(N=9)	(N=307)
Age (Avg.)	25.3	26.4	26.1	26.2	25.7	25.8	26.0
Race:							
% White	82%	75%	43%	37%	33%	36%	66%
% Black	9%	17%	42%	47%	51%	48%	23%
% Hispanic	4%	6%	12%	13%	15%	15%	8%
% Other	5%	2%	4%	3%	1%	1%	3%
Sentenced*	58%	50%	36%	43%	37%	35%	48%

*Figures describe the entire jail population (including inmates not participating in the drug treatment program).

system. The average program size was 42, (SD = 69) although programs were significantly smaller in jails of less than 250 inmates. For the 56 drug treatment programs in jails of over 500 inmates, the average program size exceeded 70 inmates. Inmate requests to participate in drug treatment programs exceeded the number of slots available, for all categories of jail size. However, it seems likely that many facilities do not keep accurate records regarding program requests due to the lack of placements available.

Only 39% of inmates participating in drug treatment completed the designated program. The proportion of successful program completions varied slightly according to the size of the overall jail facility. Fifty-four percent of program participants in jails of over 1,000 inmates completed the assigned treatment program, in contrast to only 45% of program participants in other jails. The higher rate of completion among inmates from larger jails may be due to the larger proportion of sentenced offenders in these jails.

In-jail drug treatment programs average three paid staff, with a range of two paid staff for jails less than 50 inmates (program size averaging 17), to a high of six paid staff for jails over 2,000 inmates (program size averaging 171). The number of paid treatment staff appeared to be quite small, across all categories of jails. The ratio of paid staff to inmates in drug treatment programs averaged 1/12 for all jails responding to the survey (see Table 2). The most favorable staff to inmate ratio (1/6) was reported for jails with less than 50 inmates. The least favorable ratio (1/25) was reported for jails of over 2,000 inmates. Paid male staff slightly outnumbered female staff for all types of jails. The drug treatment coordinator for in-jail programs included psychologists (in 19% of programs), psychiatrists (8%), social workers (31%), and drug specialists (30%). Psychiatrists were slightly more likely to coordinate programs in jails of 1,000 to 2,000 inmates. There were no major differences in disciplinary backgrounds of program coordinators by size of the jail facility.

In-jail programs are staffed by a large number of volunteers. The number of volunteers exceeded the number of paid staff across all categories of jail size. In-jail drug treatment programs averaged 6.5 volunteers, more than twice the number of paid staff. Use of volunteers increased according to the size of the jail population. Programs in jails of over 500 inmates report the heaviest use of volunteers, and average at least two volunteers for every paid staff. For example, programs in larger jails of 1,000-2,000 inmates report an average of 24 volunteer staff, as compared to an average of only 4.4 paid staff.

Treatment interventions. For the 28% of jails responding to the survey that had drug treatment programs other than detoxification services, the most common treatment interventions (see Table 2) were group counseling (78%), individual counseling (78%), drug education (76%), and referral to outside agencies (84%). Only 44% of in-jail programs provide transition planning prior to release. For jails of less than 50 inmates, only 26% provide transition planning. Program interventions are supplemented by use of community-based volunteers in 82% of programs.

Existing jail drug treatment programs include only about six hours of therapeutic activities per week, for each inmate. The number of hours of programming increased as a function of jail size. Treatment programs in jails of over 1,000 inmates averaged in excess of 13 hours of treatment activities per week.

Attempts were made to distinguish between drug treatment programs that provided comprehensive services and those that did not. A criterion measure for comprehensive treatment was established that included provision of each of the following services: (1) group counseling, (2) drug education, (3) transition planning, and (4) referral to outside treatment agencies. According to this criterion measure, only 7% of survey respondents (or one quarter of those reporting an in-jail treatment program) indicated that they provided a comprehensive level of services.

The 107 comprehensive drug treatment programs averaged 6.8 hours of inmate activities per week, as compared to 3.8 hours per week provided by non-comprehensive programs. One extreme value of 168 hours per week was determined to be an outlier, and was excluded from this analysis. The most intensive level of treatment activities in comprehensive programs were in jails of 1,000 to 2,000 inmates (average of 35 hours per week, n = 7), and in jails of over 2,000 inmates (15 hours per week, n = 7). However, only 19 of the jails with comprehensive drug treatment programs (17%), and only 11 jails without comprehensive programs (6%) provided more than 10 hours per week of treatment activities.

