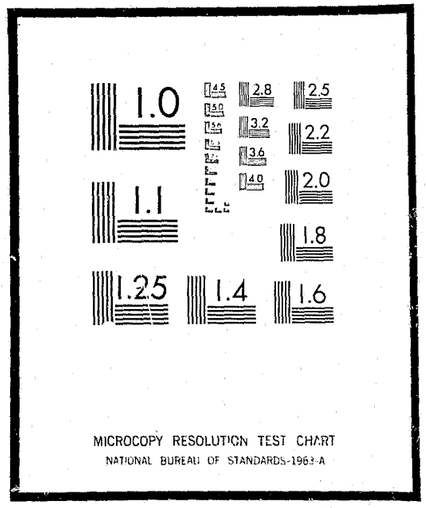

LOCAL JAILS AND DRUG TREATMENT

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ABSTRACT

The National Jail Resources Study identifies and examines rehabilitation services at local jails for drug-abusing inmates. The report describes the nature and extent of drug treatment services in jails based on the results of in-depth interviews with administrators, service providers, and inmates from a national sample of 118 local jails of varying size. Four service areas are examined including (1) intake screening, (2) medical treatment for detoxification, (3) social services, and (4) psychological counseling. Statistical findings and supporting narrative describe program content, processes for implementation, criteria for inmate selection, administration and funding, staff roles, and community agency participation. Extensive recommendations pertaining to study findings are presented. Jail profiles descriptive of inmate length of stay (LOS) are developed from an analysis of the findings. A recommendation is made that planning for services be preceded by development of LOS profiles so that jails can organize services around this critical variable. The study also recommends a service provision partnership which assigns to the jail direct responsibility for administration and provision of intake screening and referral, with all other services to be delivered by appropriate community agencies based in the jail.

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FOREWORD

In recent years, much attention has been focused on the development of treatment programs for drug abusers in the community. Similar attention has not been given to the availability and range of treatment services available to drug abusers held in local jails. This report fills that gap.

Supported by a grant from the National Institute of Law Enforcement and Criminal Justice, researchers at The Pennsylvania State University have surveyed drug treatment programs in a representative sample of the nation's jails. Their findings, presented in this report, give us the first comprehensive profile of the availability and scope of specialized treatment services for jail inmates with drug problems. Equally important, the survey unveiled some provocative approaches to drug treatment that may be suitable for further study and wider use.

The National Institute believes that the results of this research can be useful to local correctional administrators as well as those who set policy and monitor drug treatment programs at the federal, state and regional level.

Gerald M. Caplan
Director National Institute of Law Enforcement and Criminal Justice

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The data for this report was provided by a great number of people across the nation: jail administrators, their staffs, inmates and community agency personnel. Without their active cooperation and assistance, we would not have been able to conduct this study. Regrettably, we cannot name all of them here, but they should know that their candor and willingness to give of their time is greatly appreciated. It is to them that this document is dedicated.

Dr. John Ball, Dean Don Gottfredson, and Mr. Edward Brecher served as consultants to the project. Their advice and helpful suggestions served us well. Our project monitors, Ms. Cynthia Sultan of the National Institute on Law Enforcement and Criminal Justice and Mr. Carl Hampton of the National Institute on Drug Abuse provided encouragement and continuing support to our efforts.

Several former project staff contributed to the conceptualization and design of the research instrumentation. These included Dr. Patrick Gunning, Ms. Kathleen Kaufman, and Mr. Michael McGinty. The latter two also participated in the field research phase of the project. Mr. Martin Ford provided significant input to the project via his sound ability in programming and data processing.

Special thanks are extended to our first project secretary, Mrs. Nancy Johnson, who carried the burden of uncountable transcriptions with continuing good cheer, and to Nancy Gallagher Briggs and Laureen Yakich who assisted in the preparation of the final document.

Finally, we express our deepest gratitude to the National Institute on Law Enforcement and Criminal Justice for seeing merit in our study and providing the necessary funds to carry it forward, and to Dr. Donald H. Ford, Dean of the College of Human Development, The Pennsylvania State University, for providing an academic climate conducive to our research activities.

CHAPTER ONE

INTRODUCTION

In a simpler (but not necessarily more wholesome) America, the forces of social reform found in the drug addict a convenient vehicle for personifying the vice of ignorance, depicting him as a half-blinded creature, detached from reality, incapable of making decisions or pursuing any useful course of action, and living in squalor. Ironically, the same description is being applied today to those who, though charged with planning and implementing drug treatment policy and programs, are said to lack any realistic information on which to base decisions and live, not in squalor, but near the seats of government. As one illustration, a recent authoritative study of the federal government's response to the problem of drug abuse typifies that response in terms of an unrelieved series of overemphasis, insufficiency, absence, weakness, inability, and "lacks"--most of which are seen as due to incomplete understanding or inadequate information.[1]

It was with the express purpose of providing information on the nature and extent of existing resources for the treatment of inmates with drug problems in jails in the United States that the National Jail Resources Study was undertaken.

Obviously, the drug abuse problem is not the exclusive property of the criminal justice system, let alone jails; what is widely recognized,

[1]Task Force on Federal Heroin Addiction Programs, Federal Drug Abuse Programs: A Report. . . Submitted to the Criminal Law Section of The American Bar Association and The Drug Abuse Council (Washington, D.C.: Drug Abuse Council, 1972).

but not so obvious, in this connection is that, at present, the majority of drug users are identified only when they come into contact with some agency of the criminal justice system. As a corollary, most addicts in treatment programs have entered through the law enforcement process. Secondly, a larger number of the population at large experience a stay in jail rather than in any other type of confinement.

These generally acknowledged facts, taken together, not only testify to the unique position of the jail in the criminal justice system, but clearly suggest that jails have the greatest capacity for detection and the greatest opportunity to initiate treatment of drug users of any of the established institutions in this country. The recognition is timely and the issue far from merely theoretical; for, as the U.S. Department of Justice 1972 Survey of Inmates of Local Jails has suggested, and as this report further documents, there are jails that are detecting and, in some instances treating, although much remains to be done.

When the National Jail Resources Study (N.J.R.S.) began in 1974, nobody really knew "what was really out there." The 1972 Local Jail Survey (which, though limited, is still the most reliable source of data available on jails nationally) had indicated that 1,028 of a total 3,921 jails in the United States were providing some level of drug treatment services, and various studies of particular drug treatment facilities including at least one significant survey of outstanding programs offered by selected treatment agencies had appeared, but neither singly nor as a group did these studies suggest the number and kinds of drug users, the range of their needs, or the types of services provided to them. Even at the present writing, there are only very limited national standards and guidelines for dealing with drug abusers

in jails.[2] As a consequence, most existing drug treatment services in jails have evolved independently at the local level, in ignorance of alternative types of treatment and methods of service provision being employed by other, equally independent, institutions.

If jails have been left to their own treatment devices, the professional community must share with government policy makers the blame. Despite the fact that more people are incarcerated in jails than in prisons in the United States and, thus, jails have a greater impact on the general population, jail studies have been largely neglected by criminologists. This has been an important factor in contributing to the currently disjointed state of affairs. One can speculate that this seeming reluctance derives in part from the view of jails as politically controlled and openly hostile to research. In addition, contemporary criminologists have an understandable preference for working with large systems such as prisons, where reliable data can be attained more easily and results clearly demonstrated. The size and relative autonomy of most local jails prevent them from lending themselves easily to this approach. A related cause of this neglect in criminological investigation is that the state of existing statistical data on jails, particularly with regard to service delivery systems, has not encouraged methodical analysis or broad conceptual generalization.

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[2]This, unhappily, is a generous assessment. The 1970 Manual on Jail Administration (National Sheriffs' Association Standards) devotes minimum attention to programs for drug addicts. One presentation of "guidelines" for jails appears in the substantial Report on Corrections (Washington, D.C., 1973) by the National Advisory Commission on Criminal Justice Standards and Goals, which devotes a scant 37 of its 636 pages to various kinds of specific jail standards and internal policy guidelines (e.g., construction guidelines, control over inmates, jail release program, state inspection, etc.) under the rubric of "Local Correctional Institutions." See also the guidelines for State Planning Agency Grants developed by LEAA in the Guideline Manual: State Planning Agency Grants, March 21, 1975. Office of Personal Operations LEAA.

The situation is self-perpetuating and, indeed, almost circular: with only limited national guidelines and inadequate information on what others are doing, jail administrators continue to plan and implement in isolation; the more idiosyncratic these individual institutions become, the less they invite general research; with no broad research base, viable national policy and planning decisions cannot be made.

No study ever gained credibility by overemphasizing the amount of existing ignorance about the study area; yet, the real need here is not documentation of earlier information gaps but their systematic eradication. The National Jail Resources Study has tried to provide in this report an accurate description of the real "resources" drawn upon by jails for the treatment of drug abusers in order to help policy makers, jail administrators, and local government officials to design and implement drug treatment and supportive rehabilitation services for inmates and to help jails choose wisely, according to their specific needs, among alternative treatment and supportive services designs.

Realization of these goals on the local level requires effective coordination of a jail's treatment efforts with local service agencies; for this reason, the N.J.R.S. report makes an effort to illustrate interorganizational coordination. Secondly, to aid jails in choosing appropriate treatment strategies, the report describes the strengths and weaknesses of those strategies currently being employed in various correctional contexts.

The descriptive aspect of the study--determining the nature and extent of existing jail programs for drug abusers--is based upon statistical data, derived from in-depth interviews with jail administrators and service providers of large, medium-sized, and small facilities holding drug-abuser populations of varying sizes. Jails with internally,

externally, and cooperatively administered treatment programs were included in the survey.

With only the few exceptions noted in the subsequent chapter on "Research Goals and Survey Methodology," the 118 interviews conducted by the N.J.R.S. were drawn from the 1,028 institutions in the U.S. Department of Justice 1972 Survey which reported providing some treatment services to drug users--roughly, a 10-percent sample. Although there was no doubt when the sample was being selected that it would give an accurate picture of the types and scope of programs in use, there was some concern whether, in providing data on jails with average daily populations ranging from twenty or less to several thousand, depth might be sacrificed to breadth, particularly with regard to the larger jails, where conventional wisdom suggested some of the most extensive and more innovative programs would be in operation. The actual sample lays this fear to rest. The data from the 1972 Jail Survey shows a total of 113 jails holding 250 or more inmates; of these, 77 reported providing drug addiction treatment. Of jails holding 500 or more inmates, 37 reported providing drug addiction treatment programs. The N.J.R.S. sample included 50 jails holding 250 or more inmates and 25 jails holding 500 or more inmates. Thus, our sample includes a substantial proportion of all large jails and over 50 percent of all large jails reporting provision of drug treatment services.

For the first time, we believe, we can say confidently we know "what's out there."

As noted above, this report attempts to serve two audiences: those charged with establishing policy and monitoring drug treatment programs at the federal, state, or regional level and those charged with implementing some form of drug treatment program in a local jail. With these

audiences in mind, some specific observations for the benefit of each may be helpful.

The policy maker who is single-solution oriented, who judges a report on whether it provides in glowing terms a consistent, universally applicable plan for salvation will be disappointed here, due to the fact that no single solution will apply to all jails in providing services to drug abusers. What the N.J.R.S. has found, and, therefore, has reported is a range of service options, most of which are more or less effective depending on the specific context in which they are to be implemented. The appropriate term here is not solution, but alternatives.

An alternatives orientation is also a key concept in the effort to achieve national uniformity of service delivery. One of the things that government has the potential to do best is establish standards and guidelines. Rightly understood, the primary purpose of the former is to insure a uniform minimum level of performance throughout a government's jurisdiction; the purpose of the latter, to assist elements within that jurisdiction to meet the established standards. However, when standards are established purely for administrative convenience or when guidelines become so detailed and rigid that they have the effect of standards and cannot accommodate diversity of effective approaches to achieving the same goals, their purpose is perverted, their usefulness at an end, and, in the particular case of jails, they may actually act as constraints rather than stimulants to improved service delivery. Positive results are jeopardized even more where governmental jurisdictions over-lap and standards or guidelines conflict.

The individual jail administrator is less likely to be concerned with national policy than with such practical matters as the benefits to the individual institution of having a drug treatment program, the

kinds of programs other jails are using, and how to go about implementing drug treatment. (Where might the money come from? What kinds of problems can be anticipated? How can we benefit from existing programs? What kind of program is best for our institution?)

It would be well to remember that here, as elsewhere, isolated "facts" often have the property of inadvertently shrouding the real state of affairs. For example, in perusing the literature of drug treatment, it is relatively simple to come upon a statement to the effect that, in most cases, an addict with even a fairly large habit can be detoxified within five days. If a jail administrator were to plan the institution's detoxification program in the belief that the experience of others has shown five days to be sufficient for the detoxification of drug users, he or she would program a half-truth. To the extent that one can generalize on the available data, the National Jail Resources Study found not only that in almost 40 percent of the surveyed jails providing detoxification the average duration of detoxification treatment is from 8 to 21 days, but that in 68.5 percent of the surveyed jails with detoxification programs the time required for treatment varies according to patient need, rather than being based on a rigid time frame which disregards the dosage levels of drugs used previous to treatment and the physiological differences in inmates being treated--all of this despite the "fact" that an addict with a heavy habit can be detoxified in five days in "most" cases.

The point, of course, is that decisions should not be based on casually absorbed fragments, particularly fragments of statistical data, in a hasty effort to get some program into operation. We ask only that the administrator using this report bring to bear the same close atten-

tion and mature consideration that would be applied in making any other decision for the benefit of the institution.

Beyond this single caution, it is hoped the information reported here will provide a usable knowledge base for designing (or redesigning) drug treatment and supportive rehabilitation services for inmate populations. Although the N.J.R.S. report does not identify by name or make explicit evaluations of the effectiveness of specific programs in individual institutions, the types of service delivery systems in use are all clearly described so that an administrator can easily determine what the viable drug treatment alternatives are for the jail.

Our sole motive in trying to preserve the anonymity of responding institutions in our sample was that our primary interest was to gather information, not to compose a roll of honor or dishonor. In the overwhelming majority of cases, the administrators and staff personnel interviewed were, themselves, quick to point out the limitations or insufficiencies of their own programs. Given this recognition and their candid responses to our interviewers' questions, any gratuitous salting of wounds here could hardly contribute to their efforts to improve the health of their respective institutions. It should be noted, in this regard, that the National Jail Resources Study has made efforts to preserve the anonymity of respondents, but not the jails participating in the study.

This is not to say that we have attempted to maintain, at all cost, an inoffensive descriptive objectivity. This was neither possible nor, given the subject and importance of our investigation, desirable. As the following chapters witness, we have proceeded upon certain basic, necessarily value-laden, assumptions--not the least of which is that

communities and governments have the responsibility to provide services where there is a clear need and adequate resources to do so.

The results of any broad, initial investigations in any region where there has been little previous exploration must always suffer in comparison to the inevitably exaggerated expectations of what the unknown may hold and pioneers may accomplish. This study has not promised, nor has it delivered, all the wealth of the Indies: there is a vast array of questions which we have not attempted to address. For example, we did not seek to ascertain the extent to which the efforts of administrators to provide treatment resources resulted in a reduction of drug usage or drug-related crimes subsequent to release from jail; nor did we attempt to assess the critical values derived from a cost-benefit analysis of drug treatment services.

For that matter, the whole question of "success" was not considered, except in terms of a self-appraisal by service delivery personnel and, to a more limited extent, from the perspective of the service receiver.

Although some of our respondents suspected that the purpose of our study was to ascertain the extent to which clandestine use of contraband drugs in jails existed, we did not gather information on that phenomenon. Moreover, we did not attempt to verify the accuracy of the reports of some jailers that outside service providers were sometimes the importation mechanism by which illegal drugs were brought into their institutions. In many instances, both the expectation of such a problem and the reality, as found by some jails, was sufficient cause to bar outside agencies from entering the jail to provide inmate services. There is no doubt, however, that contraband does come into jails. Who brings the illegal drugs in is a matter of conjecture. It is safe to say that

visitors bring in some, staff has been known to do so, and outside service providers are not immune from suspicion.

Any investigation must confront, at the outset, the limitations of its own vocabulary; this activity has enjoyed considerably attention in drug treatment circles, and has taken its inevitable toll in human productivity. For a short time at the very beginning of the National Jail Resources Study, the staff was drawn into foraying in the same dark lexical forest, rife with semantic mindtraps and lurking ambiguities, that has seduced (and addicted) many researchers in the drug treatment area. What constitutes drug abuse?--a drug abuser? Is methadone used for withdrawal really detoxification or the substitution of another toxin? What is addiction?--dependence?--, etc.

In the midst of such terminological disputation, rescue in our case took the form of the recognition that, while no one could agree on the exact outer limits of application of the term drug abuser, in a less refined atmosphere, everyone operationally defines drug abuser as a habitual user of opiates, barbiturates, and amphetamines, singly or in combination--just as everyone recognized that, except for purposes of scholarly debate, methadone is used for detoxification. Put somewhat differently, in encountering the problem of drug abuse as distinguished from drug usage, we found grounds for agreement: a person in need of detoxification or chemical maintenance is a drug abuser; an individual who may use infrequently a nonprescribed pharmaceutical product is not an abuser. The wide expanse of drug-using behavior, as found among residents in jails, probably falls somewhere along a continuum between these extremes. On this basis then, the National Jail Resources Study

at a very early stage "operationalized" a working terminology.[3]

The order of presentation in the report has been dictated by our belief that no one should be expected to take on faith what he can be convinced of by reason. Thus, the discussion of our research goals and methods precedes the presentation of research data, and the data is presented before it is generalized upon.

We have attempted throughout the report to be candid about the limitations of the study, nevertheless, we are confident it will be of significant service in creating and implementing jail programs and policies for drug abuse treatment. If, in addition, it contributes to the improvement of existing methods of providing services or encourages others to refine upon our investigations, so much the better.

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[3]A profitable discussion of terminological difficulties in the drug abuse/drug treatment area appears in the introduction to Raymond Glasscote et al., The Treatment of Drug Abuse: Programs, Problems, Prospects (Washington, D.C.:American Psychiatric Association, 1972).

CHAPTER TWO

RESEARCH GOALS AND SURVEY METHODOLOGY

The primary research goal of the National Jail Resources Study (N.J.R.S.) was to identify the range and variety of services available at local jails for drug-abusing inmates. For the purposes of this study, a jail is defined as any local facility operated by a unit of local or state government for the detention or correction of adults suspected or convicted of a crime, and which has authority to detain longer than forty-eight hours.

A national sample of 118 jails was selected. Letters were sent to each institution requesting their cooperation. No institution refused to cooperate. After scheduling an appointment, a trained staff interviewer visited each site and administered the schedule of questions which appear as a supplementary volume to this study.

Services surveyed included all those from which drug abusers were not excluded. However, four classes of services were considered to be of greatest importance for treating drug abuse. These were: (1) jail strategies for the identification of drug abusers and their needs, (2) medical treatment for withdrawal symptoms, (3) general social services including referrals, and (4) psychological counseling. All of these services were examined in depth, and the data collected was then analyzed.

Sample Development

An initial sample was drawn using data from a 1972 U.S. Bureau of the Census Survey of Local Jails and supplemental unpublished data

provided to the N.J.R.S. by the Bureau of the Census. The Census survey questionnaire asked jails whether they provided a drug addiction treatment program. A positive response could be made either by checking a box labeled "operated by your institution," or by checking another labeled "operated from outside your institution." Of 3,921 jails in the United States, 127 indicated they had an externally operated program and 901 replied that they had a program internally operated.

Utilizing the combined positive responses from 1,028 jails, we developed an initial stratified sample of 85 institutions, using the criteria of size of inmate population, region, and whether the program was operated by the jail or by an outside agency. Size of inmate population was divided into three categories: (a) small (fewer than 21 inmates), (b) medium (between 21 and 249 inmates), and (c) large (250 or more inmates). The five regions corresponded to the U.S. Bureau of Prisons' regional breakdown (North East, South East, North Central, South West, and West). Whether the program was operated internally or externally was determined by the way in which the jail responded to the Bureau of the Census questionnaire. In addition, in choosing the sample, an attempt was made to include at least one jail from each state.

Each of the 85 jails in the initial sample was then sent a brief questionnaire asking if drug abuse services are currently available, how these are administered, and if the jail would be willing to cooperate with the N.J.R.S. Few indicated they were unwilling to cooperate. However, from the overall response to this initial inquiry, it appeared that some aspects of the 1972 Census survey data were out of date. For example, several jails were no longer in operation. More importantly, inmate services and, in particular, drug abuse services had changed

substantially since 1972. The initial variable of whether drug treatment was internally or externally administered, having served its purpose of determining the jails from which our sample would be drawn, was given minimal consideration in the further development of the sample.

Several means were used to obtain additional current data for improving the sample. Under the provisions of the Omnibus Crime Control Act of 1968, each state had established a "State Planning Agency" (SPA) to plan and administer the state's efforts in crime prevention and response to criminal behavior including that related to drug abuse. Also, under the Drug Abuse Treatment Act of 1972, each state established a "Single State Agency" (SSA) to implement and manage programs related to prevention and treatment of drug abuse. We wrote to the respective agencies in each of the fifty states requesting their aid in obtaining information concerning drug abuse services available at local jails in their states. Overall, these agencies were able to provide us with very little information about drug abuse services in jails.

We also requested information from the twenty Treatment Alternative to Street Crime (TASC) programs. These TASC programs had been developed, jointly funded and administered by the Special Action Office on Drug Abuse Prevention (SAODAP), the Law Enforcement Assistance Administration (LEAA), and the National Institute of Mental Health (NIMH). Many other agencies were also contacted, some of which were suggested by the SSAs, the SPAs, and TASC officials.

The information obtained was then used to replace jails in the initial sample which no longer provided drug treatment services and to add other jails to the sample. Whenever a replacement was necessary, it was always chosen from those jails of comparable size in the same state.

Whenever possible, jails which appeared to have an innovative or otherwise special program and those which served geographic areas reputed to have relatively high levels of drug abuse were added to the sample.

Several major cities were not included in the original sample since these jails had not responded postitively to, or may have been missed by, the U.S. Bureau of the Census survey. Our final sample was augmented to include the major city or cities in each state. Some large cities encompass several counties, each of which operates separate jail facilities. For several cities, the jails serving the metropolitan area were added to the sample. Jails in six states (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont) are state administered. Since the 1972 survey included only locally administered facilities, these states were not represented. In order to provide a comprehensive national profile of local jails, both locally operated and state administered, the jails of Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont were added to the sample.

The jail sites for two states were not included in the sample. Information provided to us by both the North Dakota Combined Law Enforcement Council and the Division of Alcoholism and Drug Abuse indicated that drug abuse in North Dakota was minimal. Moreover, phone calls to several jails in the state confirmed that the need for drug abuse services was virtually non-existent and that no services were provided. One other state, Mississippi, was not included because our best efforts failed to identify a jail providing drug treatment services.

The final sample contained a total of 118 jails. These represented 107 cities in 48 states (all but North Dakota and Mississippi). The final distribution of this sample by region was 31 in the North East, 17 in the

South East, 31 in the North Central region, 10 in the South West, and 29 in the West. Fifty of these facilities were large jails, 54 were medium-sized jails, and 14 were small.

Survey Instrument Development

In developing the survey instrument, it was necessary first to determine what services should be considered. A jail may, for example, provide a program specifically for drug-abusing inmates. However, equivalent service may be provided either through a program available to other inmates or through services which are not part of a formal program. Therefore, it was decided to examine all services from which drug abusers were not excluded.

Services can vary in their utility for helping inmates with drug abuse problems. Some may be of relatively direct benefit for drug abuse problems, while others are less likely to be directly helpful. The services were extensively surveyed which have direct applicability for the identification and treatment of inmates with drug abuse problems. As noted earlier, this was accomplished first by dividing the services into four major categories: (1) screening to identify needs, (2) detoxification or medical treatment for withdrawal symptoms, (3) social services, and (4) psychological counseling.

1. Screening. There are four general methods which a jail may use to identify inmate needs. First, the inmate's present charges or the police and other criminal justice system records may be screened for evidence of drug-related offenses. Such charges may provide initial indications of inmate needs. Second, the inmate can be interviewed. Such an interview can vary from the perfunctory administration of a "booking form" to an intensive personal interview which may include educational,

vocational, and psychological testing. Third, inmates can be given a medical examination. As with the personal interview, such an examination can vary in thoroughness. Fourth, samples of urine or blood may be tested to determine if the inmate has been recently using illicit drugs. The survey questionnaire collected detailed information concerning each of these methods in screening.

2. Detoxification. Abrupt withdrawal after prolonged use from a number of drugs, including heroin, amphetamines, barbiturates, and methadone, can result in severe withdrawal symptoms. Where detoxification treatment is provided, a detailed description of the withdrawal or treatment program was obtained. Special attention was given to the treatment provided for methadone users. Once incarcerated, a methadone user can either be: (a) abruptly terminated from methadone with or without the use of other drugs to alleviate the withdrawal symptoms; (b) gradually withdrawn using decreasing doses of methadone or other drugs for a period of up to 21 days; or (c) maintained on methadone or other drugs until sentencing or as long as incarcerated. The questionnaire determined which of these methods was employed and under what circumstances they were administered.

3. Social Services. There is no simple, concise definition of social services. Instead, social services is the category comprising a variety of important human services not included under other categories. Virtually all supportive services other than housing and security were included in this category. These services could range from such necessary but mundane activities as explaining the rules of the jail or facilitating telephone calls to the more professional casework functions like developing a case plan for the inmate. Three categories of social service were given special attention: (a) initiating requests for transfer to a

community treatment program before sentencing or before sentence completion, (b) preparation, prior to release, for re-entry to the community, and (c) referrals, upon release, to various community agencies.

4. Psychological Counseling. Psychological counseling may be defined as some form of systematic professional interpersonal interaction with the explicit purpose of causing or facilitating changes in attitude or behavior. Counseling can be provided individually or in a group, as well as within the context of an extensive program of behavioral intervention, such as in a therapeutic community. We tried to determine both the overall goal or orientation of the counseling provided and a specific description of the means or strategies used to achieve these goals. Not all services provided by psychiatrists or psychologists were considered as psychological counseling. For example, testing or some other form of evaluation or diagnosis for the specific purpose of advising the courts was not considered psychological counseling. Also, incidental counseling provided in the context of other services such as educational, vocational, or referral services, was not included as psychological counseling. Instead, such counseling was included under social services described earlier.

Model for Describing Service Delivery

The next step in constructing the survey instrument was the development of a model for obtaining detailed descriptions of each major service area. To help assure completeness, the model prescribed eight general classes of information to be obtained for each service component: (1) an overall narrative description of the service; (2) a detailed description at the behavioral level; (3) the selection criteria; (4) resources and estimated ratios of inmates served; (5) administration; (6) history

of the service; (7) subjective evaluation of various aspects of the service; and (8) inmate perception of service. We will briefly define each of these in turn.

1. Overall Description. Services classified under the same name can vary widely in both orientation and goals. For example, psychological counseling can either be directed toward alleviating the behavioral or emotional problems resulting from incarceration or intended to reduce or eliminate a drug abuser's psychological dependence on drugs. To help in determining the overall purpose and orientation, respondents were asked to provide a brief description of the services. This narrative served two additional functions First, it provided a total picture of the service which might not otherwise be recoverable, and second, it facilitated obtaining the remaining information by pointing out contingencies which may not have been anticipated. Thus, the narrative not only helped assure completeness but also enabled the interviewer to omit a number of questions which were not applicable to the particular jail.

2. Specific Behavioral Questions. Similar services can vary considerably in both content and intensity. For example, referral of inmates to local community agencies can range from distributing brochures to initiating appointments, or helping inmates to enroll in the program and possibly monitoring progress after release. Also, inmates can be referred to a variety of agencies which may provide such different services as methadone maintenance, therapeutic communities, outpatient counseling, vocational services, etc.

An assessment of the extent of each service was provided by a number of questions, each designed to measure a specific quantitative or qualitative aspect of service. These included frequency, duration, location,

times of availability, criteria for completion, etc. In addition, within each service area, a number of service-specific questions were included.

3. Selection Criteria. The inmate's need may be a major criterion for service. However, various restrictions may prevent an inmate from receiving that service. Therefore, the selection process was examined to determine how inmates in need of service were identified and what restrictions were operative. When restrictions were reported, the source, as well as the frequency with which the restriction prevented service to an inmate, was also recorded.

4. Resources and Ratios of Inmates Served. In addition to service content, we attempted to describe both the input to the service process, in terms of the material and personnel resources, and the output, in terms of the ratios of individuals served. Since, in most instances, jails did not have complete data relative to the numbers of individuals served, we accepted percentage estimates recognizing the limits of such data. The material resources included both funding and facilities (space) where the service was provided.

The physical space available for providing a given service can limit the quality of the service. For example, requiring counseling sessions to be held in the cells may both impair effectiveness and reduce interest in participation. Therefore, we obtained both descriptions of the space provided and judgements by the staff of its adequacy.

Funds for the support of a given service can either by provided by the jail or from an outside agency or a combination of each. In any case, the source can either be the regular budget or a special project grant for the service. The way in which funds were provided, including (where applicable) the initial source of a grant, was recorded.

Personnel resources refers to the staff used to provide services.

We examined the quality of the staff in several ways. First, we identified the kinds of positions which were used to provide each service; for example: for detoxification, are physicians, nurses, paramedics, counselors, correctional officers, etc., used? Second, we examined the minimal educational requirements for each position; and third, whether former drug abusers were employed in such positions. The quantitative aspect of personnel resources was measured by counting the number of personnel in each position and the number of staff hours committed to providing service.

Both the personnel and the material resources used for service delivery can be provided by either the jail or by outside community agencies (or by both the jail and outside agencies). Thus for each jail, we sought to determine if outside agencies were used to help provide service, and when community agencies were used, we asked about the range of services which were performed and what kinds of agencies were used to provide each service.

5. Administration. Since inmate services can be provided by either the jail or an outside agency or both, various service arrangements are possible; thus, we attempted to examine in some detail various aspects of the organizational interactions between the jail and outside agencies. This information was then used to develop a typology for service delivery systems which takes into account the jail, the local community agencies, and the criminal jsutice system network.

When inmate services are internally provided, they may be administered by the jail's parent agency, e.g., the sheriff's department. Internal services may also be controlled by the jail administration or by a relatively autonomous project responsible to the jail administration.

When provided by an outside agency, the jail may retain administrative responsibility for certain elements such as client selection. Therefore, for each of the major services provided, we identified who had functionai responsiblity for client selection, treatment content, personnel selection, and control of the budget.

6. History of Service. Recognizing that many local jails are in a period of rapid change with new and varied services being provided, we considered it appropriate to gather information concerning the evolution of inmate services. Thus, the study included a number of questions concerning the reason for service initiation and when the service was started, the funding history, and the recent and planned changes.

7. Subjective Evaluations. Objective evaluation of the effectiveness of the various services offered by local jails was beyond the scope of the present study, but subjective reports of administrators, service personnel, and inmates were assumed to be valuable for both a preliminary indication of effectiveness and for pointing out major issues and problems in providing inmate services. For each major service, respondents were asked to evaluate the adequacy of the present staff and facilities. If they were considered inadequate, they were asked to describe the additional resources needed.

8. Inmate Perceptions of Service. The information obtained from administrators and staff interviews was sufficient for our principal purpose, which was to describe the range of services available at the jail. For completeness, however, we also collected some additional information through interviews with inmates. Only limited information was sought from inmates for several reasons. First of all, some jails did not permit inmates to be interviewed. Others placed restrictions on which inmates could be interviewed. These variations in jail policies made it

impossible to sample inmates for interviewing in a consistent way. Secondly, even if we did determine, in principal, the types of inmates who should be interviewed, we had to depend on the jail to identify these inmates for us. The responses would depend heavily on which inmates were interviewed. Thus inmate interviews could not provide a reliable source of information for describing the available services.[1]

Recognizing the shortcomings of inmate interview data, we interviewed only a limited number of inmates. In general, the jails at which inmates were interviewed were those which readily granted the interviewer permission to meet privately with inmates. In these interviews, inmates were asked to describe the programs or services available for helping inmates with drug abuse problems and to indicate in which of these programs, if any, they were participating.

The foregoing outline is intended to provide a method for obtaining complete descriptions of each of the major human services available to inmates. However, a meaningful understanding and interpretation of such services can be achieved only in the broader context of the jail and its relation to the community it serves. We attempted to provide this information in two ways. First, for each jail, an overview section of the questionnaire contained a number of questions concerning the jail administration, inmate population, and overall range of services. Second, after the complete schedule of questions had been administered, the interviewer developed an overview in narrative form, which included any distinctive features of the jail and summary evaluations of the jail facility and its services.

[1] Such information, however, would be valuable, if not essential, in any evaluation of the effectiveness of inmate services. However, such evaluations were clearly beyond the scope of the present study.

Local jails are administratively responsible to either the city, county, or state government. In addition to variations in political constituency, jails can be administered by a sheriff's department or other law enforcement agency, a social welfare agency, or a corrections department. Such differences may affect the jail's orientation toward providing services for inmates. The overview section sought to obtain the information necessary to describe the political and administrative relationship between the jail and the community.

Variations in the inmate population can lead to significant differences in both the need for service and in the jail's ability to provide services. For example, if the jail does not serve as an initial holding (pre-trial) facility, there should not be a need for detoxification services. In other instances, if the majority of the population is held for a very short time, screening (particularly with reference to drug treatment needs) becomes a critical part of the jail service effort and its interface with the community. It may be impractical to attempt to provide certain services for inmates held for relatively brief periods (e.g., less than 30 days). Overcrowding may also limit the jail's ability to provide service. To help provide a context in which to assess inmate services in relation to needs, the overview section examined a number of factors related to jail demography. These included average daily population, as well as the inmate population distribution along several dimensions (e.g., length of stay and the distinction between detainee and convict). Diversion may have a significant impact on the need for inmate services. Programs such as TASC divert certain offenders with drug abuse problems thus reducing the need for drug abuse clinical or social services at the jail. In addition, various pre-trial release programs may serve to limit the jail's population to those offenders who are least

amenable to treatment. To help take into account such effects, the overview section examined both diversion and various other alternatives to incarceration.

Finally, variation in the physical aspects of the jail may influence the way in which services are provided. The overview questions attempted to provide an evaluation of the physical characteristics of the jail on a number of dimensions including: (1) whether the physical plant consisted of a single all-purpose facility or was composed of a number of special-purpose facilities, e.g., pre-trial detention center, honor camp, etc., (2) location of the facility or facilities, and (3) level of inmate movement.

Pre-testing

The final step in the development of the survey instrument was pre-testing. This was done in two stages. In the first stage, an initial instrument based upon the model was tested at three jails, one small, one medium, and one large jail. The results of these initial site visits convinced us of the adequacy of the basic model but, at the same time, pointed out the need for certain additions and modifications to the questionnaire. A second version of the questionnaire was then tested at ten additional jails of various sizes using five different trained interviewers, all members of the staff who had developed the instrument. From a careful analysis of the experiences of the different interviewers and the data collected by using the questionnaire, we concluded that only minor changes in format were needed. After making these changes, the information collected from all pre-test jails was transferred onto the final questionnaire forms. Any data that was not collected during the

pre-test phase was then obtained by follow-up phone calls to respondents at the pre-test jails. Thus, the data from the 13 pre-test jails was included in all subsequent analysis and reports.

The Survey Instrument

The survey instrument consisted of a schedule of over 1,400 questions. Not every question, however, was asked at all site visits. In general, the questions asked would depend upon the services available at the jail. For example, one question asked, "Do counselors attempt to facilitate diversion or transfer to a non-jail facility or community-based rehabilitation program?" If the answer was yes, a number of questions concerning the selection process for transferring inmates followed. If the answer was no, these questions were skipped.

The questionnaire schedule was divided into the following eight sections:

1. Overview: Part One: Demographic
2. Screening
3. Detoxification Services
4. Social Services
5. Psychological Services
6. Overview: Part Two: Self-analysis
7. Auxiliary Programs: General Service
8. Inmate Interviews

The overview was divided into two parts. Part one, examining the jail administration, inmate population, and total range of services provided, was designed to be administered first. The remaining part of the overview, dealing with planned changes, subjective evaluations, etc., was administered last. Each major class of services was assigned a separate

section. One additional "general service" section was added to accommodate any important service or program that could not readily be recorded within one of the major service sections. The format for this section followed the same general model for describing a service. When it was used, the data obtained was later transferred, on the basis of staff consensus, to the most appropriate parts of the sections covering the four major service categories.

Questions Asked

The questions used in collecting the information sought can be divided into four categories: (1) service policies and practices, (2) numerical or proportional data, (3) open-ended overviews, and (4) subjective evaluations. We shall briefly describe each type of question including examples of each, typical problems with each form of question, and the solutions employed.

1. Service Policies and Practices. Questions concerning specific service policies and/or practices were the most frequently used type of question. Most of these questions could be answered by a simple yes or no, or by responding yes or no to a checklist of several items asked by the interviewer.

Examples:

Does the jail provide psychological counseling?

Are drug-abusing inmates excluded from this service?

What is the average or normal session duration for counseling sessions?

a. less than ½ hour
b. ½ - 1 hour
c. 1-2 hours
d. 2-3 hours
e. other (specify)

In general, questions concerning service policies and practices provided the fewest problems. Difficulties normally occurred only when there was no formal policy or explicit rule for the way in which the service was provided. In this case, the interviewer would ask the respondent to trace through the service process as it was actually provided in order to determine what the actual practice or policy was.

2. Numerical or Proportional Data. Many questions asked for the number of inmates in a specific category or for the percent of inmates in one or more categories.

Examples:

What is the resident capacity of the jail?

What was the average enrollment in this program over the past year?

Estimate the percentage of the inmate population held for each of the following periods.

a. less than 3 days
b. 3 days to 30 days
c. one month to 6 months
d. six months or more

Estimate the proportion of the inmates enrolled in this program who were terminated for some cause other than completion.

Many questions in this form, such as that on resident capacity above, presented no problems. Others, however, such as average enrollment, were often difficult to answer because the information was not readily available to the respondent. In such cases, the interviewer would simply postpone the question until the respondent could either find the information or refer the interviewer to someone who could answer the question.

The problem was much more acute when the data or records

needed to answer the question were either not available, or kept in a form which was not useful for answering the question. This often occurred for items, such as "estimate the percentage of population . . ." In such cases, the respondent was asked to use whatever data was available to provide the best possible estimate.

Finally, for some of the questions, such as, "proportion . . . who were terminated . . ." there were no records or data in any form which would be even remotely useful for providing an estimate. To facilitate estimates for such items, the following five-point scale was used:

a. None = 0%
b. Few = more than 0%, but less than 10%
c. Some = at least 10%, but less than 50%
d. Many = at least 50%, but less than 100%
e. All = 100%

Pre-testing indicated that the use of this scale greatly facilitated obtaining responses to questions which frequently would otherwise have been unanswerable. Respondents who lacked the "hard data" to provide more precise responses, felt their answers to this scale were accurate within the broad categories defined by the scale. Moreover, it can be reasonably claimed that the scale reflects the maximum degree of precision that could be obtained for those items for which it was used. Also, by using the scale, several artifacts which may have resulted from demanding more precise estimates were avoided.

3. Open-ended Overviews. A question asking for an overview was always included near the beginning of each set of questions concerning a major service or program. After asking such questions, the interviewer

would then take notes as the respondent described how the service was provided.

Examples:

> Would you please briefly describe the social services provided to inmates?
>
> Please give us, as well as you can, a brief overview of this program.

The major problem with such open-ended questions was the variability in the quality and quantity of the responses. To attempt to assure greater uniformity and completeness of the responses, a special format was used for recording the responses. A checklist of the most important items to be covered was printed along the margin of the sheet where the responses were recorded. This checklist was used by the interviewers to provide cues for the respondent, and, later, also provided specific dimensions for coding the responses.

4. Subjective Evaluations. The second part of the overview, the "self-analysis" section, consisted almost entirely of questions which asked the respondent to give a personal appraisal or evaluation of some problem or estimate the effectiveness of some service. Also, at a few points within the main body of the questionnaire where detailed descriptions of the services were being explored, respondents were asked for their subjective evaluations of problems or needs.

Examples:

> Do you consider the community's drug treatment resources (either educational or rehabilitative) to be adequate?
>
> Are the facilities for providing this service adequate?

Any subjective evaluation obviously depends on who the respondent is and, possibly, his or her psychological state at the

time the question was asked. The only solution open at the time of analysis was to classify the responses by type of respondent and to recognize that the resulting data represents a sample of jail personnel views.

Answers Received

The data collected consisted of the responses to the questions asked the staff of the jails, community agencies, and selected inmates. While there were no formal or empirical checks on the accuracy or validity of the information collected, several factors served to prevent any gross distortions of reality. Possibly the most important of these was the fact that the data was collected by personal interviews at the sites where the service was performed. The direct, personal interviewing and observation helped to avoid many potential problems related to distortion or confusion over the meaning of words or questions. A second major factor which may have contributed to the accuracy of the data was the completeness and degree of detail built into the questionnaire. For example, near the end of the first part of the overview section, respondents were asked to respond yes or no to a long checklist of services. All important services appearing on this checklist were later examined in great detail. In several instances, interviewers who received a yes response to a service mentioned on the checklist found later when requesting more detailed information that the service was in fact not available currently or that it never existed. Conversely, further inquiry sometimes identified program services that were operational in or related to the jail but were unknown to the initial respondent.

Procedure Followed for Each Site Visit

For each site visited, a six-step procedure was followed consistently. The first step was to notify the State Planning Agency (SPA) and the Single State Drug Agency (SSA); the second step was to review all available literature related to the site; the third step scheduled an interview at the jail; after the interview was scheduled, the next step had the interviewer travel to the site and administer the questionnaire schedule to the jail administrative and treatment staff and, in some cases, inmates. As a fifth step, when appropriate, interviews were conducted with one or more local and state agencies in the community. Finally, immediately after the site visit, the interviewer prepared a summary narrative overview of the jail. Brief descriptions of each of these above six steps follow.

1. Notification of ths SSA and SPA. During the initial phase of the project, before any site visits were conducted, the SPA and the SSA in each of the fifty states were sent letters describing the project. These letters included a request for aid in obtaining any information concerning drug abuse services available at local jails in their respective states and notified them of our intent to visit jails in their state at a later time. Approximately two weeks before scheduling an appointment at each jail, the appropriate SSA and SPA was sent a second letter which informed them of the specific jail or jails to be visited and requested any additional current information which they might have on those facilities.

2. Review of Site-Related Literature. In preparation for visiting each jail, the interviewer reviewed all information provided by the jail, SSA, SPA, TASC, other local programs, and journal articles or other published reports concerning either the jail or drug abuse programs in the

community being visited.

3. Scheduling an Appointment. Each jail was sent a brief questionnaire concerning the availability of drug abuse services at the jail and requesting cooperation with the N.J.R.S. study. The interviewer arranged a site visit by first telephoning the individual at the jail who had responded to the initial request for cooperation. When necessary, the approval of an administrative superior or the jail's chief administrator was sought before scheduling an appointment with that individual. The interviewer then reviewed the nature of the project and generally described the information being sought. The respondent was asked to give a brief summary of the types of services available at the jail. Based on this information, the interviewer was then able to indicate to the respondent which jail personnel would be interviewed and the approximate amount of interview time needed. If the respondent indicated that the jail was willing to cooperate, the interviewer then scheduled the necessary appointments at the convenience of the jail.

4. Administering the Survey Instrument. The interviewer's principal task was to administer the survey instrument, which consisted of a schedule of questions. This was accomplished by reading each of the items on the questionnaire schedule to the respondent. The answer was then recorded directly on the questionnaire form.

For all but three of the 118 jails studied, the information was collected by personal interviews with jail personnel at the jail being studied. In three cases, the interviews were conducted totally by phone. These three were small jails, isolated geographically, and were identified as providing relatively low levels of service.

The interviews were conducted by seven members of the N.J.R.S. staff including the Project Director and Assistant Director. Normally, all

sites within a given state were visited by the same interviewer, with each interviewer being assigned at least one state in each of the five designated regions.

Each section of the questionnaire was administered as a unit to one person or one group of respondents. As much as possible, interviewers attempted to address each section to the most knowledgeable available respondent. Normally, this entailed interviewing the staff member (or members) directly responsible for the area of service the section covered. For example, the overview sections were usually addressed to the jail's chief administrator, the section on detoxification to medical personnel, etc. Generally, within all sections the questions were asked in the order in which they appeared on the questionnaire.

Interviewers spent as much time at each site as was necessary to complete the schedule. Depending on the extent of the services available, the time required ranged from a few hours to several days.

5. Interviews with Local Community Agencies. Many jails cooperate with local community agencies in providing services to inmates. Whenever possible, representatives of these agencies were interviewed at the jail or at the premises of the outside agency.

6. Preparation of Interviewer Overview. After visiting the jail, various local agencies, and after interviewing staff members and inmates, a great deal of potentially useful general information had been assembled. To retain this material, the interviewers then prepared an overview summary in narrative form. This summary included all information which was not recorded on the questionnaire and which enhanced understanding of how the jail provided services for drug abusing inmates.

Analysis of Data

In the chapters which follow, the analysis of the findings are presented. Data was subjected to a variety of analytical methods, including frequency distributions, cross-tabulations, and correlations between variables. The particular form of analysis to which the data has been subjected is reported within the text or tabular material.

CONCLUDING OBSERVATIONS

We have presented our methodology in detail for several reasons. First, the reader should be aware of the techniques utilized by the researcher in collecting data on the problem. Our approach in the field was rigorously defined so that several different interviewers, working independently, would comport themselves similarly when interviewing jail personnel, inmates, and outside service providers. Secondly, we have presented our research design in its complete detail to permit future researchers to view the "state of the art" at a later point in time, utilizing the same methodology, and thus facilitate comparative analyses. We can know how far we have traveled only when we know where we began. In the chapters which follow, we present where we are, as represented by this sample of jails providing drug treatment services to inmates.

CHAPTER THREE

GENERAL OVERVIEW OF DEMOGRAPHIC FEATURES IN JAILS WITH SERVICES FOR DRUG-ABUSING INMATES

INTRODUCTION

This part of the study presents statistical information about 118 jail systems which offer services for drug-abusing inmates. The demographic data was collected as background information for a fuller understanding of what jails do in terms of service provision, as well as understanding apparent gaps in service. Data is presented which provides a general overview of administrative aspects of the jail and the nature of its population.

The study does not make the assumption that the high social and personal cost of drug abuse can be solved or even substantially reduced by drug treatment programs as they now operate in jails and in communities. However, the study does assume that serious hard drug usage and abuse is a response to social and personal problems and frequently has deep rooted underlying causes. Drug treatment, then, in the form of individualized assistance to the abuser, is one appropriate response. Nonetheless, it is only one strategy for meeting the rising drug problem; it must be part of a comprehensive program involving both expanded treatment and more effective enforcement programs, as well as social reforms leading to full employment, adequate housing and meaningful education.

Jails operate at the local level for pre-trial detention, for custody and correction of those serving brief or intermittent sentences, and for temporary incarceration prior to transfer. Their populations are

...typically accommodate for shorter periods of time than those of state and federal prisons. The Bureau of the Census and the National Advisory Commission on Criminal Justice Standards and Goals define a jail as "any facility operated by a unit of local government for the detention or confinement of persons accused or convicted of a crime and which has authority to detain persons more than 48 hours." (National Advisory Commission on Criminal Justice Standards and Goals, Corrections, 1973:276) This study enlarges on this functional definition to include the six state-operated jail systems.

It is important to note that the data presented here covers only those jails which reported that they provide some level of service to the local criminal justice system (approximately 95% of all local jails) and, therefore, may underrepresent the contribution of local jails reporting only pretrial services. A study of considerably greater magnitude would have been required to provide a more precise profile of the small jail which only houses sentenced misdemeanants. Due to the nature of small jails, including their relatively low volume of activity and their frequently part-time staffing, the cost of such a study would be prohibitive.

Jail Size

...is one of the most important factors affecting the ...
...The assumption underlying the provision of ...
...the case of a single jail, a single cell may ...
...are used. The number of small jails (those ...
...(85%) providing services to fewer than ...

although the small jail is the most common in the United States, only 12% of the total sample are represented by that size category.

TABLE 5.1

Sample Composition by Size

Size (Average Daily Population)	Jails	
	Number	Frequency (%)
Small (fewer ...)	14	11.9
Medium (...)	35	29.8
Large (250 or more)	69	58.4
Total	118	100.0

Jail Organization

As was noted in the jail profiles in the earlier section, the facility inventory data and records for each jail system are frequently ...
...locations. Therefore, the jail may be a part of the facility which houses ...
...jail status (i.e., the only local facility) or one of several facilities ...
...which owes distinction of each other.

TABLE 5.2

Sample Composition by Type of Organization

Organization	Jails	
	Number	Frequency (%)
Single, multipurpose jail	54	45.8
Multiple jail system	64	54.2
Total	118	100.0

Within jail systems seven different types of facilities are delineated: detention facility, combined detention-sentence facility, sentenced facility, work release facility, female facility, honor camp, and medical center. While we identified specific facilities for study, once on the site, however, we might be informed of drug treatment-related services occurring in other facilities of the system and, where possible, the facility would be visited and additional data collected. Thus, the number of jails for which location is reported in table 3.3 exceeds the core jails studied.

TABLE 3.3

Relation Between Location and Type of Facility

Type of Facility	Location							
	Center City		City Fringe		Rural		Total	
	#	%	#	%	#	%	#	%
Single jail	40	65.6	17	27.9	4	6.6	61	100
Detention	25	89.3	2	7.1	1	3.6	28	100
Detention-sentenced	20	71.4	5	17.9	3	10.7	28	100
Sentenced	0	0	14	46.7	16	53.3	30	100
Work-release	4	57.1	3	42.9	0	0	7	100
Female only	2	18.2	4	36.4	5	45.5	11	100
Honor camp	0	0	3	27.3	8	72.7	11	100
Medical center	1	25.0	3	75.0	0	0	4	100
Total	92		51		37		180*	

*Number of institutions described exceeds the number of study jails (118) because 54 jails were systems involving multiple facilities.

The physical location of the jail is one determinant of jail utilization of community-based resources. Because ease of access and proximity for transportation are among the factors which can facilitate or impede

cooperative efforts between the jail and outside service providers, we were interested in learning about the actual location of jail facilities within the community. In general, where the system consists of a single multipurpose jail, or where it is primarily a pre-trial jail, the facility is located in the center of the city, near the courthouse or municipal building. On the other hand, a sentenced facility is more likely to be located in a rural area. Honor camps also tend to be rural based. Work release facilities, which hold sentenced inmates only generally are located close to jobs either in the city center or at city fringe. The city fringe is the outer part of the city where warehouses, commercial buildings, docks, railroad yards and other such facilities are commonly found.

Regional Distribution

The jails studies were drawn from the five regions of the United States. The regions and their states are:

North East: Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New York, Pennsylvania, New Jersey, Maryland, Delaware, Virginia, West Virginia, Washington, D.C.

South East: North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Tennessee, Kentucky

North Central: Ohio, Indiana, Illinois, Michigan, Kansas, Wisconsin, Minnesota, Iowa, Missouri, Nebraska

South West: Texas, Louisiana, Arkansas, New Mexico, Oklahoma

West: Oregon, Washington, Montana, Idaho, California, North Dakota, South Dakota, Wyoming, Colorado, Utah, Nevada, Arizona, Hawaii, Alaska

(See Appendix for names and addresses of jails which were part of this study.) Our sample consists of a larger number of jails drawn from the North East and West regions than would appear in a strictly proportional representation.

TABLE 3.4

Sample Composition by Region

Region	Sample Jails		All Jails*	
	Number	Frequency (%)	#	%
North East	31	26.3	231	5.9
North Central	31	26.3	1153	29.4
South East	17	14.4	1865**	47.6
South West	10	8.5		
West	29	24.6	672	17.1
Total	118	100.0	3921	100.0

*U.S. Department of Justice, Law Enforcement Assistance Administration, The Nation's Jails: 1972 Survey of Inmates of Local Jails (Washington, D.C.: Government Printing Office, 1975), p. 1.

**South East and South West are reported as one category, South.

Government Level of Responsibility

Information was collected from each jail concerning the unit of government responsible for the operation of the jail. Table 3.5 presents that information. A few jails are under a metropolitan form of government, which means that the city and county have been consolidated for some services. These few cases in our study are reported under the county category.

TABLE 3.5

Sample Composition by Responsible Unit of Government

Unit of Government	Jails	
	Number	Frequency (%)
County	91	77.1
City, township, boro	17	14.4
State	10	8.5
Total	118	100.0

Jail Population

The legal status of the inmate is of interest, since it may influence the types, intensity, and duration of services which the jail can provide. Some jails reported a reluctance to provide any but emergency services to the pre-convicted inmate, either due to concerns about inmate litigation, concerns about custody pending adequate evaluation and classification, or because of the very short or uncertain duration of inmate stay. Table 3.6 describes the jail population in terms of the percentage of detainees in the population.

It is clear that a substantial percentage of the jails in the study held more detainees than convicts. Since detainees frequently arrive at the jail directly from the community, these inmates are among those most in need of jail-provided services. This is especially true for those persons who are involved in drug-abusing behavior, and may be in need of detoxification. Chapter 5, "Detoxification and Other Approaches to Physical Treatment," contains descriptions of when and how these services are provided.

TABLE 3.6

Composition by Detainee in Jails Studied

Detainees as % of Population	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)
None	10	8.5	8.8
0-25	12	10.2	10.6
26-50	18	15.3	15.9
51-75	30	25.4	26.5
76-99	40	33.9	35.4
All	3	2.5	2.7
Data not available	5	4.5	—
Total	118	100.0	100.0

Note. Entries under Frequency refer to proportion of total sample (including jails for which data was not available); entries under Adjusted Frequency refer to proportion of the total number of jails for which data was available.

The relationship between sex of the inmate and provision of services was of interest and as a result we sought to determine whether jails held women and, if so, the proportion held. Table 3.7 indicates respondents' estimates of proportion of inmates who are females. One out of five jails does not hold female inmates. In general, the proportion of female inmates is very low, with an estimated 62% of jails reporting that females constitute 1% to 10% of their total population. Further, no jail has a female population in excess of 33%, excluding the two all female jails. Although verification was beyond the scope of this study, it was reported in many parts of the country that the percentage of females being held in jails is on the increase. Exclusion from services because of sex was seldom reported although, particularly in counseling, the orientation was

generally different depending on sex of participating inmates. More specific information on sex as a factor in service availability is found in Chapters 5, 6, and 7.

TABLE 3.7

Sample Composition by Female Inmate Population

Female Inmates as % of Population	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)
None	26	22.0	22.2
1-5%	39	33.1	33.3
6-10%	34	28.9	29.1
11-33%	16	13.6	13.7
34-99%	0	—	—
100%	2	1.7	1.7
Data not available	1	0.8	—
Total	118	100.0	100.0

Jail Policies

The study investigated selected jail policies as these pertained to services for drug-abusing inmates. Among the policies studied were: separation practices, guard training, diversion, and the role of jail advisory boards.

Separation. There is general consensus among correctional experts that certain classes of inmates should be separated in order to provide maximum safe custody and to facilitate appropriate services to special categories of offenders. Table 3.8 presents findings for recommended categories of separation (National Advisory Commission on Criminal Justice Standards and Goals, 1973; American Correctional Association, 1966).

Except for the separation of juveniles from adults (a category which is vague, depending on definition, offense status, and handling of the juvenile) and certain cases of detainee-convict separation, jails generally do not, as a matter of policy, follow extensive separation practices.

TABLE 3.8

Sample Composition by Physical Separation Policy

Separation Policy	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)[a]
Juveniles/adults	39	88.6 [b]	88.6
Detainees/convicts	63	53.4 [c]	60.0
Drug abusers/non-drug abusers	19	16.1	16.2
Misdemeanants/felons	41	34.7	35.3
First offenders/recidivists	23	19.5	19.7

[a]The number of cases for which data was unavailable varies with separation policy; however, in all cases the percentage of missing data was, at most, eleven percent.

[b]Only 44 jails held juveniles; thus, the percentages reported refer to the proportion of those 44 jails in which this separation policy is in use.

[c]Ten jails in the sample did not hold detainees, and three jails did not hold convicts; thus, the percentages reported refer to the proportion of the 105 jails to which this separation policy could pertain.

Training. The effective operation of a jail requires that its personnel be provided training in order to develop specific skills and to understand what they are doing. Such training is needed at the point of entry and on a regular basis thereafter in order to effectively implement new policy and procedures. Our inquiry into training for jail guards indicates that, as a matter of policy, most jails (70.3%) with services to

drug-abusing inmates reported that some training is made available to guards. There are wide variations in the scope, quality, and frequency of such training activity.

The training input related specifically to drugs and drug problems was of particular interest. Table 3.9 shows that 75% of all jails which provide any training to their guards also train most to deal with the specific drug-related problems of the inmate, rather than only custody matters related to drugs. The distribution on drug training for guards is presented in table 3.9.

TABLE 3.9

Sample Composition by Guards Receiving Drug Training

Guards Receiving Drug Training as % of Guard Population	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)
None (0%)	6	5.1	7.7
Few (<10%)	5	4.2	6.4
Some (10-49%)	8	6.8	10.3
Many (50-99%)	18	15.3	23.1
All (100%)	41	34.7	52.6
Not applicable/do not know	40	33.9	—
Total	118	100.0	100.0

Diversion. In response to the question, "Are persons ever diverted from the criminal justice process at any stage from arrest to/and including post-sentencing?", we found that about one-fourth (23.7%) of all jails surveyed reported there was no diversion available. While procedures for diversion exist at many of the jails, there is little evidence to suggest that diversion is used for any sizeable proportion of the jail population.

TABLE 3.10

Sample Composition by Diversion Policy

Diversion Policy	Jails	
	Number	Frequency (%)
No diversion	28	23.7
For all inmates	49	41.5
For drug abusers	25	21.2
For all inmates except drug abusers	5	4.2
For juveniles only	2	1.7
Not sure	9	7.6
Total	118	100.0

The data indicate 62.7% of the jails which have diversion make it available to either drug abusers or all inmates, including drug abusers, meeting specific criteria. It is not improbable that additional diversionary activities exist in some communities unknown to the jail administration, given the lack of information flow between elements of the criminal justice system and the system's general fragmentation. For example, a court-related diversion project, operating in the same building with the jail was unknown in the jail. Since it is not always possible for jail personnel to be aware of what is happening outside its confines, the information, derived principally from jail sources, may misestimate the availability of diversion acitivities. Obviously, the availability of a drug-abuser diversion program which operates prior to incarceration will have an impact upon the jail in terms of absolute numbers and how often drug-abusing inmates are received at the jail. Moreover, when the diversion operates subsequent to jail intake, the jail may not know whether the case was dismissed, the accused released, or whether diversion

occurred. In any case, the degree of system utilization of diversion for drug-abusing people will ultimately have an influence on the need for jail-provided services for inmates with drug-related problems. Clearly, further study of the relationship and impact of diversion on jail population needs is in order.

The Advisory Board. Given the current rhetoric and interest regarding community involvement in corrections, we investigated whether any formal mechanisms (e.g., advisory board) exist to channel political and community input into jail operations. We recognize that many informal advisory influences operate in all government-provided services; nonetheless, we find that about one-third of all jails (31.4%) surveyed have a formal advisory board. Further, it appears that program planning responsibilities are most frequently assigned to advisory boards. Other functions and responsibilities cited are: intermediary between jail and local government, public relations, and administration.

Organizational Responsibility. Jails perform two general functions. These are the provision of custody and human services. Organizational responsibility for the administration of each of the two functions is analyzed in table 3.11; we sought to establish whether there is an association between services available to inmates and the type of organizational responsibility. Table 3.11 indicates that law enforcement agencies (sheriff, police department) more frequently (67%) have responsibility for custody than any other organization. The pattern of law enforcement agency predominance exists also for the services function.

Type of Services and Service Providers

We attempted to establish the parameters of the services provided by the jail. In table 3.12 the reported availability of specific services

TABLE 3.11

Relation Between Jail Function and Responsible Agency

Responsible Agency	Type of Function			
	Custody		Services	
	#	%	#	%
Law Enforcement	79	67.0	70	59.3
Corrections	30	25.4	36	29.7
State	9	7.6	10	8.5
Court	0	0	2	1.7
Total	118	100.0	118	100.0

to inmates is given. General medical care is reported available at all jails, with detoxification next in frequency, followed by social services and screening. A detailed analysis of the range, scope, and nature of

TABLE 3.12

Sample Composition by Services Available to Inmates

Type of Service	Jails	
	Number	Frequency (%)
General medical care	118	100.0
Detoxification	94	79.6
Social Services	88	74.5
Academic program	82	69.5
Screening	80	67.7
Work release	76	64.4
Community re-entry help	49	41.5
Vocational training	42	35.6
Psychological therapy	41	33.8
Chemotherapy	1	0.8

the specific services as they relate to inmates with drug abuse problems is found in chapters on the specific services.

Typically, outside community agencies provide some of the services offered in jails. The fact that these agencies provide service does not, of course, in itself describe the range, quality, or frequency of the activities. More precisely, some services are provided by one or more community agencies to jails at some times under certain conditions; this does not imply regularity or quality of services delivered. While 94% (98 jails) of the jails indicate that they work with outside agencies, only 15.3% (18 jails) have formal guidelines to support these operations. As shown in table 3.13, of those jails that have formal cooperating procedures, the most frequently recorded guideline is the requirement that

TABLE 3.13

Type of Guidelines Required by Jail for Cooperating Agencies

Type of Guidelines	Jails	
	Number	Frequency (%)
Written proposal must be approved by jail	12	10.2
Agency staff must go through jail orientation	5	4.2
Program staff need security clearance	4	3.3
No ex-cons or ex-addicts	1	.8
Program staff must be accompanied by guard	1	.8
Total	23*	

*The total is more than the 18 jails reporting guidelines because some jails reported more than one guideline.