Drug treatment programs within larger jails appeared to be somewhat more comprehensive, particularly with respect to provision of group and individual counseling, drug education, and transition planning. The number of hours of treatment programming also appeared to increase according to the size of the jail, for both comprehensive and non-comprehensive programs. Of more than 1,000 jails of less than 50 inmates, only 2% provided a comprehensive level of drug treatment services. In contrast, over half of drug treatment programs in jails of over 2,000 inmates provide comprehensive services.

Factors related to development of in-jail services. Stepwise multiple regression analysis was conducted to identify factors that predicted the presence of a drug treatment program. A variety of background and demographic measures were examined as potential predictors. Categorical measures (i.e. Yes/No) were dummy coded as 1 or 0, and an alpha level of .05 was established for entry into and removal from the model. The final regression equation and the respective incremental contributions of the predictors to the explained variance are shown in Table 4. An additional requirement was that each predictor variable contribute a minimum of 1% to the explanation of the dependent measure.

The seven predictors in Table 4 combined to explain 37% of the variance in the dependent measure (whether an in-jail drug treatment program was reported). The single most powerful predictor of the presence of a drug program in a jail was the collection of educational data for jail inmates. The zero-order correlation of this measure with the dependent measure was .40. Thus, collection of educational data explained 16% of the variance in the dependent measure. As indicated in Table 4, the presence of detoxification services was also a significant predictor of drug treatment programs in a jail setting, contributing a unique 10% of the variance in explaining the dependent measure.

Analysis of variance and Chi-Square Analysis provided a secondary means for evaluating factors related to the presence of drug treatment programs in jails (see Table 5). All of the variables presented in Table 5 and discussed below were found to discriminate (at the p .00001 level) between jails that had drug treatment programs and jails that did not have programs. As expected, each of the predictor variables from the regression equation figured prominently in this secondary analysis.

In addition to these variables, the size of the jail facility appeared to be an important predictor of whether a drug treatment program had been developed. In general, the larger the jail responding to the survey, the greater the likelihood that a drug treatment program was reported. Several variables related to jail size that appeared to predict whether a drug treatment program had been developed included: (1) jail capacity, (2) inclusion in a multiple-jail system, (3) average daily inmate population, (4) total number of staff, (5) number of staff with direct inmate contact, (6) adherence to the direct supervision model of inmate management, and (7) presence of employee assistance programs.

Several other variables were positively associated with the presence of in-jail drug treatment programs. It is likely that these variables reflect programmatic changes implemented as a result of development of the drug treatment program. Jails with drug treatment programs had fewer inmates sentenced for periods of less than one month, and more inmates sentenced for over 180 days. The extended period of time required

The total yearly program cost was $83,574 for comprehensive programs in contrast to $59,156 spent on average for other programs, although this difference was not statistically significant. Fully 92% of costs for comprehensive programs were related to personnel, compared to only 61% of total costs for non-comprehensive programs. It is unclear how non-personnel expenses for less comprehensive programs are directed, and whether these funds contribute significantly to central therapeutic treatment activities.

Several additional variables related to jail size that were associated with comprehensiveness of the program should be noted. Comprehensive in-jail drug treatment programs were more likely to be located in facilities that included multiple jails, that had employee assistance programs, and that utilized the direct supervision model. Comprehensive programs were located in jails with an average of 188 paid staff, in comparison to 68 staff in jails with less comprehensive programs. As might be expected, comprehensive drug treatment programs averaged a larger number of paid staff (4.2) in comparison to non-comprehensive programs (2.1).

Seventy-six percent of comprehensive programs were located in jails that planned to develop new substance abuse treatment programs in the next six months, in comparison to 35% of non-comprehensive programs. It appears likely that jail or program administrators responsible for developing comprehensive drug treatment programs may also be responsible for initiating new programs within the same jail system. Thus, survey results indicate that development of a comprehensive drug treatment program may have a multiplier effect in promoting new services within the jail.

A number of variables related to the comprehensiveness of services may reflect programmatic changes implemented as a result of the drug treatment program. Comprehensive drug treatment programs were more likely to be present in jails with separate housing units for participants, with detoxification capabilities, jails that use random urine screens, and AIDS tests beyond intake, jails that use community based organizations (particularly for transition planning and community referral), and in jails that offer orientation information and pre-release information to inmates. Social workers and drug specialists were slightly more likely to coordinate comprehensive in-jail programs. Psychiatrists, conversely, were slightly more likely to coordinate less comprehensive programs (only 4% of comprehensive drug treatment programs were coordinated by psychiatrists). It is unclear to what extent the disciplinary background of program coordinators affected the range of treatment interventions provided.