...fore we could be confident to provide services to the jail, it was ...ebuttal to a letter request describing the services to be provided. The ...second most common was the response that either staff participate in a ...jail orientation program. The multiples established by both are given ...in Table 5.10.

Length of Stay Profiles (LOS)

...We also had data regarding the length of stay of inmates. For ...purposes of this study, length of stay was defined as the number of ...days between the date the inmate was booked into the jail and the ...date he was released. While the majority had relatively short stays, ...a significant number of inmates had very long stays. ...

...A logical question to ask was: Did the jail have to meet both inmate ...populations' needs or could it meet the needs of one group at the ...expense of the other? To answer this question, we developed a method ...to determine whether the percentage of jail population held for ...each of the following four time periods:

1. Less than 3 days
2. 3-30 days
3. 30-180 days
4. Over 180 days

...differed significantly from jail to jail. Of the 92 jail respondents ...who had all jail records in computerized form, 79% (52 jails) of the respondents ...stated that it was possible for them to retrieve the information, 79% (52 jails) of the respondents ...could answer this question.

The responses of the 92 jails were first divided into two categories. We placed all jails which held 70% or more of their inmates in two adjacent time periods in the first category (see Figure 5.11). For example,

FIGURE 5.1

Criteria for Length of Stay (LOS) Categories

LOS Category	LOS Type	Percentage of Inmates Held for Each Time Period			
		Period 1 0-2 days	Period 2 3-30 days	Period 3 30-180 days	Period 4 over 180 days
[illegible]	1	Total of at least 70% held in these two periods and at least 10% more held in period 1 than in period 2			
[illegible]	2	Total of at least 70% held in these two periods and at most 10% difference between the two periods			
[illegible]	3	Total of at least 70% held in these two periods and at least 10% more held in period 2 than in period 1			
[illegible]	4		Total of at least 70% held in these two periods and at least 10% more held in period 2 than in period 3		
[illegible]	5		Total of at least 70% held in these two periods and at most 10% difference between the two periods		
[illegible]	6		Total of at least 70% held in these two periods and at least 10% more held in period 3 than in period 2		
[illegible]	7			Total of at least 70% held in these two periods and at least 10% more held in period 3 than in period 4	
[illegible]	8			Total of at least 70% held in these two periods and at most 10% difference between the two periods	
[illegible]	9			Total of at least 70% held in these two periods and at least 10% more held in period 4 than in period 3	

Note. An asterisk (*) indicates less than 3% of the inmates held for the time period. LOS Type 10 consisted of jails which could not be classified since less than 70% of all inmates were held in two adjacent time periods.

a jail holding 50% of their inmates for less than 3 days and 25% between 3 days and 30 days; or a jail holding 40% between 3 and 30 days and 35% between one and six months, would be put into the first category. The remaining jails, i.e., those which do not hold at least 70% of their inmates in two adjacent time periods were put into the second category. For example, a jail holding 30% less than 3 days and 10% between 3 and 30 days would be put into the second category. Using this method, 84 jails fell into the first category and eight into the second category. We then proceeded to analyze this larger group of jails because of their patterning potential.

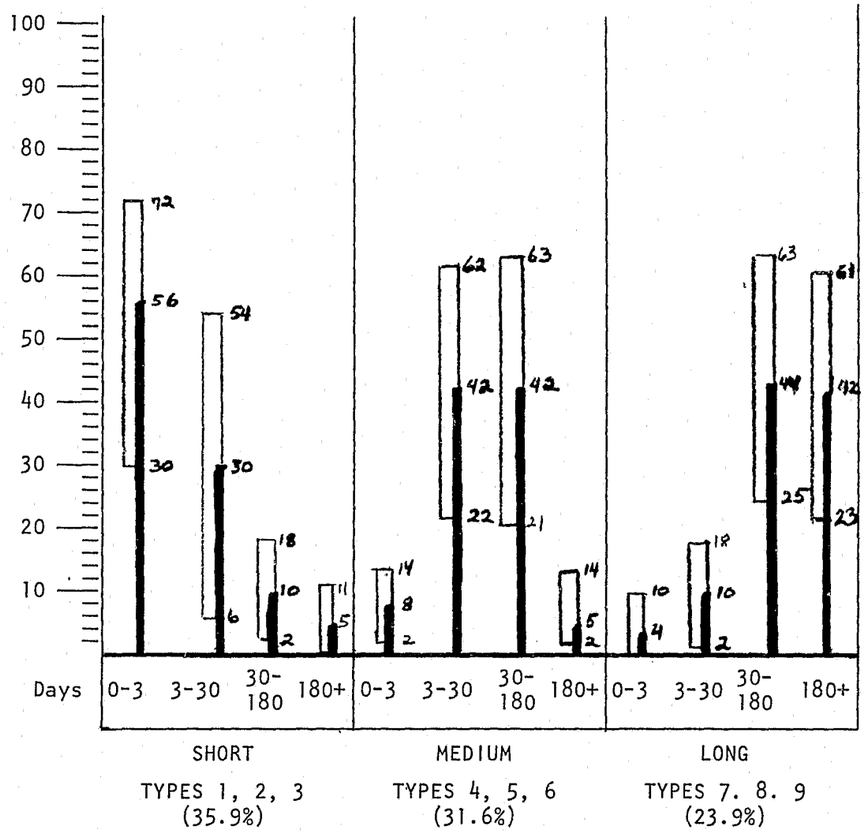
The second step was to divide the 84 jails in the first category into short, medium and long stay types. Short stay jails are defined as those which hold at least 70% of their inmates within the first two time periods, i.e., less than 3 days and between 3 and 30 days. Medium stay jails hold at least 70% of their inmates in the second time periods, 3 to 30 days, and one to six months. Long stay jails hold at least 70% of their inmates for the last two time periods, one to six months and six months or longer. Using this process 33 jails are classified as short length of stay institutions, 29 are medium length of stay jails and 30 are long length of stay jails (see figure 3.2). The jails in this study are most often short stay with medium stay and long stay less often found.

The third and final step was to divide the short, medium, and long groups each into three more refined types, yielding a total of nine types (see figure 3.3). The criteria for each type are summarized in figure 3.1. The jails which do not hold at least 70% of their inmates in two adjacent time periods were classified as Type 10, and not analyzed.

In order for a jail to adopt the LOS system, it would need to keep records on the number of days each inmate is held. From this data, the

FIGURE 3.2

Length of Stay Profiles
By Short, Medium, and Long Stay Types

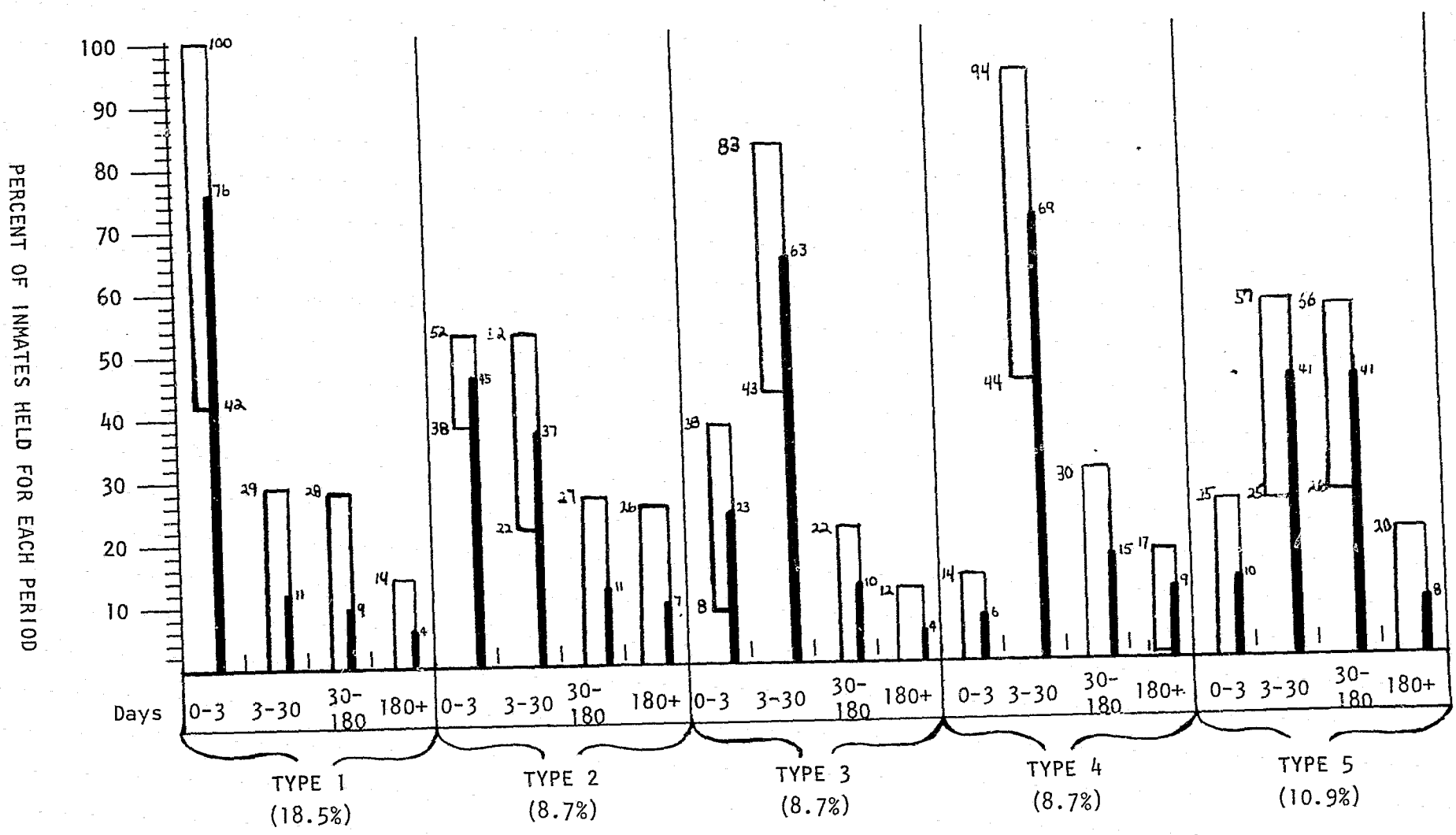


LEGEND to Figures 3.2 and 3.3

There are three numbers along each of the vertical bars of the histogram. The middle number on each bar equals the mean percent of inmates held for each period within each type of distribution. The numbers above and below this mean represent two standard deviations from the mean. These values can be interpreted as defining an interval about the mean, which is 95% certain to include the mean of all possible jails of this type.

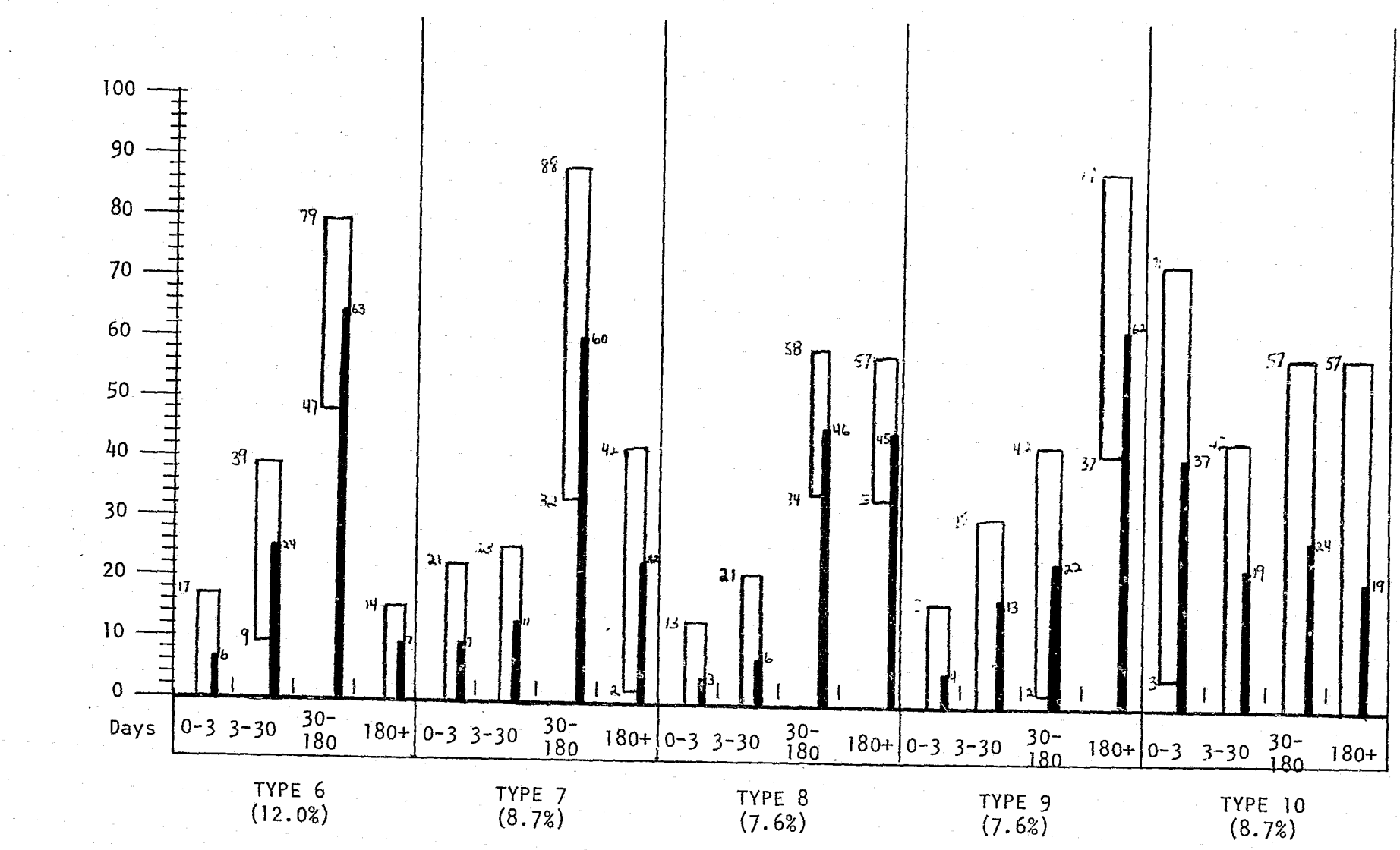
FIGURE 3.3

Length of Stay Profiles--Expanded



Note: See Page 55 for legend.

FIGURE 3.3 - Continued



Note: See Page 55 for legend.

numbers of inmates held in the time periods as defined by this report, or others of the jail's devising, can be computed. The final step is to determine, using the criteria in figure 3.1, the jail's individual LOS profile for the period in which data is collected. It is important that the period be long enough to serve as a predictor of population patterns, although seasonal variations can be accounted for by developing several profiles. By analyzing the jail population with an LOS profile, a more useful and a more accurate population picture emerges than an analysis by the conventional average length of stay index. In the latter index, important information on the jail's inmate population such as trends within more than one time frame (e.g., 1-3 days; 4-30 days; 31-180 days and over 180 days) are obscured. Thus, the conventional method of averaging daily population fails to show the presence of multiple population groups and the relative proportion of jail population in the different time periods.

Interest in the LOS data is predicated on the proposition that the temporary or long-term nature (i.e., the high or low degree of turnover) of inmate population has a bearing on the planning, organization and delivery of services to inmates both in and through the jail. Indeed the data as presented later in this chapter will, for the most part, support the proposition (see tables 3.19-3.22) that service availability is related to the LOS data.

In order to ascertain whether there is a relationship between length of stay (LOS) profiles and availability of services, the profiles have been analyzed in relation to a number of pertinent variables, including jail system, size, type of facility, region, custodial authority, screening procedures, detoxification provision and vocational and educational programs.

In some counties or cities there is one local jail, multipurpose in function. In other jurisdictions, the local jail consists of several separate facilities which constitute a local jail system. Generally, as noted earlier in this chapter, these facilities serve different functions. Single jail facilities tend to have a shorter stay population. Conversely, jails which are part of a multiple jail system tend to be medium and long term jails. The relationship between jail system type and LOS, shown in table 3.14, is statistically significant, as measured by the χ^2 test, the standard statistical test for measuring the relationship between two variables. Since the probability is, in this case, less than .008, it can be reported that less than eight times out of 1000, could the observed relationship between jail system type and LOS have occurred by chance.

TABLE 3.14

Relation Between Length of Stay and Type of System

System Type	LOS Category					
	Short		Medium		Long	
	#	Adj.(%)	#	Adj.(%)	#	Adj.(%)
Single jail	24	72.7	13	46.4	7	31.8
Multiple jail system	9	27.3	15	53.6	15	68.2
Total	33	100.0	28	100.0	22	100.0

$\chi^2(2)=9.60$, $p < .008$

LOS and Size of Jail

Table 3.15 shows that jails with short LOS profiles are evenly distributed among small, medium, and large jails. However, medium LOS jails (those that hold the largest percentage of their population 30 days to six

months) are mostly found in medium-sized jails and, to a lesser extent, in large jails. The long length of stay jail populations are also found primarily in the medium and large jails.

TABLE 3.15

Relation Between Length of Stay and Size

Size (Average Daily Population)	LOS Category					
	Short		Medium		Long	
	#	Adj.(%)	#	Adj.(%)	#	Adj.(%)
Small	10	30.3	1	3.4	2	9.1
Medium	10	30.3	18	62.1	11	50.0
Large	13	39.4	10	34.5	9	40.9
Total	33	100.0	29	100.0	22	100.0

$\chi^2(4)=11.57$, $p < .02$

The multiple jail systems can be classified by function, as suggested earlier, and examined to determine if the specific type of jail facility is related to length of stay. In table 3.16, the jails are categorized by type of facility and tabulated with length of stay. The findings are statistically significant; the largest number of short-stay LOS jails are single jails. Those jails which are part of a multiple facility system tend to hold inmates for longer periods of time, in part because they have more designated space for sentenced offenders, and in part because special function jails tend to be located in large cities where crowded court calendars cause longer stays for unconvicted detentioners.

Table 3.17 shows the regional distributions of jails by LOS. It is of interest to note that short LOS jails tend to be in the West and South

TABLE 3.16

Relation Between Length of Stay and Type of Facility

Type of Facility	LOS Category					
	Short		Medium		Long	
	#	Adj.(%)	#	Adj.(%)	#	Adj.(%)
Single jail	24	72.7	13	44.8	7	31.8
Detention	4	12.1	3	10.3	2	9.1
Detention-sentenced	4	12.1	6	17.2	1	4.5
Sentenced	1	3.0	3	10.3	8	36.4
Work-release	—	—	1	3.4	—	—
Females	—	—	3	75.0	1	4.5
Honor camp	—	—	1	3.4	3	13.6
Total	33	100.0	29	100.0	22	100.0

$\chi^2(12)=27.94$, $p < .005$

East. Long LOS jails are in the North East and North Central. Given the fact that many inmates are detainees, we can assume that overburdened calendars affect these distributions. The relationship between the regions of the U.S. and length of stay of inmates is statistically significant.

LOS and Administrative Responsibility

We sought to determine whether there is a relationship between responsibility for custody and the time inmates are held in jails. No association was found between administrative responsibility for custody and length of stay. Jail operation by a law enforcement department, by a department of corrections, or by a state agency is not related to the length of stay profiles of the jails.

TABLE 3.17

Relation Between Length of Stay and Region

Region	LOS Category					
	Short		Medium		Long	
	#	Adj.(%)	#	Adj.(%)	#	Adj.(%)
North East	4	12.1	9	31.0	8	36.4
North Central	6	18.2	12	41.4	8	36.4
South East	7	21.2	4	13.8	2	9.1
South West	3	9.1	2	6.9	1	4.5
West	13	39.4	2	6.9	3	13.6
Total	33	100.0	29	100.0	22	100.0

$\chi^2(8)=16.88$, $p < .05$

LOS and Treatment Services

The existence of a relationship between length of stay and the availability of the various discrete treatment services is of interest. We looked at the services for inmates with drug problems which included screening, detoxification, general medical services, and social services. As components of social services, we examined work release, vocational

TABLE 3.18

Relation Between Length of Stay
and Administrative Responsibility for Custody

Responsible Agent	LOS Category					
	Short		Medium		Long	
	#	Adj.(%)	#	Adj.(%)	#	Adj.(%)
Law Enforcement Agency	23	69.7	16	55.2	13	59.1
Correctional Service	8	24.2	9	31.0	7	31.8
State	2	6.1	4	13.8	2	9.1

training, academic education, legal aid, and community re-entry. The relationships between screening, detoxification, vocational training and academic education, and length of stay are statistically significant. The relationship of LOS with methadone maintenance, medical services, and general social services is not significant.

The availability, as well as kind, of screening is associated with the length of stay population profiles of jails. Table 3.19 shows the relationship between type of screening procedure and length of stay. The relationship shown in table 3.19 is statistically significant at the .02 level. Short LOS jails are more likely to have no intake screening (54% of all short LOS jails) than either medium or long LOS jails while the most comprehensive screening procedures occur with increasing frequency in medium and long LOS jails. We can assume that inmates with drug abuse problems are frequently missed for diagnostic purposes in short LOS jails.

TABLE 3.19

Relation Between Length of Stay
and Type of Intake Screening Procedure

Screening Procedure	LOS Category					
	Short		Medium		Long	
	#	Adj.(%)	#	Adj.(%)	#	Adj.(%)
None	18	54.5	5	17.2	5	22.7
Booking only	5	15.2	7	24.1	5	22.7
Medical only	5	15.2	5	17.2	5	0
Assessment interview	3	9.1	5	17.2	4	18.2
Medical & Assessment	2	6.1	7	24.1	8	36.4
Total	33	100.0	29	100.0	22	100.0

$\chi^2(8)=19.12$, $p < .02$

As might be expected, in the provision of detoxification services, length of stay is an important determinant. Short and medium LOS jails are more likely to provide detoxification than long LOS jails. Because long LOS jails hold very few inmates under thirty days, it is more likely that these are sentenced facilities, work release facilities, and honor camps. They are, therefore, not the initial intake facilities and, hence, their inmates have already been detoxified or were withdrawn without help in detention/pre-trial jails. Table 3.20 shows the relationship between detoxification services and length of stay.

TABLE 3.20

Relation Between Length of Stay and Provision of Detoxification Services

Detoxification Services	LOS Category					
	Short		Medium		Long	
	#	Adj.(%)	#	Adj.(%)	#	Adj.(%)
Provided	27	81.3	26	89.7	14	63.9
Not provided	6	18.2	3	10.3	8	36.4
Total	33	100.0	29	100.0	22	100.0

$\chi^2(2)=5.39$, $p < .07$

Vocational training is available in some local jails as part of the overall social services program. The purpose of vocational training is to develop responsible work habits and specific skills which might lead to employment upon release. The basic justification for providing vocational training and academic education in jails is that many inmates are deficient in the kinds of skills which might enable them to be self-supporting, law-abiding and effectively functioning members of society. Inmates with drug problems also exhibit these general rehabilitative needs and,

for the most part, are eligible for the range of social services which the jail has available. From the findings, it is clear that jails are more likely to offer vocational and educational programs if a substantial proportion of the inmate population remains six months or longer. There is a statistically significant relationship between length of stay and vocational and academic program availability. Table 3.21 describes the relationship between vocational training and length of stay; table 3.22 reports on academic education and length of stay.

TABLE 3.21

Relation Between Length of Stay and Provision of Vocational Training

Vocational Training	LOS Category					
	Short		Medium		Long	
	#	Adj.(%)	#	Adj.(%)	#	Adj.(%)
Provided	7	21.2	9	31.0	14	63.6
Not provided	26	78.8	20	69.0	8	36.4
Total	33	100.0	29	100.0	22	100.0

$\chi^2(2)=10.77$, $p < .005$

TABLE 3.22

Relation Between Length of Stay and Provision of Academic Educational Programs

Academic Education	LOS Category					
	Short		Medium		Long	
	#	Adj.(%)	#	Adj.(%)	#	Adj.(%)
Provided	19	57.6	23	79.3	21	95.5
Not Provided	14	43.4	6	20.7	1	4.5
Total	33	100.0	29	100.0	22	100.0

$\chi^2(2)=10.54$, $p < .006$

Crowding

Overcrowding is an ongoing problem for local jails and their administrators. Frequently, interviewers were told by respondents that overcrowding prevented development of rehabilitation programs or further expansion of existing ones. With information on average daily population (ADP) and on the facility's capacity for holding its population, it is a simple matter to develop an objective rating on crowding for each jail in the study.

The degree of crowding is computed by calculating a ratio for each jail. The ratio ($\frac{ADP}{RC}$) is the average daily population (ADP) divided by the resident capacity (RC). This proportion represents the percent of population actually in the jail on an average day in relation to the number of persons the jail was designed to hold. For example, if the jail's average daily population is 50 and the jail's resident capacity is 100, the ratio is $\frac{50}{100}$ and the jail here is described as operating at 50% capacity. On the other hand, if a jail's ADP is 110 and RC is 100 ($\frac{110}{100}$), the jail is defined as being at 110% capacity. Jails were classified as "under capacity" where the ADP was clearly below RC (up to 79% of resident capacity); and "overcapacity", e.g., overcrowded where the ADP was in excess of RC (100% and over).

On first inspection, the cut-off for under capacity may appear to have been defined rather low and one might wonder why any jail population under 99% is not considered under capacity. The categories were purposely set at low levels because the traditionally constructed jail provides few, if any, special areas for services; unused cell space is often appropriated for counseling rooms and clinic areas. In general, space for services is a very precious commodity in most local jails. Therefore, as the jail's population begins to approach its designed resident capacity,

it is, in effect, too crowded for service provision. This is so because no space was originally allocated for services.

These crowding definitions are classifications devised by the study for analysis of selected demographic variables as they relate to services for inmates with a drug problem. By our definition, nearly one-fifth of the jails are overcrowded. It should be noted that table 3.23 is not detailed enough to show extreme overcapacity; however, several jails reported holding twice their resident capacity. Table 3.23 does show that less than one-half (44.9%) of the jails are under capacity.

TABLE 3.23

Jail Composition by Estimate of Crowding

Crowding	Jails	
	Number	Frequency (%)
Under capacity (0-79%)	53	44.9
Capacity (80-99%)	43	36.4
Overcapacity (100% +)	22	18.6
Total	118	100.0

The degree of crowding is, of course, related to the average daily population. In general, the larger the jail, the more likely it is to be overcrowded. More than one-fourth of the largest jails are overcapacity, while none of the small jails are overcapacity (see table 3.24). The relationship between size and crowding is statistically significant with this relationship occurring by chance less than one time in 1000 ($p<.0001$).

The jail categories by size were then expanded so that seven size types could by tabulated with crowding. From table 3.25 the relationships

TABLE 3.24

Relation Between Crowding and Size

Crowding	Size (ADP)					
	Small (0-20)		Medium (21-249)		Large (250 +)	
	#	%	#	%	#	%
Under capacity (0-79%)	14	100	24	44.4	15	40.0
Capacity (80-99%)	0	0	22	40.7	21	42.0
Overcapacity (100% +)	0	0	8	14.8	14	28.0
Total	14	100.0	54	100.0	50	100.0

$\chi^2(4)=23.12$, $p < .0001$

are sustained showing a highly positive correlation between crowding and increasing jail size ($p < .0001$).

TABLE 3.25

Relation Between Crowding and Size

Crowding	Size (ADP)											
	0-20		21-75		76-150		151-249		250-449		450-999		1000 +	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Under capacity (0-79%)	14	100	9	75	7	29.2	8	44.4	8	42.1	4	20.0	3	27.3
Capacity (80-99%)	-	-	3	25	13	54.2	6	33.3	8	42.1	11	55.0	2	18.2
Over capacity (100% +)	-	-	-	-	4	16.7	4	22.2	3	15.8	5	25.0	6	54.5
Total	14	100	12	100	24	100.0	18	100.0	19	100.0	20	100.0	11	100.0

$\chi^2(12)=40.62$, $p < .0001$

The degree of crowding is not related to region of the country although the North East tends to have more jails that are overcrowded than other regions. Crowding is not related to agency responsibility for services (law enforcement agency or department of corrections). As one might expect, there is a relationship between crowding and jails which are single facilities. Where the facility operates alone, (as distinct from jails which are part of a system) crowding is less likely to be a problem.

A local jail which is part of a multiple facility system is more likely to be located in a high density population area where crime rates are high, producing population pressures on the jail system. In addition, the data has indicated that multiple facility systems are more likely to have long-term LOS profiles. These two facts help to explain the findings reported in table 3.26, which show a statistically significant relationship between the degree of crowding and jail system type.

TABLE 3.26

Relation Between Crowding and Type of System

Level of Crowding	Type of System			
	Single Facility		Multiple Facility	
	#	%	#	%
Under capacity (< 79%)	35	55.6	18	33.3
Capacity (80-99%)	19	30.2	24	44.4
Overcapacity (100% >)	9	14.3	12	22.2
Total	63	100.0	54	100.0

$\chi^2(2)=5.80$, $p < .05$

Services and Crowding

While there is no relationship between crowding and the availability

of either detoxification or psychological services, there is a relationship between crowding and the level of screening conducted in the jail (tables 3.27 and 3.28). The availability of social services is also more likely to occur in jails operating at or over capacity; the relationship is marginally significant ($\chi^2(2)=5.24$, $p < .07$).

TABLE 3.27

Relation Between Crowding and Type of Intake Screening

Level of Crowding	Type of Screening									
	None		Booking		Medical		Interview		Medical & Interview	
	#	%	#	%	#	%	#	%	#	%
Under capacity (0-79%)	24	66.7	12	41.4	5	33.3	4	26.7	8	34.8
Capacity (80-99%)	8	22.2	10	34.5	5	33.3	10	66.7	10	43.5
Overcapacity (100% +)	4	11.1	7	24.1	5	33.3	1	6.7	5	21.7
Total	36	100.0	29	100.0	15	100.0	15	100.0	23	100.0

$\chi^2(8)=16.67$, $p < .05$

An analysis of the relationship between crowding and screening indicates that jails which either do no screening or which do booking only tend to be under capacity while jails which do the most comprehensive screening (e.g., medical exam and a classification interview) are, for the most part, those operating at capacity (43.5%). In order to provide full service, the jail must begin with a thorough screening at intake. Extreme population pressures reduce the possibility of such functioning. Instead, overcrowded jails tend to do a booking only (half of all overcrowded jails do not screen or only book; see table 3.28). Tables 3.27 and 3.28 describe the relationship between intake screening activities in jails and degree

of crowding. The association is statistically significant.