In-jail drug treatment program costs. Only 91 of 307 jails with drug treatment programs reported total yearly costs in their responses to the survey. Of note, only 22% of jails with fewer than 250 inmates responded to this survey question. Reported program costs varied enormously, even within jails of approximately the same size. It is unclear to what extent the variance in reported program costs are attributable to use of different methods for determining costs (e.g. inclusion of expenses that would ordinarily be incurred as a result of incarceration such as overhead, costs for correctional officers assigned to treatment units, meals, etc.).

For the limited sample of respondents, total program costs averaged $74,450, with a range of $13,042 for jails of under 50 inmates, to $233,080 for jails housing from 1,000-2,000 inmates. Expenditures for each inmate enrolled in drug treatment programs averaged $4.9 dollars per day. This figure was derived using average yearly program costs and average program capacity, and is based on the assumption that in-jail programs operated at 100% of capacity during the reporting period. Average daily inmate costs ranged from $ 2.3 for jails of 500-999 inmates to $9 for jails of 1,000 to 2,000 inmates. Program costs varied as a function of jail size, number of hours of treatment activities provided per week, and the number of treatment interventions provided. Although the overall program costs were positively correlated with total personnel costs, these were only marginally related to the number of paid staff (although correlated with total personnel costs), and actually were somewhat higher for programs utilizing more volunteer staff.

Table 8 describes the various sources of funding for in-jail drug treatment programs. Over 70% of jails surveyed received funding for drug treatment programs from the county government. Over 40% of jails received additional funding from states. Very few drug treatment programs were funded with support from foundations or corporations. Jails of over 2,000 inmates received a larger proportion of program funding from city and state government in comparison to other jails. The majority of jails also received external grant support for drug treatment programs. The most common source of this support was from Alcohol, Drug Abuse and Mental Health Services Block Grants from the U.S. Department of Health and

Human Services (HHS), received by 52% of jails surveyed. Another 9% of jails indicated receiving Emergency Substance Abuse Block Grants from HHS, and 8% received grant support through the U.S. Department of Justice. Jails housing from 1,000 to 2,000 inmates were the most frequent recipients of external grant support. Only 20% of jails over 2,000 received HHS support, and none reported support through the Department of Justice.

Adjunctive Drug Treatment Services

The survey requested information regarding a number of services that are seen as adjunctive to drug treatment program activities. Table 7 describes the extent of detoxification, intake screening, urinalysis, and correctional officer training offered by jails responding to the survey, according to the size of the jail.

Detoxification. Overall, 22% of jails reported that some type of drug detoxification service was provided by in-house staff. These services are generally not available in small facilities, although over 65% of jails of more than 250 inmates reported detoxification capabilities. Almost all facilities providing detoxification reported the ability to provide Methadone for opiate withdrawal. For facilities with detoxification capabilities, 60% indicated that the length of services was seven days or less. Twenty-three percent reported detoxification programs lasting 14 days, and 17% reported programs lasting up to 21 days.

Drug screening. Most jails (77%) indicated that intake procedures included specific questions concerning the inmate's drug abuse history. Almost the same number (76%) provide a medical screening at the time of intake. Two-thirds of jails complete the medical screening within six hours of admission. Over 80% report that intake medical screenings are completed within 24 hours of admission. Larger jails tended to complete medical screenings more rapidly than smaller facilities. Only 3% of all jails reported conducting urinalysis screening at the time of intake. Larger jail facilities (of over 1,000 inmates) were more likely to provide urinalysis at intake, with 12% reporting these services. Only 13% of all jails provide random urinalysis during incarceration. Jails of over 50 inmates were twice as likely to provide random urinalysis, in comparison to smaller jails. Thirty-seven percent of jails provide urinalysis on suspicion of drug involvement, 26% for inmates on work release, and 37% under other circumstances.

Six percent of respondents indicated that AIDS screening was provided at intake. Medium-sized facilities (251-499) and extremely large facilities (over 2,000) were most likely to provide AIDS screening. A larger proportion (37%) of jails provide AIDS testing after intake, but presumably on a selective basis according to need. Only 20% of very small facilities (less than 50) provide this service, but more than half of small jails (50-250) and over 75% of larger jails provide additional AIDS testing.

TABLE 8

Funding Sources for In-Jail Drug Treatment Programs by Size of Jail

	Less than 50	50-250	251-499	500-999	1000-2000	Over 2000	TOTAL
	(N=92)	(N=113)	(N=46)	(N=27)	(N=20)	(N=9)	(N=307)
Source:							
County	73%	74%	74%	63%	55%	67%	71%
City	10%	2%	15%	11%	15%	56%	9%
State	49%	46%	33%	33%	45%	33%	43%
Federal	12%	5%	9%	15%	15%	11%	9%
Foundation	2%	3%	2%	0%	0%	11%	2%
Corporation	1%	1%	2%	0%	0%	11%	1%
Other Support:							
Justice Dept.	2%	6%	14%	0%	40%	0%	10%
ADAMHS Block Grant-HHS	%	61%	60%	44%	50%	25%	62%
ESA Block Grant-HHS	18%	3%	21%	0%	25%	25%	12%

TABLE 7

Adjunctive Drug Treatment Services Provided by Size of Jail for all Survey Respondents

Adjunctive Service:	Less than 50	50-250	251-499	500-999	1000-2000	Over 2000	TOTAL
	(N=1031)	(N=447)	(N=104)	(N=57)	(N=33)	(N=15)	(N=1687)
Detoxification	7%	32%	65%	69%	85%	73%	22%
Intake Screening:							
Drug Abuse Screening Interview	72%	83%	89%	84%	94%	86%	77%
AIDS Screening	5%	8%	12%	6%	9%	20%	6%
Medical Screenmg	67%	89%	91%	93%	97%	100%	76%
Urinalysis	2%	3%	5%	4%	12%	7%	3%
Other Urinalysis:							
Random	9%	17%	22%	21%	16%	13%	13%
On Suspicion	31%	43%	50%	64%	53%	20%	37%
Work Release	20%	35%	36%	45%	31%	27%	26%
Training:							
Inmates with Drug Abuse Problems	59%	70%	79%	79%	91%	86%	65%
AIDS Screening	47%	69%	77%	81%	85%	79%	57%

Training for correctional officers. Of all respondents, 65% reported that correctional officers receive training related to inmates with drug abuse problems. In general, larger jails were more likely to provide this training, including 90% of jails with over 1000 inmates. Slightly fewer jails (57%) provide training to officers in AIDS screening techniques, although the vast majority of large jails provide this training.

Summary

The present survey conducted by the American Jail Association sampled over 1,700 jails from 48 states across the country, to evaluate the extent of in-jail drug treatment services. The survey evaluates the scope of in-jail drug treatment programs in 1987. It is likely that other jails may have developed drug treatment programs since 1987, and as a result, the present survey may slightly underestimate the true number of jails with such programs.

Despite the high prevalence of drug abuse among inmate populations, and a growing awareness that untreated drug abusers have a negative impact on all segments of society, most jails do not have adequate drug treatment services. For the 1,687 jails that provided information regarding inmate census, only 12,894 inmates (6.7%) of an average daily inmate population of 192,461 were enrolled in drug treatment programs. Even for jails with drug treatment programs, only 12,894 of 100,389 inmates (13%) receive treatment per day. If information from the Drug Use Forecasting system is generalizable to jails in the present survey, at least 60% of inmates are involved with drugs at the time of incarceration. In this context, the survey findings point strongly to the conclusion that a small fraction (perhaps fewer than 10%) of inmates needing drug treatment actually receive these services.

The absence of drug treatment services is particularly striking in smaller jails. It is unlikely that jails of less than 50 inmates (of which only 15% report

any type of drug treatment services) are somehow exempt from the influx of new arrestees with substance abuse disorders. The survey identifies a clear need for smaller jails to begin forging linkages with community drug treatment providers, or to hire in-house staff to provide at least minimal treatment interventions, such as drug education, and group counseling.

The several factors found to predict the presence of an in-jail program were not remarkable. In general, drug treatment programs were more likely to be reported in larger jails, jails with a continuum of adjunctive support services (screening, urinalysis, training, collection of assessment data), jails with an orientation towards development of inmate and staff (e.g. employee assistance) programs, and with an orientation towards innovative approaches to inmate management (e.g. direct supervison). The survey did not attempt to assess whether adjunctive drug treatment services or use of the direct supervision system preceded development of an in-jail drug treatment program, or were instituted concurrently with the program or after the program was developed. In general, jails committed to a program of drug treatment services appeared to have developed a broad range of support services for drug-involved inmates.