TABLE 3.28

Relation Between Type of Screening and Crowding

Type of Screening	Level of Crowding					
	Under Capacity		Capacity		Overcapacity	
	#	%	#	%	#	%
No screening	24	45.3	8	18.6	4	18.2
Booking	12	22.6	10	23.3	7	31.8
Medical only	5	9.4	5	11.6	5	22.7
Interview only	4	7.5	10	23.3	1	4.5
Medical plus interview	8	15.1	10	23.3	5	22.7
Total	53	100.0	43	100.0	22	100.0

$\chi^2(8)=16.67$, $p < .05$

CONCLUDING OBSERVATIONS

In this chapter we have described many demographic features of local jails which provide services to drug abusers in order to present an array of background information prior to describing the services in depth. A failure to take cognizance of the basic features of these jails would preclude full understanding of services currently found in jails. Certain major demographic findings, identified in the course of this general overview of jails in the United States today, merit further discussion here. These facts also lead to several recommendations.

The study has found that almost half of the jails hold most of their inmates for less than 30 days. This fact leads to the first recommendation: for most jails, it is desirable to initiate services either which require very brief periods of time for results (rather than programs which

require months for completion), or which allow for continuity and completion of service in the community upon release of the inmate.

The study also reveals that most local jails which hold detention populations are located in center city. This fact suggests the feasibility of community agency involvement in serving inmate needs. It leads to the second recommendation that work release programs for sentenced inmates can be operated out of center city jails now often utilized only for detention. While there must be complete segregation of the regular inmate population from the work release group, such assignments of populations would be possible in most jails.

Further, data show that while almost all jails report cooperating with outside agencies to provide inmate services, very few have written procedures to regulate the interaction. The recommended course of action for all jails, based on the responses and complaints of both custody and treatment staff, is to formalize these procedures so that agency people understand the primary role of the jail and the implications for security and free movement within the jail. The expectations which the jail has of community experts should be carefully detailed, as well as the activities which the agency anticipates performing for the jail.

One of the most revealing aspects of the analysis of demographic information is the jail profile of characteristic population length of stay. From a jail's LOS profile, it is possible for a jail administrator to develop realistic plans for services to inmates, especially in identifying the kinds of programmatic activity suitable for a facility. The first step is to collect the necessary information by calculating, over a period of time, the percentage of the population which remains for specific time periods. The time frames used in this study can, of course, be changed. A jail should construct, for purposes of analysis, a length

of stay scheme which allows for appropriate time periods for that particular jail. Once this information is available, planning can be optimized. Initiation of services and referral programs for short-term inmates, as well as more ambitious in-jail programs for other inmates, can proceed depending on the population profile which emerges. It is recommended that: local jails should consider the nature of inmate population by developing an LOS profile and then organize services both in and through the jail accordingly.

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CHAPTER FOUR

IDENTIFYING INMATE TREATMENT NEEDS: INTAKE SCREENING

The purposes of the screening process are: inmate accounting, classification, problem identification, and needs assessment. If screening operates effectively, it can become a critical entry point for assisting the inmate in resolving problems associated with his current predicament. It points out to the jail staff those individuals who should be targeted for a response by the jail's human services resources. The screening process, if it operates on a round-the-clock basis, can identify all drug-addicts who may soon be going into withdrawal if they remain in the jail. Further, screening can alert custodial staff to potential suicides as well as provide the basis for appropriate cell assignment for preventing injury to the vulnerable inmate.

The procedures used to identify characteristics and needs of incoming inmates are referred to as "intake screening". All jails have some form of initial booking procedures, but when only this procedure is used it will not be considered "screening" in this report. The screening processes we examined are those that can identify drug users. Screening processes can be simple or elaborate, ranging from booking with questions about drug use, to an in-depth personal interview, to a medical examination, to some combination of the foregoing.

Two out of three jails (69.4%) report conducting some sort of formal screening. It is noteworthy that all of the jails which were part of this study claim to be providing services to inmates with drug-abuse problems; yet almost one-third have no systematic way of identifying needs.

The data which follows is based upon the responses of jails which identify inmates with drug problems through screening. Eighty-two jails out of the 118 studied conduct such screening. Therefore, in the discussion which follows, all data is based on 82 jails, and the percentages should be so understood.

Types of Screening

Although all jails discussed in this section provide some type of screening, the practices vary considerably in content and intensity. Jails can be classified as providing one of four types of screening: 1) booking with specific questions about drug use; 2) a personal assessment interview to identify immediate needs and special problems; 3) a medical interview and/or examination; or 4) a combination of both a personal interview and a medical examination.

TABLE 4.1

Type of Screening
to Identify Drug Abusers

Type of Screening	Jails	
	#	%
Booking--with questions about drug use	29	35.4
Personal assessment interview	15	18.3
Medical exam	15	18.3
Both interview and medical	23	28.0
Total	82	100.0

Over a third of those jails with screening do little more than elaborate on the booking procedure by including several questions, some of which pertain to drug use. This is not a thorough screening technique,

but it can help to identify some potential problems, including drug related needs of incoming inmates.

Screening that consists of a personal assessment interview attempts to identify needs with a more in-depth questioning than is possible during booking. Interviewing is structured in order to identify problems so that inmates can be placed into appropriate treatment or programs. Usually the interview occurs shortly after booking and by someone other than the booking officer or, in a few cases, by other inmates trained as interviewers.

Medical examinations or interviews are a regular part of intake screening at 30 jails. A medical screening minimally consists of a medical interview by medically trained personnel such as a paramedic or a nurse. More extensive medical screening consists of a complete physical by a physician. Urinalysis is a part of the screening process at one-third of the jails which perform screening. However at about half that number, the urinalysis is used only for selected cases.

At the most thorough level, screening involves both a personal interview and a physical examination. One out of four jails provide this comprehensive level of intake screening.

Screening Problems: Identification and Availability

From the results of these screening procedures, jail administrators should be able to identify the drug using population in the jail. Table 4.2 presents the estimated percentages of inmates identified as drug abusers through screening. We found that 44% of the jails which screen inmates responded that over half of their inmates are identified as having problems related to drug abuse.

Of course the jail's definition of who is a "drug abuser" sharply influences the number of inmates so classified. But many drug abusers,

TABLE 4.2

Estimated Percentage of Inmates Identified as Drug Abusers Through Screening

Estimated Drug Abusers in Jail Population	Jails		
	#	%	Adjusted %
None	1	1.2	1.2
1-10%	15	18.3	18.8
11-30%	16	19.5	20.0
31-50%	13	15.9	16.2
>51%	35	42.7	43.8
Data not available	2	2.4	--

by any definition, are not identified because screening is generally not systematic enough and as a result, many abusers are missed. While 82 of the jails reported that they provide some type of screening, not all inmates go through the screening process. One reason for this is that inmates may arrive when screening is not available. Inmates arrive at the jail at all times during the day and night, but the screening activities are most often provided only during the standard work week. (See table 4.3). Thus, the time of day when an inmate arrives at the jail has a great bearing on whether the need for drug treatment services is recognized.

Medical examinations are performed by any of a variety of individuals, including physicians, nurses, or paramedics. Table 4.4 gives the reported time permitted to elapse between inmate arrival and the medical exam, but the data does not give any indication of the thoroughness of the examination. In this data, as in other sections of the study, information is reported as received from the respondent since verification was

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>51%	35	42.7	43.8
Data not available	2	2.4	--

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TABLE 4.3

Availability of Screening

	Interview		Medical	
	Jails		Jails	
	#	%	#	%
Twenty-four hours a day, everyday	3	7.9	7	18.3
More than eight hours a day, five days a week	5	13.2	4	10.4
Eight hours a day, five days a week, daytime	23	60.5	18	47.7
Less than standard work week	2	5.2	4	10.4
Irregularly	5	13.2	5	13.2
Total	38	100.0	38	100.0

beyond the limits of the study. Credibility checks were performed however, by comparing reported services with the availability of appropriate staff.

TABLE 4.4

Elapsed Time Between Arrival at Jail and Medical Exam

Time	Jails	
	#	%
Within four hours	11	28.0
Within twenty-four hours	16	42.2
Over twenty-four hours	7	18.3
Irregular	4	10.5
Total	38	100.0

Screeni g Staff

Personnel involved in the various screening activities include medical, counseling, and correctional officers or uniformed guards. Approximately one in four jails assigned some full-time staff to the screening process. Table 4.5 describes the levels of personnel commitment by full and part-time status. It should be noted, however, that the frequencies refer to the numbers of jails in each category and do not report the numbers of personnel assigned per jail. For example, some jails reported utilizing up to ten counselors in the screening process, while other jails employed only one person full- or part-time in a particular category.

TABLE 4.5

Jails Reporting Utilization of Designated Staff to Perform Screening Function

Staff	Level of Employment					
	Full-time Jails		Part-time Jails		None Jails	
	#	%	#	%	#	%
Administrators	27	33.7	5	6.3	48	60.0
Physicians	7	8.7	29	36.2	44	55.0
Nurses	20	25.0	6	7.5	54	67.5
Paramedics	23	28.7	8	10.0	49	61.3
Counselors	30	37.5	9	11.2	41	51.3
Correctional officers	32	40.0	4	5.0	44	55.0

Note. Many jails report using more than one personnel category for screening.

In analyzing the data on the employer of key personnel in the screening process, we found that the preponderance of personnel are not employed by outside agencies or special projects working in the jails

(see table 4.6). Thus, we can state that if screening occurs, it most commonly utilizes jail employed staff.

TABLE 4.6

Employer of Principal Screening Personnel

Position	Employer									
	Jail		Comm. Agency		County-City		Other		N/A	
	#	%	#	%	#	%	#	%		
Administrator	25	78.1	4	12.5	3	9.4	0	—		
Physician	21	58.3	4	11.1	5	13.8	5	13.8		
Nurse	15	57.6	3	11.5	6	23.0	2	7.0		
Paramedic	22	70.9	1	3.2	3	9.6	5	16.1		
Counselor	23	58.9	5	12.8	4	10.2	7	17.9		

The hiring requirements for personnel performing the screening function were also examined. The lack of formal personnel policy or the lack of knowledge on the part of the respondent proved a limit to the quality of the responses. This is particularly true in the case of educational requirements for correctional officers, which are so flexible at many jails that it is difficult to get meaningful responses. The data reported in table 4.7 should be interpreted with these limitations in mind.

Former drug abusers are employed as counselors by one-third (34.3%) of the reporting jails which utilize such personnel for screening. While other jail staff may have had their own similar drug-related problems, the condition was not known to the respondents, or jail personnel policy is such that the informant would not admit to it, thus potentially reducing the actual numbers reported.

TABLE 4.7

Educational Requirements for Personnel Performing Screening Function

Position	Educational Level Required					
	None	HS	HS+	BA	BA+	Other*	Data not available
Administrator (n = 32)	4 (12.9%)	2 (6.5%)	0 —	7 (22.6%)	13 (41.9%)	5 (16.1%)	1 —
Physician (n = 36)	—	—	—	—	—	36	—
Nurse (n = 26)	—	—	—	—	—	26	—
Paramedic (n = 31)	3 (12.5%)	—	—	—	1 (4.2%)	20 (83.3%)	7 —
Counselor (n = 39)	—	1 (2.9%)	—	22 (64.7%)	10 (29.4%)	1 (2.9%)	5 —
Corr.Officer (n = 42)	8 (27.6%)	11 (37.9%)	—	—	—	10 (34.5%)	13 —

*Other includes special professional requirements such as medical degree, certificates, licensing, special training, or experience.

CONCLUDING OBSERVATIONS

Although all of the jails which were part of this study claim to be providing services to inmates with drug abuse problems, about one jail in three does not have any screening procedures to identify these individuals, and only minimal screening occurs at one jail in four.

Few jails operate effective, systematic screening procedures which identify all those in need of treatment. Even in some of the more comprehensive programs inmates do not get screened. Inmates may arrive when screening is not available or the screening schedule may not have the capacity to reach everyone. It is not uncommon for the screening procedure to be bypassed or ignored if it does not have the full support of jail administration or staff. This lack of support occurs most often when screening is provided by a non-jail agency (e.g., diversion programs, TASC, etc.). Additionally, some screening procedures are designed to contact only selected inmates (e.g., first offenders, women, admitted drug users). If all those in need of assistance are to be identified, screening procedures should be designed to reach all incoming inmates.

The various types of screening activities identify different types of problems. In terms of identifying a need for detoxification services, screening that includes a medical examination is more accurate than having only a personal interview. To identify a need for psychological therapy, a personal assessment interview may be the most relevant approach. Thus, the type of screening must be designed to uncover specific problems and related to the services available. Ideally, screening should consist of both a physical examination and a personal assessment interview.

Similarly, inmates in need of drug-related services may be missed if

the staff involved in screening is not trained to identify these people. Screening staff must be technically competent to identify drug dependent inmates, and services must be available to meet inmate needs if the diagnostic process is to be something more than an empty exercise.

The screening process is a critical intervention point for the inmate. If a jail is to provide a sound sequence of integrated human services, the screening-intake-diagnostic process is the appropriate place to start. But identifying needs is only the beginning; screening should lead to services that deal with the problems identified.

Based on our observations, we can conclude that without assessment of the problems and needs of all persons entering the jail, gaps in necessary services will occur. It is apparent that these gaps presently do exist even in those jails that conduct screening. Both inmates and jail staff told the study that many inmates in need of human services are never identified.

To reiterate our recommendations:

1) All incoming inmates should be screened

2) Ideally, screening should consist of both a physical examination and a personal assessment interview

3) Staff involved in screening should be technically competent to identify drug dependent inmates

4) Screening should lead to services that deal with the problems identified.

CHAPTER FIVE

DETOXIFICATION AND OTHER APPROACHES TO PHYSICAL TREATMENT

The approaches to physical treatment discussed in this section include: (1) detoxification (sometimes referred to herein and elsewhere simply as "detox"), (2) methadone maintenance, and (3) antagonist drug treatment.

DETOXIFICATION

Abrupt withdrawal after prolonged use from a number of drugs, including heroin, barbiturates, and methadone can result in severe withdrawal symptoms. When an addict is incarcerated, and thus cut off from a drug supply, withdrawal symptoms can occur within the first few days of imprisonment. This is when detoxification services are required.

In this study, a jail is considered to be providing detoxification services if some type of medical assistance is available to alleviate withdrawal symptoms. Detoxification services are available at 80% (n = 94) of the jails in our sample. All proportions referred to in the discussion of detoxification relate only to those jails which provide such medical services.

Respondents from institutions without detoxification services reported that treatment is not provided for two reasons:

1. the geographic area has little or no drug problem; or,
2. all inmates have been held in another institution prior to being placed in the sample jails and thus have passed the critical detoxification period.

There are two general types of people in jail who need detoxification. First, there are those addicted to illicit drugs such as heroin and other morphine-based drugs. Secondly, there are those who are participating in a community drug treatment program which maintains its clients with methadone for some period of time during treatment. These treatment programs are not only legal, but condoned and financially supported by criminal justice agencies. Table 5.1 illustrates the proportion of those detoxified who were methadone dependent in the jails which were studied. Twenty jails never treated any inmates who were methadone dependent. At nineteen jails, less than 25% of the inmates treated for withdrawal were methadone dependent. A few jails provided the majority, if not all, of their detoxification treatment to those who had been enrolled in community methadone maintenance programs, as opposed to those using illicit drugs. Most of the twenty jails that reported never treating a methadone patient have never encountered one; but a few of these jails do not detoxify these people as a matter of policy. Conversely, the three jails that treat only methadone clients do not provide detoxification to those using illicit drugs. Most treatment is provided for methadone inmates who were enrolled in methadone maintenance programs.

Treatment Content

In general, there are two medical approaches to detoxification. The first approach is to let an addict enter into withdrawal and then treat the symptoms. The second approach is to prevent the occurrence of withdrawal symptoms by using a substitute narcotic (usually methadone[1]) and

[1]The use of methadone to treat withdrawal symptoms should not be confused with the use of methadone to maintain (discussed later in this chapter); in maintenance, an inmate is not detoxified but remains drug dependent, albeit with a substance provided legally under certain conditions.

TABLE 5.1

Methadone Dependent Inmates as a Proportion of Inmates Detoxified by Jail

Percent of Those Detoxified Who Are Methadone Dependent	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)
0	20	21.3	32.8
1-25	19	20.2	31.2
26-50	10	10.6	16.5
51-75	7	7.4	11.6
76-99	2	2.1	3.4
100	3	3.3	4.5
Data not available	33	35.1	—
Total	94	100.0	100.0

Note. Entries under Frequency refer to proportions of total sample (including jails for which data was not available); entries under Adjusted Frequency refer to proportions of the total number of jails for which data was available.

gradually reducing the dosage until the individual no longer depends upon continued intake of drugs to avoid withdrawal.

Most jails treat withdrawal symptomatically; an addict's nausea, chills, and tension are treated with tranquilizers, antispasmodics, antihistamines, and other drugs.

Many jails also attempt to minimize the occurrence of withdrawal symptoms by administering methadone as a substitute narcotic in gradually reduced doses. Approximately 65% (n= 62) of the jails which detoxify use methadone for at least some addicts. Eight percent of these jails provide methadone only to methadone dependent inmates certified by a clinic, that is, those who were participating in a methadone maintenance program

in the community prior to incarceration. The remaining 20% use methadone to treat all opiate addicts, that is, those addicted to heroin and other morphine-based drugs, as well as those addicted to methadone. Most of the jails using methadone provide both symptomatic and substitution types of treatment, each for different sets of clients.

Most jails report that some treatment services are available for barbiturate addicts. Many of these jails deal with the problem through emergency services. We were unable to locate many jails providing a specific treatment program for persons dependent on drugs other than opiates, even though many respondents reported that withdrawal from barbiturate addiction is more "dangerous" and "serious" than that of heroin. Moreover, there is a problem identifying such people if there is no screening for them.

The various regions of the country appear to have different kinds of drug problems, depending upon the types of drugs available and in use in the community. Obviously, identifying the problem is necessary before appropriate treatment can be provided. Most of the jails providing service appear to base the content of treatment on the variety and extent of the drug problem found in the community.

Although all the jails discussed in this section provide some of the detox services described above, we found that these services vary considerably in both content and intensity. For that reason, the detoxification services examined were classified into one of three categories: (1) emergency detox only, (2) general medical detox, and (3) an integrated detoxification program including medical services supplemented by social and/or psychological support services.

TABLE 5.2

Frequency of Detoxification Services

Type of Detoxification Service	Jails	
	Number	Frequency (%)
Emergency service only	19	20.0
General medical service only	67	71.0
Integrated program of service	8	9.0
Total	94	100.0

Emergency Detox. Those jails providing only emergency detoxification services are classified in this category if (1) there is no screening procedure to identify those needing detoxification services upon entering the jail and (2) there is no regular procedure for providing service; i.e., drug addicts are treated on an ad hoc emergency basis.

The criterion for an inmate to receive service at most jails with emergency detoxification is the evaluation by a correctional officer (or other nonmedical staff) that an inmate is "sick enough" to receive some special medical assistance.

Using this criterion, 20% (n=19) of the sample provide emergency detoxification only. A jail's detoxification service is carried out in an "emergency-only" procedure, usually because this is how all general medical services are handled. If an inmate appears ill, a guard will either call the jail doctor or the inmate will be taken to a local hospital. The fact that the sick inmate is experiencing withdrawal symptoms or non-drug-related symptoms makes little difference. Rather, it is the recognition that the inmate's illness is severe and that some medical intervention appears appropriate. This "emergency" procedure may be

carried out quite frequently, at the slightest sign of illness, injury, or at any request for service. This level of service access exists at a jail where guards are instructed "not to take any chances." If there is any doubt about an inmate's condition, guards are instructed to make a medical referral. Conversely, emergency procedures may be implemented rarely if there are more stringent policies specified for when to call a doctor. There is a variation of opinion about how much physical discomfort an addict can reasonably be expected to endure. The accessibility of these detoxification services depends upon such factors as the attitude of guards, jail policy, degree of jail accountability, the availability of medical resources, and the willingness of outside medical services to treat jail inmates.

General Medical Detox. Of those jails providing some type of detox service, 71% (n= 67) are classified in the category of providing general medical detoxification. A jail is classified as having general medical detoxification if (1) there is a screening procedure to identify an addict; (2) some regular procedure exists for placing a drug addict in treatment; and (3) an addict is treated medically; i.e., drugs are administered to alleviate withdrawal symptoms.

Jails classified as providing general medical detox are those which recognize drug addiction as a problem of their inmate populations and make provisions for it. These arrangements may include a specific medical treatment and/or arrangements to work with a community medical treatment program. In general, all medical services are more accessible at these jails than they are at jails with emergency detoxification only. Thus, if an inmate is identified as a drug addict, placement into treatment is at least as accessible as general medical services. All of the

jails which comprise this category provide detoxification through general medical services. Most commonly, these services were supplemented by community methadone treatment clinics that detoxify their own methadone maintenance clients. Generally, the only detoxification treatment in these jails is the administration of drugs to alleviate withdrawal symptoms. It is possible that there may be other human services operating at the jail; that is, social service counselors at the jail may assist an inmate who happens to be going through detoxification. But there is no integrative arrangement between the two service delivery systems, and some inmates miss being helped in the process.

Integrated Detoxification Program. Jails classified as having integrated detoxification programs are those which provide general medical detoxification plus additional services to help inmates specifically with withdrawal. Thus, a jail is classified as having an integrated detoxification program if (1) there is a screening procedure to identify an addict; (2) some regular procedure exists for placing a drug addict in treatment; (3) an addict is treated medically; and (4) additional social and/or psychological services are part of treatment. Only a few jails (9%, n= 8) have such an integrated program of services to assist inmates through withdrawal. These additional services include social and psychological counseling, monitoring the patient to identify responses to treatment and/or further needs, and follow-up. Follow-up to detoxification treatment can result in the automatic placement in, or referral to, a service because of completion of withdrawal. In one jail, all those completing treatment participate in a drug education program. In a few jails, upon completion of detoxification, inmates are referred to a drug treatment program.

An illustration of an extensive integrated detoxification program in the study was found in a large jail system in a major east coast city. This detox program has its own medical facility and staff separate from general jail medical services. This program identifies clients during the jail's receiving procedures. If an entering inmate identifies him- or herself as having a drug problem, or if the addict is experiencing withdrawal symptoms upon admission, medical assistance is offered. The inmate's other medical needs are also attended to by the medical staff while in this phase of the program.

As part of this integrated program, medical services lead directly to individual and group counseling for both psychological problems and social service needs, a community and court liaison, a drug education program, and referrals to community treatment programs. There is also a program of follow-up services provided by a community agency for those eligible. It is clear that these services extend beyond the detoxification process, and medical treatment leads to the regular provision of these follow-up services. The personnel for this program include doctors, nurses, social workers, and educational therapists; all staff functions specifically for drug abusers.

Specifics of Treatment Implementation

The three-way categorization of the types of delivery of detoxification services represents our context for analysis. We now look specifically at how these general types of service delivery are implemented in order to assess specific quantitative and qualitative aspects of service. These dimensions include (1) location, (2) availability from the perspective of time required to be placed in treatment, and (3) duration of treatment.

1. Location. The location of treatment is found either outside the jail in a specilized facility, such as a hospital, or provided inside the jail. If service is offered inside the jail, an inmate may be treated in the cellblock area or in a space set aside for treatment purposes (e.g., clinic, hospital ward, nursing station).

The location of service is a qualitative factor that influences accessability and environment of treatment. The study found examples of inmates being transported to hospitals 20 to 30 miles away from the jail for medical treatment. A distant service is obviously not as accessible as a treatment service either closer by or inside the jail and, therefore, can be assumed to be a factor in a discretionary situation, regarding whether it will be utilized. When treatment is provided within the jail, the difference between receiving service in the cell area, at a nursing station, or in a jail clinic may affect quality of care in supervision of treatment, monitoring of patients, and examination with privacy.

Almost all jails which detoxify inmates do so inside the jail. An inmate receiving treatment may go to the clinic or nursing station in the jail to be examined and/or receive medication but then usually returns to the cell or living area. Areas for segregating inmates who are very ill with withdrawal symptoms are available at 36% of the sample. A few of the very large medical programs have entire detoxification medical units.

Arrangements for providing service outside the jail--in hospitals primarily, and in detox centers on occasion--occur at 27 jails in the sample. Most of these institutions also provide treatment inside the jail, although we found a few jails which did not provide any medical service in the jail. At these jails, inmates with serious health problems,

drug or non-drug-related, are transferred to a community medical facility.

TABLE 5.3

Location of Detoxification Services

Location	Jails	
	Number	Frequency (%)
Inside jail only	67	71.0
Outside jail only	3	4.0
Both in and out of jail	24	25.0
Total	94	100.0

Facilities for providing detox treatment were evaluated as inadequate by jail staff at 25% of the institutions. Most frequently, the problem identified by staff is the lack of "appropriate" space. Although many respondents commented on the need for more space, most inadequacies center around the appropriateness of the space. Often there is no privacy for an examination, many activities are going on in the same room, or the space being used was originally designed for another purpose.

2. Availability of Treatment. We were concerned about the time required to be placed in treatment, since the onset of withdrawal symptoms occurs rapidly if an addict is not getting drugs.

Table 5.4 represents the time it takes to provide treatment after the inmate has been identified as in need. About half the sample require eight hours or less to place inmates into treatment. Almost all jails can provide treatment within 24 hours of identifying a need for detoxification. This is not the time required both to identify and place in treatment, which, because it involves screening, generally involves a longer period.

TABLE 5.4

Time Lapse Between Addict Identification and Placement in Treatment

Time Between Identification of Need and Placement in Treatment	Jails	
	Number	Frequency (%)
< 4 hours	40	42.6
4-8 hours	6	6.4
8-24 hours	36	38.3
> 24 hours	6	6.4
Data not available	6	6.4
Total	94	100.0

The time needed to be placed in treatment is related to the hours when service is available, that is, the schedule on which the service operates.

TABLE 5.5

Times When Detoxification Services Are Available at Jail

Time Frame	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)
24 hours a day, everyday	40	42.6	45.5
More than eight hours a day, five days a week	6	6.4	6.8
Eight hours a day, five days a week, daytime	36	38.3	40.9
Irregular	6	6.4	6.8
Data not available	6	6.4	——
Total	94	100.0	100.0

It is noteworthy that almost half of the jails report having service available around the clock, indicating a favorable possibility for service availability when needed.

3. Duration. Frequently the duration of treatment depends on jail policy rather than the inmate's medical needs. Most jails (68.5%) operate with the policy of continuing treatment until there are no more withdrawal symptoms; thus the time required for treatment varies according to patient needs. But some jails (25.8%) have a policy specifying a maximum time for detoxification. A variety of "types" of time limits are set. Since, according to FDA guidelines, methadone detox is not supposed to take more than 21 days (Federal Register, 1974), this fact was often noted by respondents when discussing time limits. Frequently, jails permitted only very short time limits for both the methadone and the symptomatic types of treatment. For example, one very conservative treatment program administers tranquilizers for three days in decreasing doses if an inmate has "severe withdrawal symptoms." Another jail limited methadone clients to a three-day detoxification period. These limits are set without regard to the dosage level of drugs which were being used. If the purpose of detoxification services is to minimize symptoms, treatment for those addicted to very high dosage levels of opiates will require medical assistance longer than those on low doses. A rigid policy which deals in time-limited service ignores individual differences and penalizes those in greatest need of substantial help.

The average duration of detoxification treatment at most jails is seven days or less, although 17 of the jails provided detoxification treatment for up to two weeks, and less than ten percent of the sample

usually took even longer.

TABLE 5.6

Duration of Detoxification Treatment

Average Duration of Treatment	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)
≤ 7 days	39	41.5	60.9
8-14 days	17	18.1	26.5
15-21 days	8	8.5	12.5
Data not available	30	31.9	——
Total	94	100.0	100.0

Variations in availability and duration of treatment are related, in part, to the perceptions of jail administrators of withdrawal as a problem. Some administrators commented that withdrawal is like a mild case of the flu, and others felt that inmates experienced higher level of discomfort. It was suggested that some geographic locations have less potent illicit drugs on the street than other areas of the country. This variation in drug quality may, in part, account for some of the variation in attitude and treatment content, although wide variations in attitude were also found within some of the same geographic areas.

Selection Criteria for Detoxification Services: Inclusion

Although an inmate's physical need may be a major criterion for service, it is the selection process operating in the jail that determines if an inmate in need of that service will be identified and then treated. The selection process takes into consideration criteria to be included and criteria to be excluded.

The inclusive criteria used to select inmates for receiving detoxification treatment vary. The most frequently used criteria include: (1) the recommendation of an interviewer, (2) the result of a medical examination and/or interview, (3) manifestation of withdrawal symptoms, or (4) identification as a methadone maintenance client.

TABLE 5.7

Selection Criteria for Receiving Detoxification Services (n= 94)

Criterion	Jails	
	Number	Frequency (%)
Recommendation of an interviewer	19	20.0
Medical exam and/or interview	59	62.8
Exhibiting withdrawal symptoms	33	35.1
Methadone maintenance client	36	38.3

Note. Many of the jails use more than one of the above criteria for selecting inmates to be placed in treatment.

1. Recommendation of an interviewer as a result of a personal interview is one way jails place inmates into treatment. As discussed in chapter four on screening, during jail intake procedures there are a variety of ways to identify an inmate's drug problem. One of the procedures is a screening interview, which may be conducted by a variety of people for a variety of reasons. For example: (a) a guard in addition to standard booking procedures, may ask questions regarding the inmate's drug use and medical needs; (b) a counselor or social worker may interview an inmate as part of the intake screening procedures to classify the

individual for jail purposes (cell assignment, security, etc.) and to identify inmate needs for the purpose of placement into treatment and other programs; or (c) a diversion or pre-trial release program may screen inmates at the detention facilities to identify potential clients. Although many jails use one or more of these screening techniques, only 20% of the institutions depend on referrals based on an interview to place inmates into detoxification treatment. All of the jails which require an interviewer's recommendation actually do provide an intake interview of some type.

The interviewers recommending treatment are rarely, if ever, the same personnel who provide detoxification service. Although an addict's needs are identified during an interview, there is not necessarily a procedure which automatically places the inmate into treatment. In many cases, the identification of an inmate's drug problem is made for reasons other than the placement into medical treatment. Screening is, more commonly, to determine eligibility for a diversion program, for custodial classification, or for record-keeping purposes. If the interviewer thinks that the individual is in need of medical assistance, he may tell a guard, who in turn may refer the inmate to treatment. Those identifying the problem generally are not medical staff, although often they may have had some training or experience in identifying drug-related symptoms, and they are only advisory in capacity. Neither the guard nor the interviewer is directly responsible for the inmate's medical treatment.

2. A medical exam and/or a medical interview is the major (62.8% of the jails) requirement of jails in order for inmates to be placed in treatment. Of those jails (n= 59) with this requirement, 45% provide medical screening during intake. In this situation, the person doing the screening is likely to provide the treatment; thus, for the inmate, there

are fewer levels of organization to pass through between identification and treatment.

Those jails which require a medical examination or interview before service is given and which do not provide an intake medical screening necessitate a referral process; usually, an inmate makes a request to a guard, and the guard makes a referral to medical staff. Other professional staff, such as social workers, may or may not become involved in the referral process. The willingness of the guard to follow through is the key to this referral mechanism.

3. If an inmate is exhibiting symptoms of addiction withdrawal, this can be sufficient cause to be placed in treatment at many jails. This condition is the primary criterion at jails with emergency-only detoxification and which do no screening. Even when other screening procedures are available, physical signs of withdrawal are often the criterion used to identify an addict for treatment. This is because of the time it takes from arrest to arrival at the jail (and perhaps a police station or lock-up first) to booking and then to screening. These procedures can take from a few hours to several days. The longer the process, the more likely it is that withdrawal symptoms will commence.

4. Another major criterion for receiving detox service is whether, prior to incarceration, the inmate is currently enrolled in a methadone maintenance program. If an inmate is enrolled in a methadone program, this fact alone is sufficient to receive detoxification services at 38.3% (n= 36) of the jails with detoxification, and 58% of all jails using methadone. In the jails where participation in a methadone treatment program is a criterion, methadone dependent inmates are the only persons receiving methadone treatment for detox, and the jail cooperates with a community methadone clinic to provide that service to inmates.

Verification of an inmate's participation in a program is part of the screening-for-service process used by jails with this requirement and is usually accomplished by a phone call by the jail staff to the methadone center. It normally takes between 12 and 24 hours to have an inmate approved for treatment by the clinics. For most people this is not an unduly long period since methadone is a slower acting drug than heroin and, thus, permits an addict longer time intervals between doses without experiencing withdrawal.

It was found that those methadone centers providing detox in the jails usually treat only their own clients. In a few cases we found arrangements to treat methadone maintanence clients from other clinics. The criterion of being a certified maintenance client in order to be treated by the methadone clinic is usually one of the jail's requirements. Legally, methadone treatment programs may provide services in the jail for all those who would be eligible if not in jail. According to the FDA Rules and Regulations, "these services [of a methadone treatment program] should normally be made available at the primary outpatient facility, but the program sponsor is permitted to enter into a formal, documented agreement with private or public agencies, organizations or institutions for these services if they are available elsewhere" (Federal Register, 1974:11701).

Thus, it is legally possible for methadone treatment centers to provide their full range of services in the jail, as opposed to just providing detoxification of their own clients.

Selection Criteria for Detoxification Services: Exclusion

An inmate may be identified as eligible for treatment yet can be prevented from receiving it if the jail imposes restrictions. The following

exclusive restrictions were not found very often, but at least one of the following restrictions was reported at 14 of the jails visited. They include (1) legal status, (2) scheduled court appearance, (3) behavior problem, and (4) time expected to remain in jail.

1. Legal status is a factor in receiving treatment for detainees housed at jails that are primarily sentenced facilities and for sentenced inmates housed at detention facilities. These jails may be holding detainees and/or convicts because of overcrowding elsewhere. A few (n= 5) of the jails in this situation do not provide detoxification services to these "irregular" residents.

2. A detainee scheduled to appear in court may be refused treatment. Jails with this restriction do not want to be responsible for "doping-up" a defendent before trial. Thus, if there are many court appearances or a few change of dates for a court appearance, a detainee may be without assistance for long periods of time.

3. Inmates who are behavior problems, perhaps considered violent and dangerous by the jail, may not receive detoxification services; this was reported at six jails.

4. If an inmate is expected to be released within a day or two, detoxification service may not be provided. This is because the jail does not want to place an inmate in treatment and then have the addict released before the completion of detox.

Release of inmates prior to completion of detoxification is common, although only one jail mentioned this fact as being a problem. We found that 29 of the jails reported that 10% or less of their inmates in treatment were released before completion of detoxification. Another 16 of the jails reported early release for some (10-50%) of the inmates, and

11 of the jails reported that many (over 50%) inmates were released before medical detoxification was considered complete.

Selection Criteria for Detoxification Services: Voluntarism

The primary requirement to receive detoxification treatment is that it must be received voluntarily. All jails have procedures for inmates to decline treatment. Most jails (53.2%) reported that no one had ever declined treatment. But there are jails which reported that inmates refused to be treated; 21.3% of the jails reported that a few (< 10%) inmates refuse. One jail reported that over 50% of the inmates eligible for detox assistance had refused service.

In inmate interviews it was indicated that treatment is refused sometimes because it is known to be so minimal that it would not help. Inmate interviews also indicated that while detoxification services are available as reported by jail personnel, these services were either delayed or withheld as long as several days. There is considerable discretion about who receives services. Some inmates get immediate attention and others must go "cold turkey." The reasons for this phenomenon include disorganization and bureaucratic red tape, misuse of discretionary authority, and unavailability of around-the clock staff to provide services as needed. On the other hand, some drug abusers, for reasons of their own, refuse treatment even though it is available. Sometimes both the inmate and the jail concur on explanations of why services are not provided.

Administration

The administration of detoxification service can be examined by looking at the provider of service. Typically, the provision of medical and detoxification services occur in one of three organizational arrangements:

TABLE 5.8

Proportion of Inmates Declining
Detoxification Treatment

% Declining Treatment	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)
None (0)	50	53.2	69.4
Few (<10%)	20	21.3	27.8
Some (10-50%)	1	1.1	1.4
Many (51-99%)	1	1.1	1.4
All (100%)	0	0	—
Data not available	22	23.3	—
Total	94	100.0	100.0

(1) by a jail's own medical staff as direct service provider, (2) by a non-jail agency or service provider, or (3) by some combination of jail and agency staff sharing service provision.

Within each of the three provision arrangements, particular attention is given to the administrative responsibility for service and to funding. The administrative responsibility for service may lie entirely with the service provider, or, more often, the jail retains responsibility for certain elements of treatment even when an outside agency is providing the service.

Funding may come from the jail or an outside agency. If the jail is paying for the service, it is usually from the jail's general budget or, in a few cases, a jail has received a special grant for detoxification services. If an outside agency is funding the service and the agency views providing service to jail inmates as part of its normal functioning, the agency most often provides funds through their general budget. In a

few cases, the funding is provided by a special grant from LEAA or NIDA to a non-jail agency specifically designated to offer detoxification service to the jail.

TABLE 5.9

Sources of Funding
for Detoxification Services
(n= 94)

Source	Jails	
	Number	Frequency (%)
Jail budget	69	73.4
Grant to jail	9	9.6
Source: LEAA	(7)	
Other	(2)	
Service agency budget	30	31.9
Grant to service agency	11	11.7
Source: NIDA	(4)	
LEAA	(1)	
Other	(1)	

Note. Many of the jails use more than one of the above funding sources for detoxification services.

For the most part, detoxification services are administered as part of general medical services for the jail. Thus, the following organizational arrangements describe how both general medical and detoxification services are provided.

1. Jail as a Direct Service Provider. The simplest example, although not the most prevalent, is all detoxification services provided internally by jail staff with jail funding and with the jail administrator responsible for all aspects including client selection, program content, personnel, and budget. Service is an integral part of the jail

function. Internally provided services may also be administered by a parent organization, e.g., a sheriff's department or a county or state department of corrections. Those organizations are considered jail administration. The jails with their own methadone licenses or whose doctor has a license can provide service internally rather than requiring the services of local methadone treatment programs. Only seven jails in the sample report having their own methadone licenses, but others have physicians with a methadone license. LEAA grants to local jails finance detoxification programs at seven of the local jails in the sample. There is, however, no relationship between the licenses and the federal grants; i.e., these are not the same seven jails.

In almost all jails, even those with the most extensive medical services, specialized medical care is provided at a hospital.

2. Non-Jail Agency as Service Provider. A second administrative arrangement for detoxification and general medical service is a non-jail agency which provides all health services for the jail. This arrangement was found in two forms. One is when all health needs are handled on an emergency basis and all sick inmates are taken to the local hospital. The second arrangement occurs when the local hospital provides all the health service in the jail. The local government makes the decision that the responsibility for inmate health will lie with the public hospital and not the jail. The study identified instances where the public hospital set up medical facilities--ranging from a small hospital in one large jail system to a small clinic in another jail. With this type of arrangement, the health facility is equipped by the hospital and staffed with nurses and doctors employed by the hospital. This arrangement facilitates inmate access to a wide range of specialists and backup staff at

the hospital and eliminates duplication of many administrative tasks.

In this arrangement for providing treatment, administrative responsibility lies almost entirely with the hospital for treatment content, personnel selection, and budget, and non-jail staff may even have input to the client selection procedures.

3. Jail and Outside Agency Share Service Provision. The most common administrative arrangement for providing detoxification services involves a combination of services provided in part by the jail and in part by a non-jail agency. Jail medical services will treat heroin problems, for the most part, but will depend on other medical service providers to handle special cases, e.g., methadone maintenance clients or barbiturate addicts. Approximately 75% of those jails which provide detoxification cooperate with community agencies to provide that service. Most of the service provided by these agencies is methadone detoxification for maintenance clients.

Very often services provided by community agencies to inmates are not paid for out of the jail budget. In most cases, the costs are absorbed by the agency, and this is especially true in the case of methadone treatment programs. Special grants to non-jail agencies fund the provision of detoxification services at eleven jails in our sample. NIDA provided at least four of these grants to agencies and LEAA provided at least one.

The procedures for paying for inmate health care at a public hospital vary considerable. In some cases, the hospital absorbs the cost of services; in a few cases, payment for services comes from the jail budget; and in other cases, health care is financed directly by the government organization. The local government is paying for the service either way.

The difference is one of bookkeeping, and the policy varies with the local government.

Administrative responsibility for detoxification with shared service provision is occasionally divided between the jail and the service provider, but the jail usually maintains most of the functional responsibility. It is the jail which identifies those to be placed in treatment. Often the jail has major input to an agency's treatment content by imposing policy for carrying out treatment, e.g., the policy to detoxify or maintain, the length of time an inmate may receive treatment, how often and when the agency may come into the jail if the service is in the jail, or how long the agency may keep an inmate if detoxification is provided outside of the jail. Although services are provided by outside agencies, it is the jail administration that usually specifies the direction and content of treatment. Thus, such programs are most often a compromise between what the jail administration is willing to permit and what the service providers assess as necessary.

Table 5.10 summarizes the way jail administrators view responsibility for providing detoxification services. Although the most common arrangement for providing treatment is a combination of jail and agency services, rarely do administrators view the matter as one of combined responsibility and control over all elements of treatment, even when an outside agency is providing the service.

Cooperating with Service Agencies

Of those jails providing detoxification services, approximately 75% (n= 68) have cooperative arrangements with a community service agency to provide part or all of this service. These agencies, if classified by principal functions, include (1) drug treatment programs, (2) mental

TABLE 5.10

Division of Responsibility for Administration of Detoxification Services (n= 94)

Type of Responsibility	Responsible Agent		
	Jail %	Non-Jail Agency %	Combined %
Client selection	75.0	23.9	1.1
Service content	66.6	30.1	3.3
Personnel	66.3	29.2	4.5
Budget	68.6	26.8	4.6

health agencies, and (3) hospitals (table 5.11).

1. Drug Treatment Programs. Of those jails depending on community agencies to provide detoxification services, 63% (n= 43) cooperate with agencies whose only activity is drug treatment. Most of these organizations are methadone treatment programs; less often they are detoxification centers. About half of these drug treatment agencies are part of local (county) government services; most of the other agencies are nonprofit organizations, many being supported by federal grants. Approximately 20% of the drug treatment programs are state-related agencies.

TABLE 5.11

Jails Cooperating with Community Agencies by Type of Institutional Function (n= 68)

Function	Number	Frequency (%)
Drug treatment	43	63.0
Hospital	29	43.0
Mental health	12	17.0

Services provided by these drug-specializing agencies involve methadone treatment primarily, but counseling those going through withdrawal, emergency drug services, and barbiturate treatment are included as well. Most of these agencies provide only a small proportion ($\leq$ 10%) of their resources to the jail and its population; i.e., most of their clients are not in jail.

Approximately half of those jails working with agencies whose prime purpose is drug treatment have worked with them for over three years. Thus, the existence of drug treatment agencies providing services to jails is not a new phenomenon (table 5.12).

2. Mental Health Agency. A few jails (17%) used the services of mental health agencies for detoxification when these agencies had developed a special program exclusively to serve drug-abusers. A drug treatment program was classified as provided by a mental health agency if it was part of a mental health agency's regular administrative structure, supported from the agency's regular funding, and retained the same name.

Some of the agencies classified as single-purpose "drug treatment" agencies may have been created by a mental health agency initially, but developed as a separate entity--like a spin-off program--physically and administratively separate from the parent agency and funded from special sources. Nevertheless, the same services are provided by both types of agencies.

3. Hospitals. Almost half of the jails working with agencies for detoxification depend on hospitals for part of their regular service. Most of these hospitals are county- or city-operated facilities, although there were examples of jails using the services of state, federal (veteran's) and private hospitals. Forty percent of those jails depending on a hospital for detoxification use the hospital for their entire

treatment program--not just part of it. Hospitals are also used for methadone and barbiturate treatment. In fact, we found three hospitals providing special counseling assistance to supplement medical treatment. Most jails (76%) using hospital services have utilized these services for more than three years.

TABLE 5.12

Length of Cooperation Between Jails and Community Agencies by Function (n= 68)

Length of Time Cooperating	Community Agency Function (adjusted frequencies)		
	Drug Treatment (%)	Mental Health (%)	Hospital (%)
< 1 year	16.2	9.1	8.0
1-2 years	27.0	27.3	8.0
2-3 years	9.1	0	8.0
> 3 years	48.6	63.6	76.0
Total	100.0	100.0	100.0

Staff for Detoxification Services

The personnel providing medical detoxification are, in almost every jail, the same personnel who provide general medical services. Staff positions were not recorded for those jails whose only treatment was provided by sending inmates to a hospital. In identifying the types of positions available to provide detoxification, we did not tally those which were part of a hospital or community drug program staff if that staff did not come to the jail. Thus, 18 jails providing detoxification do not have their own staff for detoxification services provided at the jail.

The following table lists the types of personnel involved in detoxification services at the jail.

TABLE 5.13

Types of Staff
Involved in Detoxification Services
(n= 76)

Staff Positions	Jails	
	Number[a]	Frequency (%)
Administrators	18	24.0
Physicians	76	100.0
Registered nurses	53	70.0
Paramedics/LPN's	42	55.0
Counselors	11	14.0
Psychologists	5	6.0
Correctional officers	7	8.0

[a]Jails may have one or more staff members in any given category of staff position.

Administrators. The individuals administering detoxification services are in one of two categories. Either the administrator is a physician-in-charge or a director of treatment services in general.

Five of the 18 jails with an administrator for this service, consider their head physician as director of the service. The remaining 13 jails reported that another staff member is responsible for administering detoxification services, usually in conjunction with other inmate services. Two jails had a director exclusively for detoxification services. Most (n= 16) of the administrators are full-time personnel, although two reported having part-time staff in this position.

It is interesting to note that most (n= 12) of the programs with

administrators for treatment are those programs operated by non-jail agencies, thus the administrator is not employed by the jail directly.

Physicians. All jails with staff for providing detoxification (n= 76) include a physician as part of this staff. Only 15 of these jails have a full-time doctor(s) to provide this service; half (n= 38) of the jails use doctors who work 10 hours or less a week for the jail.

TABLE 5.14

Physician Availability for Detoxification
(n= 76)

Time on Duty/Week	Jails	
	Number	Frequency (%)
Full-time (40 hours)	15	19.0
3/4 time (30 hours)	4	5.0
1/2 time (20 hours)	27	35.0
1/4 time (10 hours)	38	50.0

Most jails use the services of only one physician. Those using more than one doctor do so in a variety of arrangements. A few jails use several full-time doctors. More commonly, when a few physicians are available, there is a combination of a full-time doctor with additional help working part-time, or an arrangement of rotating doctors with a few different people each working only a few hours.

Physicians make regularly scheduled visits or have regular hours at 75% of the jails with doctors. The range of scheduling includes full-time service at the optimal level, to regular jail sick call every morning, to coming in one morning a week. The remaining 25% of the jails where there is no schedule must depend on doctors who are "on call."

Approximately half the jails employ their own doctor. The other half of the sample use the services of doctors employed by an outside agency or service provider. Most often, the doctors employed by non-jail organizations are on the staff of either a public hospital or a public health department.

Many jails reported it was difficult to enlist the services of a physician for the jail. Usually, the cause of the problem was money or working conditions at the jail.

Registered Nurses. Most jails with medical staff use the services of registered nurses (n= 54). Approximately half the jails employ their own nurses. The other half of the sample use the services of nurses employed by either a public hospital or a public health department. Most of these nurses work full-time at the jail.

TABLE 5.15

Registered Nurse Availability for Detoxification
(n= 54)

Time on Duty/Week	Jails	
	Number	Frequency (%)
Full-time (40 hours)	43	79.6
3/4 time (30 hours)	1	1.8
1/2 time (20 hours)	3	5.5
1/4 time (10 hours)	7	12.9

Of the jails (n= 54) with nursing services, 80% have these services available at least 40 hours a week.

Although there appears to be less difficulty filling nurse positions than doctor positions, the same problem areas exist--working conditions and salary.

Paramedics/LPNs. Paramedics and/or LPNs are part of the detoxification treatment staffs at 42 jails in the sample. Seventy-five percent of the jails using paramedics employ them full-time (40 hours a week) at the jail. Most (60%) of these positions are employed by the jail.

The requirements to be a paramedic vary considerably since there are no standardized "paramedic" positions across the country. Approximately half the jails using this position required a licensed individual; this license is, in most cases, an LPN certificate or, less often, the completion of a paramedical course if available in the community. The remaining 50% of the jails used ex-military paramedics. A few jails reported difficulty in finding qualified people to fill these positions.

The paramedic's responsibilities are usually the same as a nurse's responsibilities. These individuals often take a medical history and follow a doctor's instructions.

Counselors and Psychologists. Counselors and/or psychologists are available as part of detoxification services in only a few of the jails. Although there were a few jails that employed counselors specifically to assist with detoxification, most of these individuals were employed not by the jail but by a community agency. Providing counseling to detoxification patients is only a part of their function. The most common example is the use of a drug counselor employed by TASC or a community mental health center to help those inmates requesting assistance.

Observations regarding staff. As mentioned above, personnel providing detoxification services are, for the most part, those who provide the general medical services for the jail. Of those jails providing detoxification services, 18 (20%) do not have medical staff available at the jail. Of those that do have medical staff available at the jail, 57 (75%) have

physicians on a regularly scheduled basis. The remaining 25% have physicians available on an on-call basis only. Most commonly, the on-call physician is characteristic of the small jail where the volume of service does not justify other arrangements.,

A large amount of responsibility for treatment is given to nurses and paramedics. Once an inmate is provided access to treatment, the first contact for service is often with a nurse or paramedic who, many times, makes the evaluation whether the inmate will ever see a doctor. We also found that it is not uncommon for medication to be dispensed without inmates being seen by a doctor. Nurses and medics reported that they have been instructed to administer specific drugs for certain problems, thus diagnostic evaluations are being made by these staff members. This fact is consistent with findings of the American Medical Association's (1972) Survey of Medical Care in U.S. Jails.

Besides the staff directly providing treatment, guards and counselors are often involved in providing access to these services. These individuals are rarely trained to identify health problems, and yet they do serve a medical screening function.

Relationship Between Jail Features and Type of Detoxification Services

As the preceding pages have documented, there is considerable variation between jails in the type of detoxification service provided to inmate addicts. To explain some of the variation, we examined those factors that may account for these differences. The factors examined include: (1) size of jail, (2) geographic region, (3) the existence of diversion or pre-trial release programs, (4) type of jail administration, and (5) type of intake screening.

1. Jail size affects the frequency of encountering an addict-inmate.

The size of a jail, which correlates highly with the size of the community, is a major factor in determining the size of the addict population in the jail and the type of service provided.

Ninety-three percent of the small ($\leq$ 20 inmates) jails have either no services or only emergency services for detoxification. Jails with an average daily population of 20 obviously will have less need to provide medical care, and especially detoxification services, on other than an irregular "as-needed" basis. Large jails, on the other hand, with average daily populations of over 250 inmates have more frequently both the needs and the resources to provide regular drug-related services. As can be seen from table 5.16 below, the larger the institution, the higher the likelihood of detoxification services.

TABLE 5.16

Relation Between Jail Size and Type of Detoxification Service
(% Providing Type of Detoxification Within Each Size)
(n= 118)

Type of Service	Size of Jail		
	Small $\leq$ 20 %	Medium 21-250 %	Large $\geq$ 250 %
No detox service	50.0	22.2	10.0
Emergency service only	42.9	16.7	8.0
Medical service only	7.1	55.6	72.0
Program of services	0	5.5	10.0
Total	100.0	100.0	100.0

$r(116) = .4$, $p < .001$

2. Geographic region is another factor which could account for variation in type of service, but we found no significant differences in type of detoxification service provided from one region to another. The

information in table 5.17 illustrates the distribution of types of detoxification treatment across the country from our sample.

TABLE 5.17

Relation Between Type of Detoxification Service and Geographic Region
(Number of Jails Providing Type of Service in Each Region)
(n= 118)

Type of Service	Region				
	NE	SE	NC	SW	W
No detox service	4	4	5	3	8
Emergency service	4	3	3	2	7
Medical service only	20	7	22	5	13
Program of services	3	3	1	0	1
Total	31	17	31	10	29

$\chi^2(12) = 15.5$, $p = .21$

3. Diversion of addicts out of the jail may affect the services for addicts provided inside the jail. Diversion or pre-trial release programs for drug abusers exist in two-thirds of the sample communities. Often these programs (1) divert addicts to treatment before they ever reach the jail or (2) get them out of jail within a day's time. Thus it might be expected that those communities having diversion or pre-trial release programs available to drug abusers would possibly have less need for physical treatment services in the jails. However, the data does not support this hypothesis. The observed relation between detox and diversion was not significant. Moreover, the data shows a trend which is contrary to what would be expected if diversion reduced the need for detox. That is, the greater the frequency of diversion, the higher the level of detox service provided (table 5.18).

TABLE 5.18

Relation Between Type of Detoxification Service
and Community Release Program

Type of Service	Jails in Communities with Diversion or Pre-trial Release Programs	
	Number	Frequency (%)
No detox service (n=24)	12	50.0
Emergency service only (n=19)	12	63.2
Medical service only (n=67)	44	65.7
Program of services (n=8)	6	75.0

$r(107) = 0.10$, $p < .15$

This trend suggests that those communities with the most programs have the largest number of drug abusers, and a related need for services. However, it can be stated that need alone is often not the criterion for providing a service. We suggest that perhaps more often it is a community's propensity to provide services that determines types and quantities of help which is made available.

Evidence supporting this contention is the policy (found in a few jails in major cities with known drug problems) not to treat withdrawal symptoms. This "cold turkey" policy was most often directed at users of illicit drugs, although out study also located jails which refused to provide treatment to inmates participating in maintenance programs. The jails which do not treat withdrawal symptoms as a matter of policy are located in communities which do not have diversion programs.

It appears that those communities with the resources, attitudes, and needs to provide services, provide both treatment and diversion services;

these are communities with a propensity to provide services and government which recognize a service provider responsibility.

4. Another aspect of service provision in a jail is the administration of jail services. The organizations administering jail services can be divided into two categories: (1) law enforcement organizations, such as those operated by a sheriff's office or police department, and (2) corrections organizations, such as those managed by a department of corrections or a human services agency.

It was hypothesized that jails whose services were administered by a "corrections" organization would have higher levels of service than those whose services were administered by a "law-enforcement" organization. Table 5.19 presents the information describing this relationship. We did not find a statististically significant difference in levels of detoxification service provided by jails whose services were administered by corrections organizations and those administered by law enforcement organizations.

TABLE 5.19

Relationship Between Type of Detoxification Services and Services Administration

Type of Detoxification	Services Administration			
	Law Enforcement		Corrections	
	Number	Frequency (%)	Number	Frequency (%)
No detox service	16	22.9	8	16.6
Emergency detox	12	17.1	7	14.5
Medical detox	38	54.3	29	60.4
Program of services	4	5.7	4	8.3
Total	70	100.0	48	100.0

$r(116) = .07$, $p < .14$)

Detoxification treatment is the only major service where the relationship between type of services administration (i.e., law enforcement or corrections administered) and type of service provided is not statistically significant.

5. The type of intake screening at the jail correlates h.ghly with the type of detox treatment. It is the intake screening process that identifies those in need of detox treatment.

TABLE 5.20

Relationship Between Detoxification and Screening
(n= 118)

Type of Screening	Type of Detoxification							
	No services		Emergency only		Medical only		Detox Program	
	#	%	#	%	#	%	#	%
No Screening	14	58.3	8	42.1	13	19.4	1	12.5
Drug use questions at booking	4	16.7	7	36.8	17	25.4	1	12.5
Personal classification interview	3	12.5	2	10.5	9	13.4	1	12.5
Medical exam/ interview	1	4.2	0	0	14	20.9	0	0
Medical exam and classification interview	2	8.7	2	10.5	14	20.9	5	62.5
Total	24	100.0	19	100.0	67	100.0	8	100.0

$r(116) = .34$, $p < .001$

The types of screening are a scale of levels of screening service. That is, no screening or booking only are lower levels of screening service than a procedure that includes both a personal interview and a

medical examination. Similarly, the types of detoxification are also a scale of levels of detox treatment. There is a positive correlation between these two variables.

METHADONE MAINTENANCE

According to the rules and regulations of the Food and Drug Administration, "Maintenance treatment using methadone is the continued administering or dispensing of methadone, in conjunction with provision of appropriate social and medical services, at relatively stable dosage levels for a period in excess of 21 days [italics added] as an oral substitute for heroin or other morphine-like drugs, for an individual dependent on heroin. An eventual drug-free state is the treatment goal for patients, but it is recognized that for some patients the drug may be needed for long periods of time" (Federal Register, 1974:11700).

None of the institutions in our sample has a formal methadone maintenance program. When asked if any inmates were maintained, most respondents answered with a definite "no," but a few responded with "no, but . . ." The exceptions fall in the area of either time or dosage level. Whenever there is maintenance, it is being provided unofficially through detoxification procedures.

We found only four general situations where maintenance occurred. They are described below.

If it is known that a methadone dependent client will be in jail for only a "short" period of time, i.e., less than 30 days, a jail that has a policy to detoxify may, in some cases, permit the inmate to remain on a maintenance dosage rather than be detoxified. This procedure is handled similarly to detoxification. If the jail has its own methadone license, it may be used for detoxification or maintenance. In most

instances, a community methadone treatment center comes into the jail to treat its own clients. Some jails have more than one methadone agency providing service. Again, their license may be used to gradually withdraw from the methadone dependent status or to maintain that status. The decision is one of policy; first the jail's policy and then, secondly, that of the agency. For example, it is possible that a jail will permit maintenance, but the treatment clinic will choose, alternatively, to detoxify, perhaps because of staff limitations or time constraints. Another "maintenance" situation occurs when the jail permits a community drug treatment clinic to detoxify its own clients; and, instead, the clinic administers a maintenance level dosage for 21 days, hoping that the inmate will be released by then. If the methadone dependent person is not released, the inmate is still addicted when the jail expects the detoxification to have been completed. Under these circumstances, the inmate then receives no assistance or is treated by the jail's emergency medical procedure. In such a situation, the jail has made arrangements to provide a service that is not being properly provided. The treatment clinic may often be successful at having a client released; but, when this is not possible, the inmate is receiving a disservice, and the jail's cooperation is being abused.

Another example of maintenance in jails occurs when the gradual reduction of methadone for the purpose of detoxifying intentionally lasts over 21 days. The longest time reported for detox was 80 days. By the FDA definition quoted earlier, such treatment could certainly be called "maintenance," except that the drug is administered in gradually reduced doses. Occasionally, it was reported that a longer time was taken with older addicts or those who have been on very high doses for a long time. Time needed to gradually detoxify depends on the dosage level of the addict.

Another procedure we found for maintaining addicts in jails is not yet operating but planned for the near future at two of the jails in the sample. It is anticipated that a community methadone treatment agency will operate a maintenance program in those jails. The agency would be able to recruit clients from the jail population regardless of whether the inmate was previously a maintenance client. It would also be possible for the jail to operate its own maintenance program if it acquired the appropriate staff. As mentioned earlier, the ability to provide maintenance in a jail setting is a matter of jail policy. Many respondents reported that maintaining an inmate on methadone in the jail was against the law. While state laws may vary, we could find no evidence to support that contention.

ANTAGONIST DRUG THERAPY

Antagonist drugs block the effects of opiates, thus preventing a narcotic high and drug dependence when an opiate is taken. The antagonist drug is not addictive and produces no drug-seeking behavior.

> In methadone maintenance, the same type of drug on which the individual is dependent physically and psychologically is administered to satisfy these cravings. This is not true of the antagonist. Although an antagonist will prevent response to heroin, it will not satisfy the individual's desire for the drug. . . .
>
> The prevalent theory underlying treatment with narcotic antagonists is that narcotic addiction is analogous to a conditional response: The addict responds to stress in his environment with drug-seeking behavior. His repeated use of heroin without the anticipated relief of stress, through attainment of a euphoric high, should lead to extinction of this learned drug-seeking behavioral pattern (Task Force on Federal Heroin Addiction Programs, 1972:126).

In other words, antagonist treatment expects that the addicts will repeatedly attempt to overcome the block, and these attempts will lead to frustration. Greater time intervals should separate these frustrating

attempts to overcome the narcotic blockade. This would lead to conditioning and, eventually, to an extinction of the drug-seeking behavior.

This behavior modification technique suggests that if drug-taking behavior is not reinforced by a "high," it will cease. The survey located only one jail using antagonist drugs as part of its drug treatment effort. In this program, positive reinforcement to the abstinence from drugs is provided in the form of a total package of services including work release. Previous to the initiation of this program, inmates with a drug history were not permitted to participate in the work release program. The antagonist program is limited to males over 21 who are in good physical and mental health. Health eligibility is established by a complete physical and a battery of psychological tests.

Inmates in this program, in addition to participating in a job, often through traditional work release, receive twice-daily doses of the antagonist drug, a mini-physical every morning and evening, and extensive counseling and attention to each inmate participant. Vocational training and educational programs outside the jail are also available to qualifying inmates. A urinalysis is made every evening. The program has a follow-up component for at least two years after a participant's release from jail.