Fewer than 20% of all jails surveyed reported a drug treatment program involving paid staff. The following results suggest that many of these programs are inadequate to meet the needs of drug-involved inmates: (1) 75% do not provide group therapy, drug education, transition planning and referral to community drug treatment agencies, (2) only 30 programs (2% of all survey respondents) provide more than 10 hours per week of treatment activities, (3) programs average only three paid staff, and (4) only 12% of programs are able to isolate participants from the general inmate population.

Another 10% of jails sampled provided a drug treatment program staffed entirely by volunteers. It is unlikely that these programs are able to provide more than minimal professional staff supervision, quality control, and to develop a therapeutic treatment milieu of sufficient intensity to achieve lasting behavior change among inmates released from the program. Unfortunately, programs relying on volunteer services are more common among metropolitan jails, in which the need for structured and intensive treatment programs may be the greatest.

Most jails surveyed did provide basic adjunctive services such as a screening interview for drug abuse, medical screening, and correctional officer training related to drug abuse. However, very few jails offer detoxification services. For many offenders, the lack of detoxification is likely to prevent meaningful involvement in treatment. Despite the presence of adjunctive services such as drug abuse screening or detoxification, the lack of additional drug treatment services is likely to undermine the recovery of most drug-involved inmates.

The profile provided by survey results for in-jail drug treatment programs across the country is one of great diversity. Even among the sample of jails over 2,000 inmates, programs varied tremendously in the scope of services offered, the number of paid staff, and the program budget. However, survey results describing the components of in-jail drug treatment, the number of hours of weekly activities, and levels of staffing strongly suggest that even among many of the more comprehensive programs, treatment services are not comparable to those provided in a community residential or intensive outpatient program.

The lack of transition planning/case management services (available in only 8% of jails) provides cause for some concern. The impact of other in-jail services may be significantly reduced if an inmate is not provided assistance in planning for follow up treatment in the community. Critical activities such as meeting a new community program counselor, setting an initial appointment for aftercare treatment, and planning for transportation to outpatient treatment sessions are all essential in ensuring that the commitment to maintain abstinence, use of coping skills, and other gains made during in-jail treatment are not forgotten following release from jail.

The inadequate level of drug treatment services available in most jails signals the need for development of a set of recommended standards to guide administrators and treatment staff in provision of these services. These standards might address recommended staffing patterns and credentials, evaluation and quality assurance procedures, and staff training. Standards may be disseminated through inclusion in such publications as "Standards for Health Services in Jails" (National Commission on Correctional Health Care), "Federal Standards for Prisons and Jails" (U.S. Department of Justice), in the "Jail Resource Manual" (U.S. Department of Justice, National Institute of Corrections), and in publications of the American Jail Association and the American Correctional Association.

Efforts to enhance existing programs, or to initiate new programs may be hindered by the absence of comprehensive in-jail programs in many areas. Jails

will benefit from consultation with staff from public and private drug treatment agencies, from state human services agencies, and from other sources to identify a plan for developing new drug treatment services. Administrators may wish to develop an advisory board of community members, local drug treatment coordinators, and correctional staff to assist in program planning.

Technical assistance and consultation in staff training, treatment curriculum development, and assessment and evaluation are of critical importance to jails developing a new drug treatment program, particularly those with no existing services. Without this support, it appears likely that jails will continue to take a disjointed approach in program development, will continue to rely on volunteers, and may neglect key program components such as thorough screening and assessment, group counseling, and transition planning.

Jails currently planning or developing programs are encouraged to take advantage of technical assistance currently available through the American Jail Association model demonstration program, and through the National Institute on Corrections Jail Center. Additional support in developing new in-jail treatment programs will be provided by the Office for Treatment Improvement, U.S. Department of Health and Human Services during the next several years.

The costs involved in operating an in-jail drug treatment program is quite modest. At an average program cost of $83,574 per year, jails rated as having comprehensive programs provided drug treatment services for seven hours a week (per inmate) for an average of 65 inmates. Services included drug education, group counseling, transition planning, and referral to community agencies. This average program cost translates into a cost of $3.5 dollars per day, per inmate, above and beyond the ordinary cost of incarceration.

It should be noted that the level of treatment intensity provided by seven hours of program activities is not adequate to meet the needs of drug-dependent inmates with a chronic history of cocaine or heroin abuse. It is estimated that a desirable level of drug treatment services for 65 inmates would include the following staffing pattern: one program coordinator, four treatment counselors, one transition/case management counselor, and several volunteer assistants. This staffing pattern would facilitate a greater variety of treatment activities, and more intensive weekly programming - perhaps up to 20 hours per week, or almost three times the amount of activities occurring within an average comprehensive in-jail program, according to the present survey. This recommended staffing pattern would require approximately $165,000 in personnel costs, and approximately $30,000 in additional expenses for staff training, travel, consultation and materials. The total cost for this enhanced in-jail drug treatment program amounts to $195,000, or $8 per day, per inmate. In comparison to the $50-60 daily expenditure per person for residential treatment in state-subsidized public facilities, in-jail treatment programs appear to be extremely cost effective.

APPENDIX A

AMERICAN JAIL ASSOCIATION
DRUG TREATMENT PROGRAM SURVEY

INTRODUCTION

The purpose of this AJA survey is to collect data on drug treatment programs within jails across the nation. We have divided the survey into three categories:

I. **Background Information**
II. **Statistical Data**
III. **Drug Treatment Programs**

The questions appear in three different forms:

1. **Yes/No**
2. **Multiple Choice**
3. **Fill-in**

For **"Yes/No"** and **"Multiple Choice"** questions, please place a check next to the desired response. For **"Fill-in"** questions, please enter your response into the space provided. Some questions will require more than one response: those will be indicated. If a question does not pertain to your facility or program, please enter **"N/A"**.

Throughout this survey, there may be questions that you feel you cannot answer because you do not have data readily available. In those cases, please make an estimate -- and let us know, by writing **"estimate"** or **"guess"** next to your responses. **We would rather have a "rough guess" than no answer at all.**

Our survey results depend on your providing thoughtful and precise answers to the questions before you. Should you have any questions, please call **301/790-3930.**

We recognize that your time is valuable and we wish to thank you in advance for your assistance and participation in this most needed effort. We will be happy to share the results of this survey with you. Please let us know if you are interested.

Please complete the following four questions so that we can contact you should any clarification or follow-up become necessary.

1. Your Name?

_____

2. What position do you hold in the jail?

_____

3. How long have you held this position?

_____

4. How long have you been employed at this jail?

I. BACKGROUND INFORMATION

1. Name of Jail _____

2. Street Address _____

3. City _____ **4.** State _____

5. County _____ **6.** Zip Code _____

7. Telephone No. ( ) _____

8. Name of Jail Administrator _____

9. Title of Jail Administrator _____

10. Year in which your jail was built _____

11. Year in which your jail was renovated _____

12. How many inmates was your jail designed to house? _____

13. Does your agency operate more than one jail?

Yes ____ No ____

14. If your answer to question **13** is **"Yes,"** how many? _____

15. Do you have an **employee assistance program** for troubled employees (e.g., drug and/or alcohol related problems, psychological problems, legal and financial difficulties, etc.)?

Yes ____ No ____

16. Who funds your jail?

a) County ____
b) City ____
c) State ____
d) Other (specify) _____

17. Was your facility built or renovated as a "direct supervision" jail (i.e., Do your officers supervise inmates directly in a common area, with no barriers between the officers and the inmates)?

18. Do you use a direct supervision model of inmate management?

Yes ____ No ____

II. STATISTICAL DATA

1. What is your **average total** daily inmate population during "peak" periods, (*i.e.*, holidays, Saturday nights)? ____

   a) Number of Males ____
   b) Number of Females ____
   c) Number of Juveniles ____

2. What is your **average total** daily inmate population during "non-peak" periods? ____

   a) Number of Males ____
   b) Number of Females ____
   c) Number of Juveniles ____

3. What **percentage** of your **total** inmate population stay:

   a) Less than 3 days ____
   b) 3 - 30 days ____
   c) 31 - 90 days ____
   d) 91 - 180 days ____
   e) More than 180 days ____
   TOTAL **100%**

4. What **percentage** of your **total** inmate population are sentenced? ____ %

5. What **percentage** of your *sentenced* inmate population stay:

   a) Less than 3 days ____
   b) 3 - 30 days ____
   c) 31 - 90 days ____
   d) 91 - 180 days ____
   e) More than 180 days ____
   TOTAL **100%**

6. What is the **estimated percentage** ethnic makeup of your inmate population?

	Category	**Percent**
a)	Whites	____
b)	Blacks	____
c)	Hispanics	____
d)	Asians	____
e)	American Indians	____
f)	Other	____
	TOTAL	**100%**