Because of the experimental nature of antagonist drugs, the program is currently under intensive evaluation. The program selects a control group of inmates from the jail's general population, keeps very complete records on all participants, and employs a professional staff that far exceeds that of other treatment programs. There are ten full-time staff, and the program serves fifty men in one year's time. The staff includes a medical doctor, a psychologist, four registered nurses with psychiatric training, three community counselors who help participants after release

from jail, and a research aide. One of the unusual features of this program is that all staff members have research responsibilities beyond their standard job responsibilities. The jail has also assigned a few officers to participate in the program.

Those involved with the project felt that when programs of this type are fully operational and not merely experimental, a smaller and less "degreed" staff will be sufficient. Indeed, from a practical point, for programs of this type to become operational, it would be a necessity to have a lower staff-inmate ratio.

Evidence of the ability of antagonist drugs to effectively extinguish drug-taking behavior on its own remains unproved. In conjunction with many other services, a very selective screening process, and a follow-up program, the particular drug program described here has shown success.

CONCLUDING OBSERVATIONS

It is a matter of policy that inmates who are drug dependent (either illegally on "street" drugs, or legally as methadone patients) are withdrawn, with or without medical assistance, while in jail. While some jails make addicts withdraw "cold turkey," most jails provide some type of medical assistance to help inmates through the withdrawal period. There are two medical approaches to detoxification. The first approach is to let an addict enter into withdrawal and then treat the symptoms. The second approach attempts to prevent the occurrence of withdrawal symptoms by using a substitute drug (usually methadone) and gradually reducing the dosage until the individual no longer depends upon continued intake of drugs to avoid withdrawal.

While some type of treatment is available at most jails, we found

that screening is often lacking to identify all those in need of treatment. When screening is available it is not systematic and thus many people can be missed. Even when some form of treatment is available, there are still addicts in the jail who do not receive medical assistance for withdrawal symptoms.

Dealing with the problems associated with drug use is a task facing almost all jails to some degree. With this in mind, we present the following conclusions and suggest several recommendations concerning (1) jail's treatment policies toward drug dependent inmates, (2) identifying those in need of assistance, and (3) implementing treatment for inmates, both those on methadone and "street" addicts.

Treatment policies. As mentioned above, all jails have policies to detoxify, rather than maintain, drug dependent inmates. Although a few jails occasionally, on an ad hoc basis, permit methadone dependent inmates to be maintained for short periods of time, most maintenance patients and other addicts are detoxified while in jail. In some cases these people must go through unassisted withdrawal or with the limited assistance of tranquilizers.

The general policy of whether to detoxify persons already under treatment should be re-examined by jail administrators. First, a policy for the handling of methadone maintenance patients should be formalized. The fact that an individual is arrested is no guarantee of guilt, or for that matter, conviction. Arrest and incarceration of these individuals should not put an end to their treatment. Arrangements can be made for a methadone maintenance clinic to continue treatment for inmates while awaiting trial (or longer). The methadone can be (and in many jails is) delivered daily to the jail by the community methadone program. Counseling and other aspects of treatment can also be provided while the inmate

is in jail. Even if maintenance in jail is not possible or desired, a methadone dependent inmate should be gradually detoxified with methadone. "Cold turkey" withdrawal from methadone is neither humane nor is it appropriate, responsible behavior on the part of the jail in whose custody the inmate is held. Moreover, methadone treatment clinics which are responsible for their clients will provide detoxification dosages to their jailed clients.

Second, a policy toward users of illicit drugs should be formalized. Methadone treatment is one alternative strategy. Jails can make it possible for an opiate addict who is eligible to begin a program of methadone maintenance while in jail. Not all addicts will be eligible for this type of treatment and some will not want to participate, but it is our recommendation that methadone detoxification and/or maintenance should be options available to addict inmates. Local jails should formulate policies regarding services to users of illicit drugs which provide for humane medical detoxification for those not otherwise enrolled in methadone maintenance programs. This is not a recommendation for methadone treatment per se, but rather a recognition that it is an important and prevalent treatment modality.

Identifying Drug Abusers. While most jails have some form of detoxification services available, few jails have fully effective procedures which identify all those in need of treatment. Early intake screening to identify drug addicts is essential if treatment is to be provided to all inmates in need of service. There are three general reasons that screening procedures are not fully effective.

First, often all inmates are not medically screened at reception. Inmates may arrive when screening is not available or the screening schedule may not have the capacity to reach everyone. It is not uncommon for

the screening procedure to be bypassed or ignored if it does not have the full support of jail administration or staff. This lack of support occurs most often when screening is provided by a non-jail agency (e.g., diversion programs, TASC, etc.). Additionally, some screening procedures are designed to contact only selected inmates (e.g., first offenders, women, admitted drug users). If all those in need of assistance are to be identified, screening procedures should be designed to reach all incoming inmates.

Secondly, screening may not identify inmates in need of treatment because of staff shortcomings. For example, most jails do not use medically trained staff during intake procedures. Thus, medical problems are often missed. Also, the intake interviewers may discover the need for detoxification only by chance. Screening staff needs to be technically competent to identify drug dependent inmates, and to have supportive jail policy to actualize treatment.

Thirdly, even if there is a screening procedure for medical needs, there must be a mechanism which translates identified needs into the treatment delivery.

Implementing treatment. We observed a wide range of approaches to detoxification. Medical guidelines for detoxification treatment are needed so that there are some consistent and reliable methods for (1) identifying drug problems, and (2) treating the effects produced by a variety of drugs including opiates, barbituates and many of the non-addicting drugs.

We did locate some jails with strict procedures for treatment, but more often than not these guidelines were constraints rather than aids to service. Policies regarding the implementation of treatment should not be so rigid that individually prescribed care is not possible. Drug

dependent inmates are addicted to different drugs at various dosage levels, for different lengths of time. They are not alike in age nor general physical condition. Each of these factors affects the type of treatment necessary.

This report presents descriptions of detoxification procedures with aggregate data. The information gives a general idea of detoxification treatment, but the "averages" presented here should not become the "limits" of future programs. Treatment content and length must be prescribed on an individual basis within the framework of standardized guidelines. Moreover, medical detoxification treatment should be available on an around-the-clock basis provided by personnel who are properly trained to recognize both the need for treatment and the appropriate range of modalities.

In describing detoxification services in local jails, attention has been concentrated on the medical aspects of treatment because that is primarily the type of activity found in jails today. However, detoxification programs which go beyond medical treatment and consider, in addition, the whole person, with attention to psychological and social needs offer a better chance that the detoxification process will result in post-release drug-free behavior. Therefore, it is the recommendation of this study that medical services be the first step in an integrated detoxification process consisting of counseling for both psychological and social service problems as well as, where appropriate, referral to a community drug treatment program and other human services.

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CHAPTER SIX

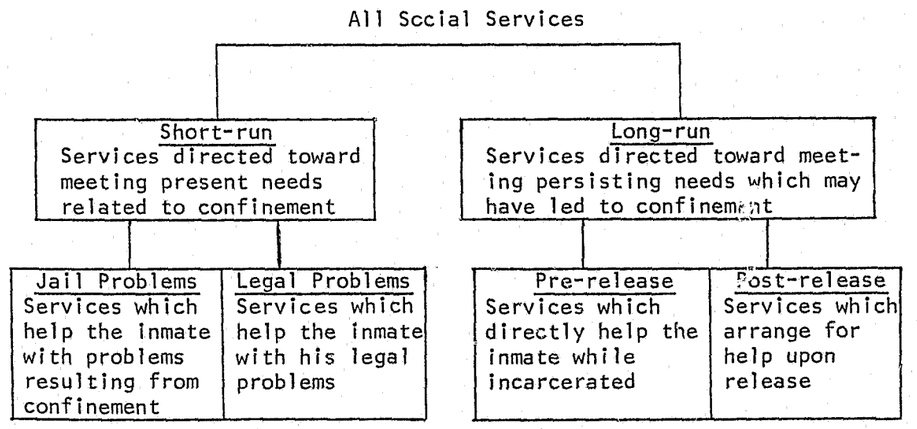
SOCIAL SERVICES

In this chapter we shall be describing and analyzing the range of social services the jail may make available to its inmates. These include all services except those directed toward medical or physical needs, which have been discussed in the previous chapter, or those specifically intended to change the inmate's behavior or attitudes, which are described in the subsequent chapter entitled "Psychological Services."

Social services can be divided into two major categories (see figure 6.1). The first category consists of those services which deal with inmates' immediate, short-run needs or those related to confinement. The second category consists of those services which respond to inmates' long-run needs or those which led to confinement.

FIGURE 6.1

Classification of Social Services



The services directed to inmates' immediate short-run needs can be vivided into two groups. One group consists of services aimed at those problems that arise from being confined (jail-related); the other group consists of those services which help the inmate deal with the court or his legal problems. The long-run services can also be divided into two groups. One group consists of those services which attempt to directly benefit incarcerated inmates, and the second group consists of those services which arrange for help upon release through various community agencies. Jails provide social services directed toward short-run needs; all but two jails provided at least some services directed toward long-run needs.

A total of 88 jails studied, 75% of the sample, provide social services casework in some form. Neither the jail's size, as measured by average daily population (ADP), length of stay of inmates (LOS), or geographic region appeared to be related to whether a jail provides social service counseling. However, two variables, (1) form of service administration and (2) type of screening, were significantly related to the provision of social services.

The relation between service administration and provision of social service is presented in table 6.1. From table 6.1, it appears that social services are much more likely to be available if inmate services are the responsibility of a corrections department rather than a law enforcement agency. A standard test for the reliability of a relation between two variables revealed that the observed frequency could have occurred by chance less than once in a thousand.

The relation between type of screening and social service is presented in table 6.2.

TABLE 6.1

Relation Between Services Administration and Provision of Social Services

Agent Responsible for Administering Inmate Services	Jails Providing Social Services	
	Number	Frequency (%)
Law enforcement agency (e.g., sheriff's dep't.) (n=70)	43	61.4
Corrections department or social welfare dep't. (n=48)	45	93.8

$\chi^2(1)=13.98$, $p < .001$.

TABLE 6.2

Relation Between Type of Screening and Provision of Social Services

Type of Screening	Jails Employing Each Type of Screening		Jails Within Screening Type Providing Social Services	
	Number	Frequency (%)	Number	Frequency (%)
No screening	36	30.5	21	58.3
Booking only	29	24.6	19	65.5
Medical screening	15	12.7	12	80.0
Personal interview	15	12.7	15	100.0
Medical and personal interview	23	19.5	21	91.3

$\chi^2(4) = 15.01$, $p < .005$

The five types of screening listed in table 6.2 can be viewed as forming an ordinal scale. That is, reading down the list, the types can be interpreted as increasingly complex levels of screening for identifying inmate problems. "No screening" is the lowest level and "medical and personal

interview" the highest level. With this interpretation, it appears from table 6.2 that jails that provide the high levels of screening are more likely to provide social services. This relation also has a high statistical significance, because the observed frequency could have occurred by chance less than five times out of a thousand [$\chi^2(4)=15.01$, $p < .005$]. Since an appropriate means of determining social service needs is through a personal interview, the finding that 36 of the 38 jails using a personal interview to screen inmates (with or without a medical exam) provide social services indicates the close association between the two activities.

For the remainder of this section describing social services, we shallbe referring exclusively (unless stated otherwise) to the 88 out of the 118 jails studied which provide social services. Also, unless otherwise stated, frequencies will refer to the percentage of these 88 jails which provide social services.

At most jails (72%) social services are not organized or provided differently for drug abusers than for other jail inmates. When differences were reported, they were usually minor. The most frequently reported difference is some additional special services for drug abusers (24% provided additional services for drug abusers). One jail reported limiting the services available to drug abusers, and two jails provided social services to drug abusers exclusively.

When a jail was reported as providing social services, this did not necessarily imply that the jail had an identifiable program staffed by professionals working full time at providing services to inmates; in fact, there was considerable variation in the extent and organizational arrangement for providing social services. At several small jails, these functions were performed by personnel who were assigned primarily to

other duties. Frequently, the jail chaplain or one or more correctional officers would serve in this role. At a few jails in the sample the sheriff or chief administrator would also act as a social service counselor. Several larger jails also provide social services through part-time assignment of custodial staff to such duties. Overall, 30% of the jails provided some level of social services without employing any regular, professional social service staff.

The lack of a full-time professional staff did not necessarily imply that the services provided were inadequate to meet inmate needs. At a few small jails, the opposite appeared to be true. For example, at one small jail (ADP = 20) the sheriff personally attempted to assure that each inmate received the benefits of all social services available in the community.

However, at large jails the lack of any professional staff often meant that the social service needs of inmates were not being met. For example, at one large jail (ADP = 900) social services were provided by a group of 16 volunteers organized by the chaplain. Each volunteer was assigned a cellblock to walk through once a week, talking to inmates when requested. Other large jails employ so few social service personnel in relation to the ADP that it would be impossible for the staff to adequately meet even the minimal needs of all inmates. For example, one very large jail (ADP= 10,000) employed only six full-time social service personnel.

Short-term Services: Jail-related Problems

Social service personnel can provide a variety of services for helping the inmate with his jail-related problems. These can range from explaining the rules of the jail to providing crisis intervention for the

inmate's family. In general, these services can be classified in three categories: (1) communication within the jail, (2) communication with the outside world, and (3) providing social support. Table 6.3 presents the frequency with which specific services within each category are provided.

TABLE 6.3

Services for Jail-related Problems

Service	Jails Providing Specific Service	
	Number	Frequency (%)
Communication within jail		
Explain rules of jail	57	65.5
Inform inmate of available services and how to get them	80	90.9
Facilitate access to other jail services	70	80.5
Communication with outside world		
Facilitate phone calls	67	76.1
Facilitate visits	59	67.0
Counseling of inmate families (crisis intervention)	58	65.9
Social support[a]	32	40.0

[a]No item of the questionnaire schedule specifically addressed this service, but it was recorded if explicitly mentioned by respondents when asked to describe social services.

In general, the need for these services depended, in part, upon the confinement policies of the jail. For example, all jails limited the inmate's communication with the outside world. However, the degree to which such communication was restricted varied considerably. Some

jails limit phone use to one call to an attorney, while other jails permit almost unrestricted access to phones. However, most jails control or supervise the inmate's use of the telephone. When phone use is controlled, social service workers are frequently (76%) assigned the responsibility of facilitating or regulating its use.

The inmate's communication with the outside world by means of visits was also regulated, and 67% of the jails providing social services reported that social service controlled or facilitated the arranging of inmate visits.

The inmate's communication within the jail was also usually restricted. Frequently, social service personnel served as messengers or facilitators of requests for other jail services such as medical, library, or religious services. Ninety-one percent of the jails providing social services reported that social service personnel were responsible for informing inmates of the services available, and 81% indicated the counselors facilitated access to other jail services.

Incarceration may contribute to familial crises. In describing social services, respondents frequently described crisis intervention as an important, frequently needed service. Sixty-six percent of the jails providing social service reported that social service workers provided some counseling of inmate families. The range, type, context, and duration of that family service varies considerably with the jail, the personnel, and the nature of the problem identified.

Besides the specific needs indicated above, incarceration can lead to those amorphous, but important, needs which perhaps can best be labeled as a need for social support. Various respondents have described the services provided in response to this need as "allaying anxieties" or "providing someone with whom inmates can talk freely or confide in,"

etc. Although the questionnaire schedule did not specifically ask if social service workers acted in this function, 40% of the jails indicated that providing social support was an important component of social service counseling. Had this question been explicitly asked, it is likely that virtually all jails would have responded that some staff provided social support.

Short-run Services: Legal Problems

The second group of relatively immediate needs associated with the inmate's confinement are his legal problems (see figure 6.1). Social service workers usually provided minor legal assistance such as helping the inmate contact his attorney. Sixty-six percent of the jails reported that social service workers contacted attorneys for inmates. However, at some jails, social service personnel performed some of the functions of a legal ombudsman. Assistance for legal problems which were reported included: helping the inmate arrange bail or other forms of pre-trial release, keeping the inmate abreast of his case, and trying to have the various charges faced by the inmate consolidated. Possibly, the most important form of legal assistance given was the provision of information and recommendations to the court. Often such information was required in arranging transfer to a community treatment program. Also, the court would occasionally request information from social service counselors. Sixty-nine percent of the jails reported that their social service staff provided some information or recommendations to the courts.

Long-Run Services: Pre-release

Many jails attempted to help the inmate directly with his long-run needs while he was incarcerated by performing one or more of the following three functions: (1) determining the inmate's long-run needs,

(2) developing a case plan for meeting those needs, and (3) providing social skills training.

How Long-run Needs Are Determined. Three methods were used to collect the information necessary to evaluate the inmate's needs. The most frequently used method was a personal interview. Often the initial interview was performed as part of the intake and screening process. At some jails the initial interview was limited to evaluating immediate or emergency needs such as detoxification or crisis intervention. In this case, one or more subsequent interviews were then held to examine needs in greater detail.

The second means used to evaluate needs was through the administration of formal tests. Tests used included those designed to evaluate academic ability and achievement, vocational skills and vocational preferences, and various psychological or personality tests for assessing attitudes. Few institutions used formal testing procedures, and even fewer used them extensively. However, one jail employed an extensive battery of tests which were regularly administered to all inmates.

The third method for assessing needs was to consult with other service agencies or counselors that had knowledge of the inmate. At some jails, counselors reported consulting with the inmate's previous counselor if he was a recidivist. Overall, consultation with other service agencies by personal communication or examination of existing records was reported infrequently. Moreover, frustration or lack of cooperation from outside agencies was reported as frequently as successful consultation.

The frequencies with which jails provide other services intended to directly benefit the inmate while incarcerated are presented in table 6.4.

TABLE 6.4

Social Services Directly Benefiting Inmates While Incarcerated

Service	Jails Providing Each Service	
	Number	Frequency (%)
Develop case plan	50	58.6
Pre-release training	35	40.2
Employment counseling	42	47.7
Formal social skills program	8	9.1

Case Planning for Inmate Needs. Once an inmate's needs and problems have been assessed, the next logical step is to formulate a plan for meeting these needs. Fifty-seven percent of the jails reported that social service counselors did work at developing case plans. Case plans could include both how to make the most of the time spent in jail and what to do after being released. The content of a particular case plan depended upon the inmate's needs and the resources available both at the jail and in the community. For those jails that provided educational programs, case plans would frequently include a commitment to complete the G.E.D. certificate before release. Similarly, for those jails which provide vocational training, case plans often include plans for inmates to either obtain new skills or enhance their present vocational skills. In this way, social service counselors often act as motivators or facilitators for inmates to participate in the jail's educational or vocational programs.

Social Skills Training. At 56% of the jails, social service personnel provided some form of social skills training or advice. Often, this was done as part of a program designed to prepare the inmate for leaving

jail and re-entering the community. Forty percent of the jails indicated they provided pre-release orientation or training sessions prior to release. These sessions were given between 1 and 12 weeks prior to release and lasted from 1 to 10 weeks.

Employment counseling was the most frequently reported content of social skills training, with 48% of the jails providing some form of employment counseling. However, 14% provided it exclusively as part of the pre-release orientation. At a few jails, employment counseling included extensive formal training in how to gain employment. This included how to represent past experience (e.g., how to prepare a personal resume) and how to dress and conduct oneself in a job interview.

Eight jails (9%) provided a formally organized social skills training program. Besides employment skills, these programs provided training in such areas as money management (personal budgets and bank services) and how to make use of community services.

Long-run Services: Post-release

The only long-run services jails normally provide to inmates following their release are referral and transfer to community treatment programs.

Referral and Transfer to Community Treatment Programs. Arranging for treatment through a community agency, by either of these processes, may be the most important service a jail can provide for drug-abusing inmates. This is because treatment in the community begins more closely to resemble the real world pressures and temptations with which the inmate must deal in order to avoid contact with the criminal justice system. Also, since approximately 45% of the jails in the study released at least 70% of their inmates within 30 days, the incarceration period

is obviously too brief in most cases to evaluate inmate needs, and to plan and execute an effective rehabilitation program. Moreover, less than 15% of the jails held 50% or more of their inmates for more than 6 months. Thus, for drug treatment to be effective, it is essential that jails attempt to enroll drug-abusing inmates in a community-based treatment program upon release and, thereby, provide ongoing support and sufficient time for resolution of problems.

Drug-abusing inmates can be enrolled in community treatment agencies either before completion of their sentences or upon sentence completion. Release and enrollment before sentence completion is referred to as transfer; release and enrollment upon sentence completion is described as referral.

Transfer and referral not only have the same end product but involve similar processes. Therefore, when both of these services are provided, they are usually provided by the same staff personnel or program.

Transfer to community agencies for treatment can be either temporary or terminal. Terminal transfer (or diversion) involves the inmate's release from jail custody with the requirement that he be enrolled in a community treatment program. Temporary transfer is a process in which the inmate is transported to a community agency for treatment while remaining under the custody of the jail. Temporary transfer includes both transporting the inmate during the day to a treatment facility and having the inmate housed at a treatment facility for more than one day. In either case, the inmate is returned to the jail before release.

The most frequent use of temporary transfer is for detoxification. The other major use is for some form of psychological evaluation and/or therapy. Several jails transferred inmates to community facilities where they received a combination of both medical and psychological

treatment. For example, at one jail all inmates with serious drug abuse problems, including the need for detoxification, were transferred to a comprehensive treatment center for two weeks as inpatients. The inmates were then returned to the jail but continued to receive treatment at the community facility on an outpatient basis.

Sixty-nine jails (78%) indicated that social service counselors refer inmates with drug problems to various community services. Forty-four of these jails also reported they facilitate transfer. In addition, five jails not making referrals reported facilitating diversion. Thus a total of 49 jails (56%) reported they facilitated transfer or diversion of drug-abusing inmates to a community rehabilitation program. The relation between transfer and referral is presented in table 6.5.

TABLE 6.5

Relation Between Transfer and Referral

Provide Referral	Jails Facilitate Transfer			
	NO		YES	
	Number	Frequency(%)	Number	Frequency(%)
No	13	72.2	5	27.8
Yes	25	36.2	44	63.8

Note. Data for one jail was not available and is not included in the table.

$\chi^2(1)=6.12$, $p<.02$

Of those jails facilitating transfer, most did so at both the pre-sentence and post-sentence stages. However, two jails indicated that they transferred only detainees, and one reported they transferred only convicts.

The level of jail involvement in the transfer process varied considerably. A few jails did little more than allow a diversion program to function at the jail. In these cases, the jail did not initiate the program and was relatively unaware of, how the program operated. At the other extreme, at one jail in a major eastern city, transferring of drug-abusing inmates to community treatment programs was the core of an extensive drug treatment effort employing a large professional staff.

Several factors concerning the demography and organization of the jail were related to whether a jail facilitated transferring inmates to community treatment facilities. Recall that the two factors, service administration and level of screening, were statistically significant predictors of whether the jail provides social services. They were also statistically significant predictors of transfer; that is, limiting discussion to only those jails which provide social services, the jails in which services are administered by a correctional agency are much more likely to transfer inmates than jails in which services are administered by a law enforcement agency. Only 25% of the jails in which services were administered by a law enforcement agency provided transfer, while 66% of the jails in which services were administered by a correctional agency provided transfer. These proportions could have occurred by chance less than once in 10,000 [$\chi^2(1)=18.0$, $p<.0001$].

Level of intake screening was also significantly related to transfer. The more comprehensive the screening, the more likely a jail would be to provide transfer services. This relation was also highly significant, [$\chi^2(1)=24.3$, $p<.0001$].

Two other factors which appear to be related to transferring inmates to a community program are size of jail, as measured by average daily population, and distribution of length of stay (cf. Chapter Three,

Length of Stay Profiles, for descriptions of these variables).

The relation between jail size and transfer is presented in table 6.6.

TABLE 6.6

Relation Between Size of Jail
and Provision of Transfer Service

Size	Jails in Each Size Category		Jails in Each Size Category Providing Transfer	
	Number	Frequency(%)	Number	Frequency(%)
Small				
0-20 inmates	8	9.1	3	37.5
Medium				
21-75 inmates	8	9.1	4	50.0
76-150 inmates	18	20.5	10	55.6
151-249 inmates	16	17.0	11	73.3
Large				
250-449 inmates	14	15.9	11	78.6
450-999 inmates	16	18.2	7	43.8
1000^+ inmates	9	10.2	3	33.3
Total	88	100.0	49	--

The data summarized in table 6.6 suggests a curvilinear relation between size and transfer. As jail size increases from 20 inmates to 250 inmates, the proportion of jails transferring inmates increases from 37% to a maximum of 79%. As jail size increases beyond 250 inmates, the proportion providing transfer services begins to decrease, with the largest jail transferring only 33% of their inmates. A statistical analysis of this relation indicates that it could have occurred by chance less than 20 times out of 100 [$\chi^2(6)=8.87$, $p<.20$] and, thus, is not considered

statistically significant. However, since most of the large jails in the U.S. were included in our sample, we can be relatively confident in the generality of the results for large jails.

From an examination of the relation between length of stay and transfer, it appeared that Types 3*and 4 transferred inmates less frequently than the remaining types. Types 3 and 4, taken together, transfer inmates 33.3% of the time while Types 1, 2, 5, 6, 7, 8 and 9, combined, provide transfer service 60% of the time. This relation was not statistically significant [$\chi^2(1)=1.81$, $p<.20$]. Note that Types 3 and 4, however, hold most inmates between 3 and 30 days, while Types 1 and 2 hold most inmates for 3 days or less and Types 5-9 hold most inmates for more than 30 days. This suggests that transfer tends to occur either very soon after arrival (within 3 days) or much later, i.e., at least 30 days after arrival.

It might be assumed that the lack of adequate treatment facilities in the community accounts for jails not providing transfer services. We did not collect data on the actual availability or relative adequacy of community drug treatment facilities. However, some of the responses to the open-ended questions suggests that a perceived lack of adequate local treatment facilities cannot account for failure to provide transfer service. Respondents at only 17 jails indicated that they felt that the community drug treatment resources were inadequate. Thirteen of these jails are now providing transfer services, and two felt that drug treatment was not the responsibility of the jail. Of all jails who do not provide transfer service, only two indicated that they felt community resources are inadequate.

*See Figure 3.3, p.56

Transfer Process

We shall now consider the process by which drug-abusing inmates are transferred. The first step for the jail consists of selecting those inmates who will be considered for transfer. We examined five possible factors jails consider in selecting inmates for transfer. They were (1) recommendation as a result of personal interview, (2) referral by some outside agency, (3) self-admitted drug abuser, (4) recommendation as a result of a medical exam, and (5) drug-related charge. The frequency with which these factors were considered sufficient to attempt to transfer inmates is presented in table 6.7.

TABLE 6.7

Selection Criteria for Considering Inmates for Transfer

Criterion	Jails	
	Number	Frequency(%)
Recommendation as a result of personal interview	20	40.8
Referral from non-jail source	16	32.7
Self-admission of drug abuse	12	24.5
Recommendation as a result of medical exam	7	14.3
Drug-related charge or drug-related arrest record	6	12.2
A combination of the above criteria	16	32.7

Once the inmate has been identified as a potential candidate for transfer, the next step is to assess the inmate's needs and attitude toward treatment. This usually requires an extensive perscnal interview covering personal background, history of drug abuse, previous history of drug treatment, present attitude toward drug abuse, interest in obtaining help,

and attitude toward various treatment modalities.

At most jails, the social service staff employed by the jail identified and evaluated those inmates who were considered for transfer or referral to a community agency. However, for 14% of the jails, this function was performed by the staff of the community agencies to which inmates were referred or transferred.

In general, needs were evaluated in relation to potential sources for treatment. Community resources for treating drug abuse varied considerably in both number and scope. It was not unusual for a large jail to have 25 or even 50 programs available in the community for referrals and transfer. Often these agencies would differ in services provided, enrollment capacities, admission criteria, willingness and interest to accept former inmates, legal and funding restriction, etc. In such cases, the development and maintenance of an effective comprehensive referral network is a huge task. Also, effective use of community treatment by jails requires coordination with the courts, with the rest of the criminal justice system, and with the other referral and monitoring agencies.

Many larger communities had local agencies specifically for this purpose. Nevertheless, the jail's social service staff would also to some degree serve this function as well. At several jails, one member of the social service staff spent full time in this function. At one jail, the liaison person was both a lawyer and professionally trained as a counselor.

All community resources were not equally available to all inmates. Various criteria frequently served to restrict an inmate from being transferred to community treatment programs. The following six factors were examined in detail:

1. Severity of offense: requirement that present charges do not involve a crime against persons, other felony offense, or selling drugs

2. Personal background: requirement that the inmate's personal history reflect a satisfactory record of employment or exhibit a satisfactory degree of community attainment

3. Psychological or emotional criteria: requirement that inmate not be neurotic or exhibit behavioral problems and is able to deal with emotional stress.

4. Drug history: requirement of evidence for drug abuse for some minimal period of time

5. Physical criteria: sex, age, etc.

6. Required plea: requirement that the inmate plead guilty to some offense as a means of clearing all pending charges

Table 6.8 presents the frequency with which each of the above restrictions was operative at those jails which provided transferral services.

In addition to determining whether a restriction was applicable, we also asked respondents to indicate for each restriction the source of the restriction (e.g., jail policy, court ruling, etc.) as well as the approximate proportion of those inmates considered who were subsequently declared ineligible. The restriction source and the proportion ineligible also appear in table 6.8.

Besides external restrictions prohibiting transfer of inmates, the inmates themselves often decline transfer to a treatment program when offered. The frequency of jails reporting inmates declining and the proportion declining is also presented as a discrete category in table 6.8. Only seven jails (14%) indicated that there was no formal or consistently

TABLE 6.8

Restrictions on Inmate Transferrals for Jails Providing Transferral Services (n = 49)

Restriction	Proportion of Jails Using Restriction		Source of Restriction			Proportion Ineligible				
			Frequency (%)			Estimated frequency of proportion declared ineligible because of restriction[a]				
	#	%	Jail Policy	Community Agency Policy	Law	None 0%	Few 1-10%	Some 11-49%	Many 50-99%	All 100%
Severity of offense	36	73.5	29.4	8.8	61.8	6.3	43.8	25.0	25.0	0
Personal background	25	51.0	23.8	33.3	42.9	5.0	60.0	35.0	0	0
Psychological or emotional criteria	23	46.9	33.3	52.4	14.3	10.0	85.0	5.0	0	0
Drug history	9	18.4	28.6	28.6	42.9	14.3	57.1	28.6	0	0
Physical criteria	9	18.4	0	87.5	12.5	0	100.0	0	0	0
Required plea	7	14.3	20.0	0	80.0	0	66.7	33.3	0	0
Declined transfer when offered	20	40.8	—	—	—	44.4	38.9	16.7	0	0

[a]For some jails, respondents were uncertain of the source of the restriction or of the frequencies with which inmates were considered ineligible because of the restriction. The frequencies reported in the table are based only on the cases where information was available.

used criteria for restricting inmates from being transferred. The most frequently reported restriction was severity of offense. As expected, inmates charged with serious offenses such as felonies were generally not eligible for transfer. This was also the only criteria that was reported as affecting many (over 50%) inmates.