7. Do you collect educational background data on your inmates?

   Yes ____ No ____

8. If you answer to question **7** is **"Yes,"** is this data readily accessible?

   Yes ____ No ____

9. What is the **estimated percentage** of your inmate population functioning below the 6th grade level ? ____ %

10. What is the average age of your inmate population? ____

11. What is the **total** number of staff (*i.e.*, uniformed and non-uniformed) you employ in your jail? ____

a) Number of Males ____
b) Number of Females ____

12. What is the **total** number of staff you employ who have **direct contact** with the inmates? ____

13. Do your officers receive any training related to:

a) Inmates with drug abuse problems Yes ____ No ____
b) AIDS Screening Yes ____ No ____

14. Do you ask **all** inmates specific questions about their drug history at intake?

Yes ____ No ____

15. Do **all** inmates receive, at intake, a:

a) Drug Urinalysis Screening Yes ____ No ____
b) AIDS Screening Yes ____ No ____

16. Do you conduct urinalysis screening at any time **other** than at intake? (check more than one, if appropriate)

a) At random ____
b) On suspicion ____
c) Work release ____
d) Other (specify) _____

17. Do you conduct AIDS testing at any time **other** than at intake?

Yes ____ No ____

If yes, specify _____

18. Do inmates receive a medical screening at intake?

Yes ____ No ____

19. If your answer to question **18** is **"Yes,"** what is the time period between the arrival of the inmate and the medical screening examination?

a) Within 6 hours ____
b) 6 - 12 hours ____
c) 13 - 24 hours ____
d) 25 - 48 hours ____
e) More than 48 hours ____

20. Is detoxification from drugs administered by in-house medical personnel?

Yes ____ No ____

21. What is the nature of your drug detoxification program: (check more than one, if appropriate)

a) Methadone ____
b) Other (specify) _____

22. What is the length of your drug detoxification program?

a) 7 days ____
b) 14 days ____
c) 21 days ____
d) Other (specify) _____

23. Do you administer questionnaires or conduct interviews with inmates immediately after they complete detoxification -- to determine their drug rehabilitation needs?

Yes ____ No ____

III. DRUG TREATMENT PROGRAMS

1. If you do not have a drug treatment program now, do you have active plans to implement one within the next 6 months?

Yes ____ No ____

2. If you do not have a drug treatment program now, or you do not have active plans to implement one within the next 6 months, is that due to: (check more than one, if appropriate)

a) Lack of funds ____
b) Lack of need ____
c) Other (specify) _____

3. Do you have any drug treatment programs in your facility other than detoxification?

Yes ____ No ____

NOTE: If your answer to question **3** is **"No,"** we thank you for your time. You need not answer any further questions.

4. Does your program include community-based volunteer organizations?

Yes ____ No ____

5. If your answer to question **4** is **"Yes,"** does your volunteer program include: (check more than one, if appropriate)

a) Meetings (e.g., Narcotics Anonymous) ____
b) Drug Education ____
c) Group Counseling ____
d) Individual Counseling ____
e) Transition Planning ____
f) Referral to Outside Agencies ____

6. Does your program consist **solely** of volunteer services?

Yes ____ No ____

NOTE: If your answer to question **6** is **"Yes,"** we thank you for your time. You need not answer any further questions.

7. Do you provide inmates with information **at orientation** on the availability of your drug treatment program?

   Yes ____ No ____

8. Do you provide inmates with information **at pre-release** on the availability of community-based drug treatment programs?

   Yes ____ No ____

9. Who funds your drug treatment program? (check more than one, if appropriate)

   a) County ____
   b) City ____
   c) State ____
   d) Federal ____
   e) Foundation ____
   f) Corporation ____
   g) Other (specify) _____

10. Does your program receive any financial support either directly or through state channels (e.g., single state agency for substance abuse) from the following federal sources:

    a) Department of Justice
       Yes ____ No ____ Don't Know ____

    b) Alcohol, Drug Abuse and Mental Health Services Block Grant (HHS)
       Yes ____ No ____ Don't Know ____

    c) The Emergency Substance Abuse Block Grant (HHS)
       Yes ____ No ____ Don't Know ____

    d) Other (specify) _____

11. What is the **total** number of paid staff assisting in your drug treatment program, including contract employees?

    a) Number of Males ____
    b) Number of Females ____

12. Referring to question **11**, are these staff employed by:

    a) Jail ____
    b) Outside Agency ____
    c) Both ____

13. What is the **total** number of volunteers assisting in your drug treatment program? ____

14. How much time do volunteers spend assisting in your program?

    a) Hours per day ____
    b) Days per week ____

15. Is the drug treatment program coordinator a:

    a) Psychiatrist ____
    b) Psychologist ____
    c) Social Worker ____
    d) Drug Specialist ____
    e) Other (specify) _____