Generally, the law or the receiving agency rather than the jail was most frequently reported as the source of the restriction.

Once the inmate's needs have been assessed and an appropriate program (or programs) identified, the next step is to inform the inmate of what is available. From interviews with both treatment personnel and with drug abusers or former drug abusers, it was apparent that many inmates with severe drug abuse-related problems are not well informed about the variety of treatment modalities and their availability in the community. Frequently, drug-abusing inmates were unaware of one or more of the following:

1. Range of services offered
2. Enrollment requirements for various services
3. How to go about enrolling
4. Ancillary support programs such as financial aid and family counseling

As a result, the attitudes of drug abusers toward drug treatment programs were based upon incomplete or erroneous information. Providing complete accurate information may serve as a first step in reversing negative attitudes toward treatment. However, many jails did more to motivate inmates to accept drug treatment. Respondents frequently reported that former drug abusers were most effective for this purpose. However, only 11 jails (or 12.5%) reported employing former drug abusers as social service counselors.

The variety and complexity of the legal arrangements used to transfer inmates was so great that it was impossible to obtain a clear picture of the legal process. Frequently, the respondents themselves did not have a clear picture of the legal process. In some cases, the jail had the authority to transfer inmates to a community treatment program without court approval. Most often, however, court approval was required. In these cases, the social service staff was usually responsible for providing the necessary information and/or recommendations to the court. The willingness of the courts to cooperate with transfer programs appeared to depend upon the quality of the available community agencies, the ability of the jail and/or community agency to convince the court of the desirability for transfer, and the program's past performance.

When inmates were transferred before sentence completion, they were usually enrolled in residential drug treatment programs. When inmates were referred after sentence completion, however, they were referred to a wide variety of programs of services. We asked respondents to indicate the types of agencies to which they most frequently referred inmates. We also asked them to estimate the proportion of drug-abusing inmates referred to each type of agency. Their responses are summarized in table 6.9.

From table 6.9 it appears that, as expected, drug-abusing inmates are most frequently referred to agencies which provide drug counseling. The remaining services indicated in the table are those which may be helpful to all inmates. Note that four jails reported referring female inmates with drug abuse problems to an agency specializing in women's problems. It is clear that female drug abusers are perceived as having unique problems related to their gender. At least, this is true from the perspective of the communities which maintain such programs. The

fact that four jails in our study utilize these programs may mean that jail staff also see a need for such a service, or, it may only mean that the staff place people in all appropriate community services with space.

From the last column of table 6.9 it appears that at many jails the respondents were unable to even estimate the proportion of the drug-abusing inmates they referred to the various community agencies. For all but two types of service, the respondents felt they did not have enough information to make this estimate using the approximate categories None, Few, Some, Many, and All. This suggests that jail counselors generally do not keep any systematic information on the way they provide referral services.

From the information that is available, it appears that very few jails regularly or consistently make referrals for drug-abusing inmates. Even if we adjust the frequencies by considering only those cases for which respondents could make estimates, we note that less than half (46%) of the jails refer more than one-half of their drug-abusing inmates to an agency providing drug counseling. Furthermore, the proportion of drug-abusing inmates referred to the other services appearing in table 6.9 is quite low.

Referral service can be provided with varying degrees of intensity on the part of the jail; that is, counselors might simply inform inmates of available services or they could actively work towards arranging enrollment and, in some cases, following up or monitoring the inmates' progress in treatment after release. Intensity of referral effort was measured by a four-point scale: (1) inform, (2) make initial contacts for referral with agency, (3) directly help in assessing enrollment, and (4) follow up by monitoring progress. The frequency of each of the four levels of referral intensity, relative to each type of service to which inmates are referred, is provided in table 6.10. It appears that, for

TABLE 6.9

Frequency of Referrals of Drug Abusers to Various Community Services
(For 69 Jails Providing Referral Service)

Service Provided	Jails Referring Inmates to Each Type of Service		Estimated Frequency of Proportion of Drug-Abusing Inmates Referred to Each Type of Service					
	Number	Frequency (%)	None 0%	Few 1-10%	Some 11-49%	Many 50-99%	All 100%	Data not available
Drug counseling (outpatient)	49	71.0	0	10.2	20.4	12.2	14.3	42.9
Vocational services	30	43.5	0	20.0	13.3	20.0	3.3	43.3
General social services	24	34.8	4.2	20.8	12.5	0	8.3	54.2
Therapeutic community	21	30.4	0	9.5	19.0	9.5	0	61.9
Housing services	13	18.8	7.7	30.8	23.1	0	0	38.5
Educational services	7	10.1	0	14.3	28.6	14.3	0	42.9
Medical services	4	5.8	25.0	50.0	0	25.0	0	0
General social services specializing in women's problems	4	5.8	0	0	0	25.0	0	75.0

all service areas, the claimed level of referral effort was approximately evenly distributed between the four levels. Thus, although only approximately one-fifth of the jails indicated they followed up or monitored the progress of the inmates they referred, more than 80% of the jails reported doing more than merely informing inmates of the services available in the community.

TABLE 6.10

Relation Between Level of Referral Effort and Various Community Services
(n=69)

Service Provided	Level of Referral Effort (Frequency of Jails at Each Level)			
	Inform (%)	Make initial contact (%)	Assist in enrollment (%)	Follow-up or monitor progress (%)
Drug counseling (outpatient)	16.7	33.3	29.2	20.8
Vocational services	10.0	50.0	30.0	10.0
General social services	16.7	33.3	33.3	16.7
Therapeutic community	5.3	26.3	47.4	21.1
Housing services	23.1	30.8	23.1	23.1
Educational services	33.3	16.7	33.3	16.7
Medical services	40.0	20.0	40.0	0.0
General social services specializing in women's problems	0.0	75.0	26.0	0.0

Who Provides Social Services?

Use of Community Agencies. Eighty-one of the 88 jails that provided social services cooperated to some degree with outside agencies. However, the level and form of involvement with outside agencies varied considerably. At some jails, cooperation consisted of little more than occasional contact with the agencies to which inmates were referred. At other jails,

cooperation consisted of total dependency upon the outside agency or agencies to provide some or all social services. (An analysis of service provision and the jail relation to outside agencies is found in Chapter Ten, Alternative Organizational Arrangements for Service Delivery in Jails).

In considering the level of cooperation or involvement with outside agencies, one critical division point is whether the cooperating community agency uses its staff to directly provide service to inmates while they are in the custody of the jail. Sixty jails in the sample (68%) used community agencies at this level, at least, to provide one or more of the social services which the jail offered.

None of the factors measuring the overall characteristics of the jail, e.g., size, distribution of length of stay, etc., appeared to be related to the use of outside agencies. However, one of these factors, form of services administration, was related to the number of outside agencies used. Jails in which services were administered by a correctional agency were more likely to use several outside agencies; if services were administered by a law enforcement agency, the jail tended to use only one agency (see table 6.11).

TABLE 6.11

Relation Between Services Administration and Number of Outside Agencies Used

Responsibility for Administering Inmate Services	Number of Agencies Used			
	Only One		More Than One	
	# Jails	% Jails	# Jails	% Jails
Law enforcement agency	20	67.0	10	33.0
Corrections or social welfare department	11	37.0	19	63.0

Services Provided by Community Agencies. When community agencies were used, they usually provided some, rather than all, of the social services available at the jail. However, community agencies were used in providing virtually every form of service. The frequencies with which outside agencies provided various social services is presented in table 6.12.

TABLE 6.12

Jails in Which Social Services Are Performed by Community Agencies

Service	Jails	
	Number[a]	Frequency (%)
Arranging transfer	38	43.2
Drug counseling	29	33.0
Pre-release training and/or orientation	28	31.8
Intake, screening and evaluation	12	13.6
Legal counseling	11	12.5
Family counseling	10	11.4
General counseling (i.e., any or all of the social services)	31	35.2

[a]Many jails reported using outside agencies for multiple services.

From table 6.12 it appears that the service most frequently provided by outside agencies was arranging transfers or making referrals. Thirty-eight jails utilized the staffs of outside agencies for interviewing inmates and generally facilitating the transferral and referral process. Two other services were frequently provided by outside agencies; these were drug counseling at 29 jails and pre-release training or orientation sessions at 28 jails. The remaining services were provided much less

frequently by outside agencies. However, 31 jails depended on outside agencies for counselors who provided a variety of social services rather than any specific service.

In addition to directly providing services to inmates, some outside agencies indirectly provided service by supporting the jail's social service program. Community agencies at six jails recruited and organized volunteers who served as social service counselors at the jail, and, at one jail, a community agency provided additional training for the jail's social service staff.

Types of Outside Agencies Used. Cooperating community agencies can be classified along two independent dimensions. One dimension is the function of the agency and the other is its agency auspices. Function refers to the principal activity of the agency. The major functional categories of agencies are: (1) general social service, (2) drug treatment, (3) civic services, including religious services, (4) health services, including mental health, (5) criminal justice services including law enforcement, and (6) educational services.

The other major dimension, auspices, refers to whether the agency is a government or non-government agency and the type of government or non-government agency it is. The major categories of auspices are: (1) local government agency, (2) state government agency, (3) federal government agency, (4) professional non-profit agency (e.g., methadone clinic, Odyssey House), and (5) volunteer, civic non-profit agency (e.g., Chamber of Commerce, church, Junior League, etc.).

The frequency with which jails used agencies of differing agency function is presented in table 6.13, and the frequency with which jails used agencies of differing auspices is presented in table 6.14.

TABLE 6.13

Jails Cooperating With Community Agencies by Agency Function

Agency Function	Jails	
	Number	Frequency (%)
General social service	22	25.0
Drug treatment	20	22.7
Civic services including religious services	14	15.9
Health and mental health services	11	12.5
Criminal justice or law enforcement services	13	14.8
Educational services	6	6.8

TABLE 6.14

Jails Cooperating With Community Agencies by Agency Auspices

Agency Auspices	Jails	
	Number	Frequency (%)
Local government	30	50.0
State government	13	21.7
Federal government	7	11.7
Professional, non-profit	40	66.7
Volunteer/civic non-profit	8	13.3

Concerning function, jails tended to use social services and drug treatment agencies somewhat more frequently than the remaining types.

With respect to auspices, the most frequently used type was professional non-profit agencies, with two-thirds of the jails using such agencies. The only other type frequently used was local government agencies.

Regardless of the type of outside agency used, jails seldom directly paid for their services. Only 6 jails (10%) indicated that the services were paid for out of the jail's budget.

Administration of Social Services

When the jail uses an outside agency, administrative responsibility for service delivery may be retained by the community agency providing the service, come under the control of the jail, or be divided between them. Of the sixty jails which use outside agencies, only 16 (27%) assign total responsibility for service to the outside agency. Thirty-two of these jails (53%) retain control entirely within the jail, and the remaining jails share responsibility for service delivery.

When responsibility is divided, the division could be arranged in several ways. The jail and the community agency sometimes cooperate in the overall administration of the service and sometimes divide various areas of service responsibility between them. The functional areas which can be divided for responsibility are: (1) client selection; (2) service content; (3) personnel selection, and (4) control over the budget.

When the jail provides one or more areas of service, program responsibility can be divided between the jail administration and the staff or agency providing the service. The overall way in which each area of service responsibility is divided, for both jails using and not using outside agencies is summarized in table 6.15.

TABLE 6.15

Division of Responsibility for Service Areas
(For 88 Jails Providing Social Services)

Service Area	Responsible Agent					
	Jail				Outside Agency Adj.% (#)	Data not Available Adj.% (#)
	Jail Admin. Adj.% (#)	Jail Prog. Staff Adj.% (#)	Total Adj.% (#)			
Client selection	21.9 (17)	53.1 (43)	74.1 (60)		25.9 (21)	7.9 (7)
Service content	13.6 (11)	60.5 (49)	61.7 (50)		25.9 (21)	7.9 (7)
Personnel selection	38.3 (31)	30.9 (25)	69.1 (56)		30.9 (25)	7.9 (7)
Budget	53.8 (43)	15.0 (12)	68.8 (55)		31.2 (25)	9.0 (8)

Note. Number of cases for which data was unavailable varies with service area. For all service areas the proportion of missing cases was less than 10%. Adjusted frequencies represent proportion of total number of cases for which data was available.

Overall, approximately 25% of the jails assign the responsibility for client selection and service content to outside agencies, and 30% of the jails relied on outside agencies for personnel selection and control of budget. When client selection and service content is controlled by the jail, the responsibility for these elements is more frequently left to the jail program staff. When personnel selection and budget is controlled by the jail, the jail administration rather than the program staff more frequently control these functions. Overall, only four jails retained responsibility for all service areas at the administrative level; a total of six jails assigned responsibility exclusively to the jail program staff.

It is also of interest to see if jails who cooperate with outside

agencies divide responsibility for the various service areas differently than those jails who do not cooperate with outside agencies. The way in which those jails who cooperate with outside agencies divide responsibility for service is presented in table 6.16.

TABLE 6.16

Division of Responsibility for Each Service Area
(For 60 Jails Which Use Outside Agencies)

Service Area	Jail			Outside Agency	Data Not Available
	Jail Admin. Adj.% (#)	Jail Prog. Staff Adj.% (#)	Adj.% (#)	Adj.% (#)	Adj.% (#)
Client selection	15.3 (9)	59.1 (26)	67.3 (35)	32.8 (15)	8.3 (5)
Service content	[illegible] (3)	60.0 (33)	65.5 (36)	34.5 (19)	8.3 (5)
Personnel selection	30.9 (17)	32.7 (18)	63.6 (35)	36.4 (20)	8.3 (5)
Budget	59.0 (27)	[illegible] (8)	64.8 (35)	35.2 (19)	10.0 (6)

From table 6.16 it appears that for each service area, approximately one-third of the jails that used outside agencies, allowed some aspect of responsibility for service to rest with the outside human services provider. A comparison of tables 6.15 and 6.16 suggests that when jails retained responsibility for service administration, those jails which used outside agencies tended to relinquish that responsibility for each service area more frequently to the respective outside agency service provider.

Details of the Daily Operation of Social Services

In order for an inmate to benefit from a social services program, including those directed toward present needs and long-run needs (see figure 6.1), there must be an awareness of its existence. We asked respondents to indicate how and when inmates were informed of the availability of social services. From their responses, which are summarized in table 6.17, it appears that at approximately one-half the jails, inmates first learned of social services through a counselor.

TABLE 6.17

How and When Inmates Are Informed
of the Availability of Social Services

How and When Informed	Jails	
	Number	Frequency%
How		
Informed by social services couselor	47	53.4
Depend on "grapevine" or other irregular means	41	46.5
When		
During intake or orientation procedure	55	62.5
At various other times	33	37.4
Usual time between arrival and initial meeting with counselor:		
Same day	30	34.1
Next day	22	25.0
Within a week	24	27.3
Other times	12	14.7

For the remaining jails, various other sources were reported, including correctional officers, medical personnel, printed handouts, and the omnipresent jail "grapevine." In addition, it appears that at only slightly more than one half the jails, inmates learned of social services

during intake procedures. For the remaining jails, respondents indicated that the inmates learned of social services at various times, including at the time they first received services. Respondents were also asked to indicate the usual or normal time inmates spend in the jail before their initial meeting with a social service counselor. Slightly more than one-half of the jails indicated the first meeting took place either the day of arrival or the next day. An additional one-fourth of the jails indicated various times, including whenever inmates first request it or whenever the counselor manages to see them.

Once service begins, the counseling session can either be regularly scheduled or provided upon request. At most of the jails (64%) social service counseling sessions were provided only when inmates requested it. Twenty percent of the jails used regularly scheduled sessions exclusively, and the remaining 16% used both methods.

It is also of interest to examine how frequently inmates meet with counselors, independently of the method of scheduling. One-half of the jails (50%) indicated counselors met with the inmate "irregularly," (e.g., only once biweekly or less). For the remaining jails, the frequency of meetings was approximately evenly divided between daily, twice a week, and weekly.

Since crisis intervention was frequently reported as a social service function, we asked respondents about the availability of emergency or after-hours counseling. About one-half of the jails (55%) responded that emergency counseling was available. For most of these cases (67%), a counselor was either on duty or available by phone. In the remaining cases, a correctional officer was responsible for handling emergency counseling.

The locations at which counseling takes place are summarized in

table 6.18.

TABLE 6.18

Location of Counseling

Location	Number	Adjusted Frequency (%)
Office or private space suitable for counseling	31	35.6
Space not designed for counseling	24	27.3
In cell	11	12.6
In cell and in office	21	24.1
Data not available	1	—

From table 6.18 it appears that 36% of the jails regularly use an office or other private space suitable for counseling. However, at some jails (13%) counselors only met with inmates in the cells. When asked to evaluate the adequacy of the space available for counseling, the respondents were about equally divided between those who felt the space was adequate and those who did not. Of those who felt the space was not adequate, the most frequently reported needed change was for more appropriate space (54%). The remaining respondents wanted either more space (34%) or both more space and more appropriate space (12%).

At slightly more than one-half the jails (58%), inmates were assigned to individual counselors. Where this occurred, we asked the respondents to indicate the normal caseload. To obtain comparable statistics for cases in which counselors were not individually assigned, we divided the respondent's estimate of the number of inmates receiving counseling by the total number of social service counselors. The variation in caseload, as calculated, was enormous--ranging from two inmates/counselor up to 500 inmates/counselor. Furthermore, for discussion purposes, we can

categorize caseloads of less than 20 as low, 20 to 40 as moderate, 41 to 75 as high, and over 75 as excessive. The resulting frequencies for these categories were calculated and are presented in table 6.19.

TABLE 6.19

Caseload of Social Service Staff

Caseload	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)
Low (1-20 inmates/counselor)	12	13.6	19.0
Moderate (21-40 inmates/counselor)	21	23.9	33.3
High (41-75 inmates/counselor)	14	15.9	22.2
Excessive (over 75 inmates/counselor)	16	18.2	25.4
Data not applicable [a]	13	14.8	—
Data not available	12	13.6	—

[a]These jails used outside agencies whose staff did not exclusively serve the jail.

The low caseloads are found in small jails, with one individual performing the functions of a social service counselor. For approximately one-fourth the jails, caseloads were excessive. In many of these jails the number of social service counselors in relation to the number of inmates was so low that it was obviously impossible for counselors to individually help all inmates. At these jails, relatively few inmates received more than minimal attention from social workers.

At the majority of jails (77%), counselors kept a record or file for each of their inmate clients. The content of these files varied from simple contact records to extensive evaluations of the inmate's needs

and progress. Table 6.20 summarizes to whom these records were normally available.

TABLE 6.20

Individuals and Agencies to Which Casework Records were Available
(For 63 Jails Keeping Casework Records or Files)

Individual or Agency	Jails		
	Number [a]	Frequency (%)	Adjusted Frequency (%)
Probation and parole department	48	76.2	81.4
Court	45	71.4	78.9
Chief administrator of jail	42	66.7	71.2
Defense attorney	39	61.9	67.2
Prosecuting attorney	28	44.4	48.3
Other criminal justice agency	13	20.6	22.4
Client inmate	25	39.7	42.4

[a]The number of cases for which data is unavailable varies with the individual or agency. Adjusted frequencies are based on only the cases for which data is available.

The availability of records is a critical issue in terms of the inmate's legal status relative to the right to privacy. On the other hand, the ability of the correctional system to provide some continuity of service both in the jail and after release hinges on the availability of records on inmate progress. If there is to be a systematic effort to initiate either inmate services in the jail, diversion, temporary transfer, or referral after release, then service continuity becomes possible only if some records are available to appropriate recipients. The issue of confidentiality of inmate records is not now resolved.

History of Provision of Social Services

We asked respondents to indicate the earliest date for which their present program of social services was available to inmates. The results are summarized in table 6.21.

TABLE 6.21

Year of Initiation of Social Services

	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)
Before 1968	13	14.8	16.3
From 1968-1969	6	6.8	7.5
From 1970-1971	10	11.4	12.5
From 1972-1973	30	34.1	37.5
From 1974 to Present[a]	21	23.9	26.3
Data not available	8	9.1	—
Total	88	100.0	100.0

[a]"Present" refers to time of site visit, which varies from March to August, 1975.

From table 6.21, it appears that social services are changing and/or being provided with increasing frequency. Only about 15% of the jails are providing at present the same level of social service as seven years ago. For each two-year period from 1968, an increasing number of jails instituted programs of social service.

To gain some initial information on how and why social services were initiated, we asked respondents to indicate which of the following best describes the reason social services were initiated.

1. Initiated by the jail's staff because of a recognized need or problem

2. Initiated by an outside, community agency
3. Services mandated as a result of court action
4. Initiated as a result of a constraint attached to other funding
5. Initiated as a result of inmate demands

The frequencies with which each of these reasons was considered appropriate is summarized in table 6.22.

TABLE 6.22

Reasons for Initiating Social Services

Reason	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)[a]
Jail staff-initiated	48	54.5	60.8
Outside agency-initiated	30	34.1	38.0
Legal mandate	6	6.8	7.6
Constraint attached to funding	2	2.3	2.5
Inmate-initiated	2	2.3	2.5

[a]The number of cases for which data was unavailable varied with each reason for initiating services. The adjusted frequencies are based on only those cases for which data was available.

As might be expected, services were initiated by the jail's staff in most cases (61%), because of a recognized need. In a substantial number of instances (38%), however, services were initiated by an outside provider. Also, at six jails respondents reported that social services were not available until the courts intervened and required that they be provided.

Funding

Since many jails use outside agencies for social services, funds for

the support of these services could be channeled either through the jail or through the outside provider. Also, in either case, the funds could either be derived from the operating budget of the jail or agency, or provided by a grant intended to support social services at the jail. The frequency with which each of these funding sources is used is presented in table 6.23.

TABLE 6.23

Source of Social Service Funding
(n=82)

Source	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)[c]
Jail			
General budget	40	45.5	45.5
Grant			
NIDA[a]	7	8.0	8.3
LEAA[b]	24	27.3	28.6
Other	5	3.4	3.6
All grant sources combined	36	40.9	42.9
Outside provider			
General budget	26	29.5	29.5
Grant			
NIDA	3	3.4	3.7
LEAA	5	5.7	6.1
Other	5	5.7	6.1
All grant sources combined	13	14.8	15.9

[a]NIDA is the National Institute of Drug Abuse.

[b]LEAA is the Law Enforcement Assistance Administration.

[c]Number of missing cases varies with source.

From table 6.23, it appears that social services were most frequently supported through the regular budget of either the jail or outside agency. However, for many jails (44%) grants from the federal government contributed to the support of social services. Finally, it may be interesting to note that some jails provided social services with no funding; that is, at 14 jails (16%), unpaid volunteers provided social service at the jail.

Social Service Staff

For simplicity, we can initially classify the staff providing social services into the following three categories, depending upon their job title or job description: (1) administrators, (2) correctional officers, and (3) social workers. Administrators refer to staff members who are assigned administrative responsibility for providing social services. However, those classified as administrators often also served in other capacities, such as counseling. An individual was classified as a correctional officer if the job title under which he was employed referred to a police or guard function, e.g., deputy sheriff, guard, etc. Although the job title may have specified "guard," someone classified in this category may have spent full-time in social service functions. The last category, social service worker, essentially includes those who did not fit into the previous categories. The actual titles or job descriptions of those included in this category varied considerably.

Fifty-four jails employed one or more individuals as administrators. Most of these jails (39 jails) had one full-time administrator. Twelve of the remaining jails had two full-time administrators, and three jails had one part-time administrator. When the jail employed an administrator, there were additional staff who worked at providing social services. At two jails, the additional staff consisted exclusively of correctional officers. Overall, correctional officers were used to provide

social services at 17 jails (19.3%) and seven of these jails used correctional officers exclusively.

Eighty-one of the 88 jails providing social services used staff who fell into the third category, i.e., those classified as social workers by job title. To further describe the staff in this category, it may be useful to classify them by the principal function they served. At many jails, social services were performed by staff whose principal function was other than general social service counseling. For example, at some jails, psychological counseling was not separated from the provision of social services. At these jails, social services were often provided by psychologists or psychiatrists. At other jails, social services were provided by those whose primary function was education, i.e., by vocational and/or academic teachers. Finally, social services was sometimes provided by the staff, who were used primarily for referring and/or transferring inmates to outside treatment programs. Thus, social workers can be further classified as either: (1) general social service counselors, (2) intake and classification specialists, (3) teachers, or (4) psychological counselors. To gain additional descriptive information on the staff providing social services, we asked respondents to indicate the minimal educational requirements of each staff position. Table 6.24 summarizes the relative frequency with which jails employed staff in each of the above categoires, and table 6.25 presents minimal educational requirements of the staff used in each category.

From table 6.24, it will be clear that most of the jails (82%) employed general social service counselor From table 6.25, it appears that most social workers were professionals with college training in social work or some social science. Overall, those hired as social workers faced more stringent educational requirement than those hired as

social services at 17 jails (19.3%) and seven of these jails used correctional officers exclusively.

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correctional officers. The majority (87%) of social workers had bachelor's degrees, while only 23.5% of the correctional officers serving in a social service role had bachelor's degrees.

TABLE 6.24

Classification of Social Service Staff

Position	Jails	
	Number	Frequency (%)
Administrators	54	61.4
Correctional officer	17	19.3
Social workers (all functions)	81	92.0
Principal function of social workers:		
General social service counseling	72	81.8
Education	19	20.5
Intake and classification	14	15.9
Psychological counseling	10	11.4

TABLE 6.25

Minimal Educational Requirements of Social Service Staff

Position	Minimal Educational Requirement (Frequency of Jails at Each Level)					
	None (%)	H.S. (%)	Special Training (%)	B.A. (%)	B.A. and other training (%)	Ph.D./M.D. (%)
Administrator	2.0	2.0	6.1	24.4	59.1	6.1
Correct.officer	35.5	23.5	17.6	17.6	5.9	0
All functions combined	5.0	1.0	6.9	54.4	26.7	5.9
Counseling	2.3	0	9.4	60.9	26.6	0
Intake/classif.	18.2	9.1	0	63.6	9.1	0
Educational	6.3	0	6.3	56.3	31.3	0
Psychological	0	0	0	0	40.0	60.0

Also from table 6.25, it appears that the minimal educational requirements were highest for those whose principal function was psychological counseling. All jails required their staff in this category to have training beyond the bachelor's degree. The second highest educational requirement was for administrators. The minimal educational requirement for administrators was nearly as high as it was for psychological counselors.

CONCLUDING OBSERVATIONS

Approximately 75% of the jails studied provided social service casework in some form. There was, however, considerable variation in the range and extent of these services. Few jails provided a full range of social services and even fewer jails regularly provided services for all inmates. We observed, however, that a clear trend has developed in recent years of an increase in both the frequency with which jails are providing social services and in the range and intensity of the services provided.

We found no evidence of a relationship between the level of inmate needs and the provision of social services. Instead, the attitudes and organizational arrangement of the jail administration determined both whether or not social services were available and the range and level of services provided. Social services are much more likely to be provided if they are the responsibility of a corrections department.

At almost all jails which provide social services, both the content and administration were similar for drug abusers and other inmates. The content of these services can be divided into two major categories, those directed toward meeting immediate needs arising from confinement, and those directed toward meeting long range needs which may have led to confinement. The short run services include facilitating the inmate's communication within the jail and with the outside world, providing crisis

intervention, help with legal problems, and social support. The long range services include developing a case plan, offering employment counseling and assisting with referral or transfer to community agencies upon release.

The need for short run services depends upon the confinement policy of the jail. Restrictive confinement policies increase the need for short run services. However, excessive restrictions on inmate communication and movement appear to impair the effectiveness of social services by both creating additional inmate needs and by limiting a counselor's ability to help inmates with their more important long term needs. In jails with highly restrictive confinement policies, counselors spend most of their time facilitating communication rather than helping the inmate avoid future confinement. Obviously, the jail is not providing necessary services if it fails to provide assistance which will reduce recidivism. This will require augmentation of social services personnel to meet that objective.

Possibly the most important long range service a jail can provide to inmates is to arrange for continued help upon release through a local community service agency. This is especially true for inmates with drug abuse problems since most inmates at local jails, including those with drug abuse problems, are released within 30 days. This period is too brief to plan and execute an effective rehabilitation program. Therefore, without continuing help and supportive services after release, drug dependent individuals are likely to return to the anti-social patterns of behavior which led to their confinement.

Jails can arrange for continuing help for the inmate by either transferring the inmate before sentence completion (with court approval), or referring the inmate to a community agency after sentence completion. While most jails made some effort to arrange for continued service in

the community, many did so at a very minimal level. We found no evidence that jails which failed to arrange for continuing services were in communities which lacked necessary resources. Instead, as was true for services generally, it appeared that the attitude and form of the jail's administration was the best predictor of the level of referral and other services.

Providing referral requires that jails cooperate at some level with community agencies. Almost all jails providing social services cooperated to some degree with outside agencies. One half of the jails surveyed, however, also used outside agencies to provide services to inmates while they were in the custody of the jail. Extensive use of outside agencies is essential for an effective program of social services for several reasons. First, our observations of jail programs and from interviews with inmates, it is clear that inmates at local jails have an enormous range of needs and problems. Since the resources available can affect the perception of needs, inmate needs often go unrecognized or are misperceived because of the limited jail resources available. As a result, inmates are frequently not helped or inappropriately helped. Cooperation with a wide variety of community agencies is recommended as one way of extending the range of services available. For many jails, this may be the only practical means of expanding services since the use of community agencies seldom entailed direct costs to the jail.

The extensive use of outside agencies may both extend the range of services and facilitate motivating the inmate to accept help. As might be expected, most inmates are initially hostile or distrustful of jail staff, wanting only "to get out." It was observed, however, that counselors at those jails which offered immediate help (e.g., responsive and efficient medical detoxification) or had a wide variety of programs or services, (e.g., educational or vocational training, work release,

psychological counseling, etc.), were able to use the availability of these programs as a bridge to gain the inmate's acceptance or trust, thus enabling them to better identify needs and plan an effective rehabilitation program.

It is clear that an inmate cannot be helped by a social service program if there is no information provided regarding its availability. Grapevine communication leaves wide gaps in the information flow. More than one-third of the jails in the sample providing social services, however, had no regular procedure during intake for informing inmates of the availability of social services. In addition to a general orientation relative to jail rules and regulations, the jail should inform inmates of social services availability as a regular part of intake procedures. A counselor should meet with the inmate within one day after arrival. This practice is recommended because inmates are likely to be most apprehensive and anxious immediately after arrival, the need for crisis intervention is likely to be greatest at this time, and inmates may otherwise be released without being informed of, or referred to, appropriate sources of help which are available in the community.

Jail size appears to be unrelated to the provision of social services, and only minimally related to the range and level of service provided. And, from our observations, it appears that size, either very large or very small, does not necessarily present any barriers to providing effective social services. Obviously, a very small jail cannot be expected to support a large, full-time, professional social service staff. We have, however, observed several small jails that provide a complete range of social services by assigning the responsibilities for such services to one or more members of their staff, and by the effective utilization of community agencies.