16. What does your drug treatment program consist of:
(check more than one, if appropriate)

a) Drug Education ____
b) Group Counseling ____
c) Individual Counseling ____
d) Transition Planning ____
e) Referral to Outside Agencies ____
f) Other (specify) _____

17. Does your facility include a separate housing unit for inmates participating in your drug treatment program?

Yes ____ No ____

18. How many hours per week does an inmate spend in some aspect of drug treatment? ____

19. How many inmates can participate in your program at one time? ____

20. How many inmates **requested** participation in your drug treatment program in 1987? ____

21. How many inmates **participated** in your drug treatment program in 1987? ____

22. How many inmates **completed** your drug treatment program in 1987? ____

23. What was the **average** age of the inmates who participated in your drug treatment program in 1987? ____

24. Was your answer to question **23 actual** or **estimated**?

Actual ____ Estimated ____

25. What is the **estimated percentage** ethnic makeup of the inmates who participated in your drug treatment program in 1987?

	Category	**Percent**
a)	Whites	____
b)	Blacks	____
c)	Hispanics	____
d)	Asians	____
e)	American Indians	____
f)	Other	____
	TOTAL	**100%**

26. What was the **total** actual cost of your drug treatment program in 1987?
(Do not include the normal costs of housing and feeding inmates) $ _____

27. What were the **total** actual personnel costs of your drug treatment program in 1987?

$ _____

APPENDIX B

Respondents to American Jail Association Survey by State

State	# Jails Responding	# Jails in State*	% of Jails Responding per State	% of Total Survey Respondents	Cumulative % of Responses
Alaska	1	5	(20)	.1	.9
Alabama	39	110	(35)	2.2	3.1
Arkansas	20	87	(23)	1.2	4.3
Arizona	12	23	(52)	.7	5.0
California	51	149	(34)	2.9	7.9
Colorado	37	61	(61)	2.1	10.0
Connecticut*	5	--	--	.3	10.3
Dist. of Columbia	1	1	(100)	.1	10.4
Delaware	1	--	--	.1	10.4
Florida	69	102	(68)	4.0	14.4
Georgia	71	196	(36)	4.1	18.5
Iowa 44	90	(49)	2.5	21.0	
Idaho 18	37	(49)	1.0	22.0	
Illinois	59	95	(62)	3.4	25.4
Indiana	50	90	(56)	2.9	28.3
Kansas	65	94	(69)	3.7	32.1
Kentucky	60	95	(63)	3.5	35.5
Louisiana	21	90	(23)	1.2	36.7
Massachusetts	12	19	(63)	.7	37.4
Maryland	19	35	(54)	1.1	38.5
Maine 13	15	(87)	.7	39.3	
Michigan	67	85	(79)	3.9	43.1
Minnesota	28	71	(39)	1.6	44.7
Missouri	50	123	(41)	2.9	47.6
Mississippi	22	96	(23)	1.3	48.9
Montana	32	46	(70)	1.8	50.7
North Carolina	33	102	(32)	1.9	52.6
North Dakota	19	26	(73)	1.1	53.7
Nebraska	62	66	(94)	3.6	57.3
New Hampshire	8	11	(73)	.5	57.7
New Jersey	16	28	(57)	.9	58.7
New Mexico	17	34	(50)	1.0	59.6
Nevada	11	19	(58)	.6	60.3
New York	50	75	(67)	2.9	63.2
Ohio 70	122	(57)	4.0	67.2	
Oklahoma	49	100	(49)	2.8	70.0
Oregon	24	29	(83)	1.4	71.4
Pennsylvania	53	75	(71)	3.1	74.4
Rhode Island	1	--	--	.1	74.5
South Carolina	18	55	(33)	1.0	75.5
South Dakota	19	29	(66)	1.1	76.6
Tennessee	63	108	(58)	3.6	80.3
Texas 136	275	(49)	7.8	88.1	
Utah 13	25	(52)	.7	88.8	
Virginia	64	95	(67)	3.7	92.5
Washington	34	60	(57)	2.0	94.5
Wisconsin	50	73	(68)	2.9	97.4
West Virginia	30	52	(58)	1.7	99.1
Wyoming	16	22	(73)	.9	100.0
Missing Data(14)				(.8)	(.8)
TOTAL	1737	3296	(2601)	100.0	100.0

* National Jail Census, 1988

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