Conversely, largeness does not guarantee an adequate level of social services. In the course of the study, several very large jails were encountered that employed either little or no social service staff and made no use of the abundance of the drug treatment and other resources available in the community.

The inmates held at local jails are one group among several in the community who have a great need for social services, but have limited knowledge of what is available and are least skilled in making use of available resources. From our survey of local jails, it appears that jails are recognizing and responding to this need with increasing frequency. At present, however, much remains to be done to assure that all inmates at local jails receive appropriate help for their social service needs.

CHAPTER SEVEN

PSYCHOLOGICAL SERVICES

In this chapter we shall be describing and analyzing the variety of psychological treatment services the jail may make available to its inmates. Some form of psychological therapy is available to inmates in 41 of the jails in the sample (34%). All proportions referred to in the discussion of psychological therapy relate only to those jails providing this service. Jails were identified as having psychological services if (1) there is a counseling program attempting to change attitude or behavior, and (2) the counseling is provided by professionally trained staff. The staff might be paraprofessional mental health workers or group leaders at one level, or psychiatrists and psychologists at another level. Not all services provided by professional psychologists or psychiatrists were considered psychological counseling. For example, where the service was limited to testing or some other form of evaluation or diagnosis for the specific purpose of advising the courts, it was not considered counseling. The service had to be therapeutic for the inmate to be "counted" as psychological treatment. Also, incidental counseling provided in the context of other services, (e.g., educational or vocational services) was not included as psychological counseling. Instead, such counseling was included under social services.

The types of psychological services found in the jail can be classified in three general categories:

1. General psychological therapy designed to meet individual needs (i.e., no pre-set goals); goals for counseling are shaped by client needs.

2. Special purpose therapy (i.e., counseling with pre-set goals); clients are selected based on the goals or orientation of the planned counseling. Drug counseling or marriage counseling are examples.
3. An extensive (and intensive) program of behavior modification exemplified in the therapeutic community or similar isolated residential therapy. This type of treatment includes a variety of counseling and other intervention techniques.

TABLE 7.1

Frequency of Psychological Services
(n=41)

Type of Service	Jails	
	Number[a]	Frequency (%)
General counseling	27	65.0
Special purpose counseling	19	46.0
Drug orientation	(12)	
Non-drug orientation	(3)	
Both	(4)	
Therapeutic community	12	29.0
Drug orientation	(7)	
Non-drug orientation	(3)	
Both	(2)	

[a] Jails may offer more than one type of psychological service.

Each of these techniques may or may not be drug abuse oriented. None of the identified psychological treatment services were found to exclude drug abusers. Of the 41 institutions with counseling (see table 7.2), 21 have some type of counseling especially for drug abusers, and at 10 of these jails the only psychological counseling available is the service provided for drug abusers.

TABLE 7.2

Frequency of Drug and Non-Drug Orientation of Counseling Services

Orientation of Counseling	Jails	
	Number	Frequency (%)
Drug abuser-oriented only	10	24.0
Non-drug abuser-oriented only	20	49.0
Both	11	27.0
Total	41	100.0

Ideally, inmates are diagnosed and then assigned to therapy programs best suited to their individual needs and personalities. More often, clients are assigned simply because a particular modality of counseling is the only one offered. Most (65%) of the jails providing psychological services have only one type of program available. The information presented in table 7.3 illustrates the frequency with which a variety of different types of psychological programs are available.

TABLE 7.3

Number of Psychological Treatment Programs Available at the Same Jail

Number of Treatment Types	Jails	
	Number	Frequency (%)
1	27	65.0
2	7	17.0
3	6	15.0
4	1	2.0
Total	41	100.0

provide therapeutic family counseling in both group and couple formats staffed by family counselors. One program was initiated by a group of inmate wives. These women contacted the jail's director of services, who in turn involved a local family services agency, which now provides a counselor for this program at no charge to the jail. These counseling programs attempt to work out the problems of a marriage and a family disrupted because one of the mates is in jail.

Communication and decision-making skills programs were found to be very structured in nature, similar to taking a course. Both types of programs used techniques of role playing extensively. One decision-making program, called Threshold, is standardized nationally. It is a volunteer program with trained staff. Several jails in New York, Pennsylvania, and Tennessee reported using this program.

3. A therapeutic community is available as a treatment modality for inmates at 29% of these jails. A therapeutic community is an intensive psychological treatment technique which utilizes behavior modification and operates in an isolated environment or setting. For the purpose of this study, it is this factor of being isolated from other inmates and from people other than those participating in the community that differentiates a therapeutic community from other psychological services.

The general model of therapeutic communities (whose origin in most cases is an adaptation of Synanon) is one of "addicts helping addicts" within a rigidly structured social setting. The "community" has a set of norms stressing personal growth and social responsibility. Self-discipline and self-reliance are two of the primary values stressed by the group. Self-discipline is demonstrated primarily by following rigid rules for behavior. Self-reliance is manifested by accepting responsibility for one's own actions. In this respect, drug use as a

behavior is considered the stupidity of the individual rather than an illness to be cured by someone else.

The skills required to live up to these social norms are acquired through a variety of techniques of group psychotherapy. The primary techniques include the following:

a) Confrontation therapy, also referred to as encounter groups or "The Game." The game is a session among residents of the community which announces and reinforces the values of the group. This is done by aggressive discussions focusing on the daily behavior of each member. One member "confronts" another with comments about his behavior and how it relates or conflicts with group values. The confrontation groups follow strict rules of procedure. Confrontation is usually negative and is supposed to arouse guilt feelings.

b) Hierarchial structure is a technique which permits members to progress in authority, privileges, and responsibilities. Members may be promoted to various positions in the community, each with its own particular job. Higher levels of positions have actual policy decision-making responsibilities in determining how the community functions. Similarly, some therapeutic communities have "phases" or levels such as freshman, sophomore, junior, and senior levels at school. Rising through the positions or levels to places of authority is a reward for acceptable behavior and progress in treatment. Conversely, members may be demoted as a negative sanction.

c) Community rules. All therapeutic communities have strict codes of behavior. These range from broad general rules at one level (e.g., no use of drugs is permitted, all members must participate

in an educational program, be on time for all activities), to rules concerning specific behavior details (e.g., walk with good posture, do not stand with hands in pockets, do not lean on walls, do not sing in the shower). Following these rules, it is maintained, promotes self-discipline.

d) Discipline procedures. "Learning experiences" and "haircuts" are terms representing internal discipline techniques for members of the community. Haircuts are structured verbal reprimands of an individual because of undesirable behavior. We were informed that haircuts may be actual head shaving at some therapeutic communities, but this form of punishment was not found at any of the therapeutic communities in the study. A "learning experience" is usually for more serious offenses and involves punishments such as wearing signs, dunce hats, making apologies, and, most important, losing privileges.

The above four components of a therapeutic community program (i.e., confrontation, hierarchial structure, rules, and discipline) were found in all the therapeutic communities visited. The following three components were also found in most of the therapeutic communities.

e) Small family group also called static or intimate groups. A small group of from four to six residents (usually formed in the larger communities) operates like a close family to discuss intimate emotional problems. These groups always keep the same participants, and conversations within the groups are confidential. Small family sessions help an inmate to expose and examine personal emotional problems that might not be mentioned in another setting. These sessions also develop helping skills for participants.

f) Seminars. "New" subjects are presented to the group to expand

interests of residents beyond that of dwelling on themselves. Topics of current events, art and music, world affairs, and local issues may be researched by a member and presented to the group for discussion. Special speakers may be invited into the "community." Productive leisure activities are stressed. These activities attempt to provide new conventional alternatives as a pleasurable experience.

g) Work release. The ability to obtain and stay with a job are important at the later stages, or higher levels, of the therapeutic community. Although work release is not a type of psychological therapy, all non-jail therapeutic communities, and even some of the jail communities have a work release program which is considered an important part of the total package of therapy.

Our findings indicate a similarity between the program content of therapeutic communities exclusively for drug abusers and those where drug abuse is not a client selection criterion.

Treatment Implementation

The psychological services just described are provided in a wide variety of ways in jails throughout the country. Similar services vary considerable in both content and intensity. To identify these differences, we shall now examine specifically how these general types of therapy are implemented.

Presumably, if an inmate is to participate in a psychological treatment program, he or she must first be informed that it exists. Respondents were asked to indicate how and when inmates were informed of the availability of psychological therapy. These responses, summarized in table 7.4, indicate that inmates are told about psychological services during intake at more than half of the jails when such resources are available.

TABLE 7.4

Informing Inmates About Psychological Services

How and When Informed About Service	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)
HOW:			
Informed by a counselor	25	61.0	73.5
Informed by a correctional officer	2	5.0	5.8
Learned through the grapevine & other irregular means	7	17.0	20.7
Data not available	7	17.0	—
WHEN:			
During intake to jail	21	51.2	
At various other times	20	48.8	

Once an inmate enters a psychological program, the treatment may be conducted in a variety of ways. Each type can be conducted either on an individual, one-to-one basis between inmates and counselor, or on a group basis (see table 7.5). The size of groups for counseling ranged from five to thirty-five persons.

TABLE 7.5

Relationship Between Type of Psychological Treatment and Method of Service Provision

Provision Method	General Counseling		Special Purpose Counseling				Therapeutic Community			
			Drug		Non-drug		Drug		Non-drug	
	#	%	#	%	#	%	#	%	#	%
Individual counseling	14	52.0	1	6.0	1	14.0	0	0	0	0
Group counseling	1	4.0	6	38.0	5	72.0	1	12.5	0	0
Both	12	44.0	9	56.0	1	14.0	7	87.5	5	100.0

Counseling sessions can be either regularly scheduled or provided upon request (see table 7.6). Only "general counseling" was provided on request, although, more often than not, these sessions are regularly scheduled. Special purpose counseling usually involves group programs (as seen in table 7.5); thus, these sessions must be regularly scheduled. Therapeutic community programs are very structured. As might be expected, most have only scheduled therapy. A few programs that function primarily with regularly scheduled sessions also make provisions for counseling assistance at other times if an inmate requests it.

TABLE 7.6

Relation Between Type of Psychological Treatment and Availability of Counseling

Availability of Counseling	General Counseling		Special Purpose Counseling				Therapeutic Community			
			Drug		Non-drug		Drug		Non-drug	
	#	%	#	%	#	%	#	%	#	%
Upon Request only	10	37.0	0	0	0	0	0	0	0	0
Requlary scheduled only	12	44.4	15	92.3	7	100.0	6	75.0	4	80.0
Both upon request and requlary scheduled	5	18.5	1	7.7	0	0	2	25.0	1	20.0

Inmates have access to emergency "after-hours" counseling at 75% of the jails. At half of these jails, a counselor is available for this purpose (usually on call). At the other half of the jails, correctional officers or medical personnel are responsible for handling emergency situations.

The extent of services for the inmate can be identified by examining

the quantitative aspects of session frequency and duration, and the duration of the treatment program (see tables 7.7 and 7.8). Inmates participating in therapy meet with counselors with different frequencies depending on the type of treatment. The more structured and intensive counseling programs meet more often than general counseling programs. Most therapeutic communities provide therapy daily. Almost all of the special purpose counseling occurred at least once a week. In contrast, almost half (44.4%) of general counseling is provided irregularly.

TABLE 7.7

Relation Between Type of Treatment and Frequency of Counseling Sessions

Frequency	General Counseling		Special Purpose Counseling				Therapeutic Community			
			Drug		Non-drug		Drug		Non-drug	
	#	%	#	%	#	%	#	%	#	%
Daily	1	3.7	2	12.5	2	28.6	7	87.5	4	80.0
2-3 times/week	7	25.9	6	37.5	2	28.6	0	0	1	20.0
Weekly	7	25.9	7	43.8	3	42.9	1	12.5	0	0
Irregularly	12	44.4	1	6.3	0	0	0	0	0	0

TABLE 7.8

Relation Between Type of Therapy and Duration of Counseling Sessions

Duration	General Counseling		Special Purpose Counseling				Therapeutic Community			
			Drug		Non-drug		Drug		Non-drug	
	#	%	#	%	#	%	#	%	#	%
< ½ hour	2	7.4	2	12.5	0	0	0	0	0	0
½-1 hour	6	22.2	0	0	0	0	0	0	0	0
1-2 hours	8	29.6	7	43.8	4	57.1	3	37.5	1	20.0
≥ 2 hours	3	11.1	5	31.3	3	42.9	3	37.5	1	20.0
Varies	8	29.6	2	12.5	0	0	2	25.0	3	60.0

Most treatment programs are available to inmates for as long as they are incarcerated, although time limits are set by some programs. For example, as described earlier, some of the special purpose counseling programs are designed like a "course," with a pre-set number of "classes." In these cases, there is a specified duration for the program. Respondents from therapeutic communities often commented about participants reaching their "peak" after a certain amount of time; spending more time in therapy is seen as useless.

TABLE 7.9

Relation Between Type and Duration of Treatment

Treatment Duration	General Counseling		Special Purpose Counseling				Therapeutic Community			
			Drug		Non-drug		Drug		Non-drug	
	#	%	#	%	#	%	#	%	#	%
As long as incarcerated	13	48.1	12	75.0	3	42.9	4	50.0	2	40.0
< 6 months	1	3.7	1	6.3	3	42.9	2	25.0	1	20.0
6-9 months	0	0	1	6.3	0	0	0	0	0	0
9-12 months	0	0	0	0	1	14.3	2	25.0	2	40.0
Data not available	13	48.1	2	12.5	0	0	0	0	0	0

The purpose of providing psychological treatment to inmates is to change attitudes or behavior. Counselors usually make formal evaluations of clients' needs and/or progress as related to this goal of "change." These evaluations in many instances include psychometric tests to measure various personality characteristics and changes thereto. The evaluations of clients usually also contain the counselor's personal assessment and, sometimes, recommendations for further treatment. The reported use of counselor evaluations and psychometric testing is presented in table 7.10.

TABLE 7.10

Frequency of Evaluation of Inmates and Use of Psychometric Testing for Each Type of Treatment

Type of Treatment	Evaluations of Inmates		Psychometric Tests as Part of Evaluation	
	# Jails	% Jails	# Jails	% Jails
General counseling	23	85.2	19	70.4
Special purpose counseling: drug	8	50.0	3	18.8
Special purpose counseling: non-drug	5	71.4	3	42.9
Therapeutic community: drug	8	100.0	6	75.0
Therapeutic community: non-drug	4	80.0	4	80.0

The formal records kept by counselors include their evaluations, the results of tests given to inmates, and, often, jail report forms. We found that the disclosure of treatment records is a concern to inmates and affects how open and honest they feel they can be with their therapist. Recently enacted privacy regulations may affect how information is disseminated in the future.

TABLE 7.11

Availability of Counseling Records

Those with Access to Inmate Records	Jails	
	Number (#)	Frequency (%)
Warden	25	61.0
Sentencing judge	26	63.4
Probation/parole	23	56.1
Prosecuting attorney	17	41.5
Defense attorney	22	53.7
Criminal justice agency	12	29.3
Inmate	12	29.3

Location. The location of therapy can have a direct effect on the the quality of treatment. The setting for counseling can influence the effectiveness and client interest in the service. Psychological treatment is provided at settings both inside and outside of the jail (see table 7.12).

TABLE 7.12

Relation Between Type of Therapy Program and Location

Location	General Counseling		Special Purpose Counseling				Therapeutic Community			
			Drug		Non-drug		Drug		Non-drug	
	#	%	#	%	#	%	#	%	#	%
Outside jail	1	3.7	2	12.5	0	0	1	12.5	0	0
Inside jail	25	92.6	12	75.0	7	100.0	7	87.5	5	100.0
Both	1	3.7	2	12.5	7	0	1	0	0	0

Only 17% of the jails which provide psychological services report that inmates receive such treatment outside of the jail. A few of these jails have no in-jail psychological service and take all inmates in need of treatment to the service provider's location. Several jails which have psychological programs in the jail permit some inmates, usually those nearing release, to participate in designated community programs. The intent of having inmates involved in community programs is that it may lead to continued treatment following release from jail.

Only one jail was identified which permitted inmates to participate in a non-jail therapeutic community. In this case, inmates live at the treatment house which is sponsored by the county mental health organization. This temporary transfer for treatment has been operating for less than a year with just a few inmates participating. The jail's director

of rehabilitation feels this approach to treatment is appropriate for some of the inmates, but the jail does not have the resources to conduct a program of its own. By using an existing program, the treatment is available to jail inmates. The jail's treatment director works closely with the staff of the therapeutic community.

Treatment located inside the jail can be provided in a variety of physical settings. Table 7.13 gives the physical setting in which each treatment type is provided.

TABLE 7.13

Relation Between Type of Treatment and Setting

Physical Setting	General Counseling			Special Purpose Counseling				Therapeutic Community			
				Drug		Non-drug		Drug		Non-drug	
	#	%	Adj. %	#	%	#	%	#	%	#	%
Cell	0	0	0	1	6.0	0	0	0	0	0	0
Special cell area	2	7.0	9.0	2	12.5	0	0	2	25.0	3	60.0
Private space	12	44.0	54.0	5	31.0	1	14.0	4	50.0	1	20.0
General purpose space	7	26.0	32.0	6	38.0	6	86.0	1	12.5	1	20.0
Outside jail only	1	4.0	5.0	2	12.5	0	0	1	12.5	0	0
Data not available	5	18.0	---	0	0	0	0	0	0	0	0

Both general and special purpose counseling are usually provided either in some type of private space, such as a counseling room or an office, or in a general purpose or other setting, such as a chapel or meeting room.

The therapeutic communities are usually isolated from the rest of the jail population. Approximately half of the communities occupy special cell areas, such as a tier, wing of the building, or a dormitory unit. About half of the communities are isolated in non-cell areas where the spaces are like large apartments or houses, with a less institutional appearance than those in special cell areas. Since a therapeutic community stresses self-discipline, self-reliance, and mature behavior, the less jail-like environment demonstrates a greater degree of trust for those in the therapy and is more appropriate to the treatment modality.

All of the therapeutic community programs have separate housing for participants. A few special purpose therapy programs also house their participants together.

TABLE 7.14

Frequency of Separate Housing for Inmates by Type of Treatment

Type of Treatment	Jails with Separate Housing	
	Number	Frequency (%)
General counseling	0	0
Special purpose: drug	4	25.0
Special purpose: non-drug	2	28.0
Therapeutic community: drug	8	100.0
Therapeutic community: non-drug	5	100.0

Facilities used for psychological services were evaluated as less than adequate by jail staff at 44% of the jails providing general counseling, 52% of the jails providing special purpose counseling, and

17% of the jails with therapeutic communities. The most consistently expressed need cited is more counseling space. Another frequently mentioned need is space which provides more privacy. In addition, respondents commented that "more appropriate" space conducive to therapy is needed. Very few jails were found to have space originally designed for counseling services. Those jails providing treatment are, for the most part, adapting existing space to new programs, which is not surprising, since 80% of all psychological programs were initiated since 1972.

Selection Criteria for Treatment

In actuality, only a very small proportion of all inmates participate in any psychological treatment. At those jails providing therapy, less than 10% of the inmate population participate in psychological treatment programs. Although an inmate's emotional needs may require attention, it is the selection process operating at the jail that determines if an inmate in need of psychological treatment will be identified and then treated.

The selection criteria to be discussed must be understood in the context that most jails do not provide any counseling, and the jails that do have psychological treatment only have a very limited repertoire of types of programs which, in turn, have a restricted intake capacity. Further, there are two types of selection criteria operating--those that "include" or make someone eligible for service, and those that "exclude" or restrict someone who otherwise may be eligible.

The eligibility criteria used by a jail depends, first of all, on the type or types of treatment programs provided. Twenty-four percent of the jails (n=10) provide counseling only for drug abusers (table 7.20).

However, when jails offer counseling which may not have substance abuse as its specific focus, drug abusers generally are not excluded from these services.

Table 7.15 shows the variety of criteria jails use to place inmates into psychological treatment programs.

TABLE 7.15

Criteria Established for Inmate Eligibility for Psychological Treatment

Criteria	Jails	
	Number	Frequency[a] (%)
All inmates eligible	6	14.6
All drug abusers	6	14.6
Any inmate who requests	20	48.8
Recommendation of jail staff based on an interview or observation of need	13	31.7
Referral from a non-jail source (e.g., judge, prosecutor or community agency)	10	24.4
Combination of a request and a subsequent recommendation by a jail staff member	7	17.0
Detainees only	1	2.4
Convicts only	6	14.6

[a] Column totals more than 100% because respondents could answer with more than one category.

Most jails have more than one route by which an inmate can enter into counseling. The most common path is simply a request by an inmate to see a counselor or to join a therapeutic group. Some of the jails reported that they place inmates into treatment either as a result of a referral from a judge or upon a recommendation of a correctional officer when the inmate has not personally sought help.

No statistical relationship was found between the way an inmate gets into treatment and the various types of treatment services. It appears that the eligibility criteria and the selection process are based more on each individual jail's operational policies than on the type of treatment. However, it is usually those who are directly involved with providing treatment who make client selections.

Inmates may be identified as eligible for treatment and yet be prevented from receiving it because of special restrictions imposed as part of the selection process. Of the 41 jails which provide psychological treatment, 68% have at least one of the following restrictions:

1. Psychological or emotional criteria. The most frequent restriction that excludes inmates from psychological treatment is severe behavioral problems. Most of the treatment services for inmates were reportedly not prepared to handle severely disturbed people. Instead, these individuals are processed through social services, which attempts to transfer them to psychiatric facilities, or they are handled by jail security, which physically isolates them as behavior problems.

2. Time in jail. Psychological treatment requires the inmate's participation for some given length of time to be effective; the time varies according to the type of treatment and the emotional state of the client. A few of the special purpose non-drug counseling programs had established time minimums for participation. All of the therapeutic communities require some minimum time, thus eliminating from consideration those inmates who will remain at the jail less than the prescribed time.

3. Severity of offense. This requirement excludes those whose present charges involve crimes against persons or certain felony

offenses. This restriction is explained by the fact that participation in counseling requires some degree of inmate movement. Jails which impose this restriction do so to limit movement of "high-risk" inmates.

4. Physical criteria. This is a requirement concerning age, sex, or physical condition. Where this restriction was found, it excluded women inmates from treatment.

In addition to determining whether a restriction is applicable, we also asked respondents to indicate the source of the restriction (i.e., the jail, an outside service provider, or legal mandate) as well as the approximate proportion of those inmates considered for treatment who, because of the restrictions, were declared ineligible.

Most restrictions are imposed by the jail, rather than by an outside service agency. Table 7.16 illustrates the frequency of each restriction, its source, and the proportion of potential clients declared ineligible.

TABLE 7.16

Restriction for Receiving Psychological Counseling

Restriction	Number of Jails With Restriction	Source of Restriction (frequency for each proportion)			Proportion Ineligible Because of Restriction (frequency for each proportion)			
		Jail	Outside Agency	Law	None 0%	Few <10%	Some 10-50%	Many >50%
Psychological or emotional criteria	15	73%	27%	0	7%	93%	0	0
Time expected to remain in jail	11	78%	22%	0	0	33%	67%	0
Severity of offense	6	67%	33%	0	0	40%	40%	20%
Physical criteria	6	50%	33%	17%	20%	60%	20%	0

There are only 14 jails which provide more than one type of treatment. At these jails, inmates are usually assigned to particular types of treatment either by the inmate's request, by the joint decision of the inmate and a counselor, or by the decision of jail staff. At a few jails placement is the result of a professional diagnostic evaluation.

There is general agreement that involvement in counseling should be a voluntary activity on the part of the client. Inmates may decline to participate in counseling programs at most jails (88%). In fact, at most of these jails some inmates did refuse to participate in treatment. The frequency of refusals reported is illustrated in table 7.17.

TABLE 7.17

Proportion of Inmates Declining Psychological Treatment

Inmates Declining Treatment	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)
None (0%)	3	7.3	12.5
Few (10%)	15	36.6	62.5
Some (10-49%)	5	12.2	20.8
Many (50-99%)	1	2.4	4.2
All (100%)	0	0	—
Data not available/ or not applicable	17	41.5	—
TOTAL	41	100.0	100.0

Administration

The administration of psychological treatment services can be examined by looking at three basic components: (1) the actual provider of the service, (2) the responsibility for service operation, and (3) the source of funding.

1. Provider. As is true for other services, psychological treatment services are provided either by the jail as a direct service provider or by an outside agency such as a mental health program or psychiatric hospital or by some combination of jail and outside agency.

TABLE 7.18

Provider of Psychological Treatment Services

Provider	Jails	
	Number	Frequency (%)
Jail as total service provider	14	34.1
Outside agency as total service provider	8	19.5
Combined provision by both jail and agency staff	19	46.4
Total	41	100.0

2. Responsibility for service operation. The responsibility for service may lie entirely with the professional staff providing service (jail or non-jail), or the jail administrator may retain control over service operation or certain elements.

Questions were asked specifically about four different aspects of responsibility for service operation: (1) client selection, (2) service content, (3) personnel selection, and (4) budget management. Total responsibility for service operation is defined as having responsibility for all of these aspects. Shared responsibility may indicate either that all aspects of service management are handled jointly by staff and administrator or that responsibility is divided.

From the distributions in tables 7.19 and 7.20, it appears that for psychological services, jail administrators delegate much of the

administrative responsibility to the staff providing the service. This is especially true for client selection and program content. Jail administrators retain, to a slightly greater degree, responsibility for personnel and budget matters.

TABLE 7.19

Responsibilty for Psychological Service Operation

Responsibility for Psychological Service Operation	Jails		
	Number	Frequency (%)	Adjusted Frequency (%)
Jail administrator has total responsibility	2	4.9	5.2
Psychological service staff has total responsibility	13	31.7	33.3
-Jail	(5)		
-Non-jail	(8)		
Shared responsibility	24	58.5	61.5
Data not available	2	4.9	——
Total	41	100.0	100.0

TABLE 7.20

Responsibility for Each Aspect of Service Operation by Position

Position of Responsibility	Client Selection		Program Content		Personnel Selection		Budget Management	
	#	%	#	%	#	%	#	%
Jail administrator	6	14.4	3	7.2	12	29.3	16	39.2
Service staff	31	75.8	33	80.8	24	58.7	18	44.0
-Jail	(22)		(21)		(12)		(6)	
-Non-jail	(9)		(12)		(12)		(12)	
Shared responsibility	2	4.8	3	7.2	2	4.8	4	9.6
Data not available	2	4.8	2	4.8	3	7.2	3	7.8

It should be noted that administrators of jails which cooperate with outside agencies, as well as those who do not, both delegate responsibility for service operation to staff providing the service. The only difference found was that when a jail administrator shares responsibility with an outside agency, the jail retains control of client selection. When a jail administrator shares responsibility with a jail staff service provider, the control retained is budget management and, to a lesser degree, personnel selection.

3. Funding. Financial support for psychological services may come from a single source or combination of sources. Table 7.21 describes the sources of funding used to support the delivery of psychological services to inmates.

TABLE 7.21

Sources of Funding for Psychological Treatment Services (n = 41)

Source	Jails	
	Number[a]	Frequency (%)
Jail budget	13	31.7
Grant to jail	16	39.0
Source: NIDA	(4)	
LEAA	(11)	
State mental health	(1)	
Service agency budget	15	36.6
Grant to service agency	8	19.5
Source: NIDA	(3)	
LEAA	(3)	
State mental health	(2)	
Volunteer (no funding)	1	2.4

[a] Column totals more than 100% because jails reported multiple program funding sources.

As can be seen from table 7.21, psychological services are supported largely by "non-jail" funds, e.g., government grants and service agency budgets. Most community agencies which provide psychological assistance for inmates do not receive payment from the jail for services rendered.

Cooperating with Community Service Agencies

Services provided to the jail by cooperating agencies include drug counseling, general psychological therapy or counseling, referrals, placing inmates in treatment after release from jail, and social-service support functions. At a few jails, the agencies provide staff training for jail personnel.

Jails (66%) providing psychological treatment often have cooperative arrangements with one or more community service agencies to provide all or part of this service. Most (70%) of these jails use community agencies in addition to services provided by the jail, but eight jails depend exclusively on these non-jail service providers for all their psychological treatment services.

Types of Cooperating Agencies

Human service agencies providing services to jails may be classified along two dimensions: (1) agency function, which describes the principal activity or focus of an organization, and (2) agency auspices, which describes the authority of an organization as being government or non-government.

Agency function. The agencies cooperating with the jail, if classified by functions, include: (a) drug treatment, (b) mental health, (c) criminal justice system, (d) education, and (e) social service.

Drug treatment and mental health agencies usually provide most of the psychological services if the jails utilize outside service providers.

Such agencies can provide both the therapeutic functions and many of the social service support functions. Many of these drug treatment organizations were created by mental health agencies initially but later developed as separate entities. These drug treatment services employ mental health workers. Often both drug treatment and mental health agencies provide similar services to the jails. These drug treatment agencies usually have counseling and social services staff, and some provide methadone maintenance for their registered clients after release.

TABLE 7.22

Jail Cooperation With Community Agencies by Agency Function

Function of Agency	Cooperating Jails	
	Number	Frequency (%)
Drug treatment	14	51.8
Mental health	14	51.8
Criminal justice	2	7.4
Education	2	7.4
Social services	2	7.4

Social services agencies identified here include various public welfare and private social service organizations. In several instances, psychological services were provided to inmates by university student interns in college counseling and psychology curricula. In table 7.22, these arrangements were labeled as "Education." Court forensic services, whose primary purpose is evaluation of inmates for the court, also provide therapeutic services in two jails.

Agency auspices. The agencies cooperating with the jail to provide psychological counseling, include: (a) local government, (b) state

government, (c) professional non-profit organizations, and (d) volunteer or civic groups.

Although volunteers are active in jails, psychological therapy is a service area requiring specialized competence which most volunteer groups are not competent to offer. It is therefore of interest that three jails use volunteers in "Threshold" as part of their psychological services.

TABLE 7.23

Jail's Cooperation With Community Agencies

Auspices of Agency	Cooperating Jails	
	Number	Frequency (%)
Local government	12	44.4
State government	10	37.0
Professional non-profit	11	40.0
Civic/volunteer	3	11.1

The relationship between agency function and auspices is shown in table 7.24. Over half the drug treatment agencies serving jails are professional non-profit organizations, most of which have grants as their major source of funding. Almost all mental health agencies are in the public sector, either as part of county or state mental health programs.

We attempted to discern whether a relationship existed between the use of community agencies and size of jail, administrative organization, or the variety of psychological services offered. The only factor that appears to be related to the use of community agencies is the length of time inmates remain at the jail. By examining the length of stay

TABLE 7.24

Relation Between Agency Function and Auspices

Auspices of Agency	Agency Function				
	Drug Treatment (%)	Mental Health (%)	Criminal Justice (%)	Education (%)	Social Service (%)
Local government	26.3	43.7	100.0	0	0
State government	21.0	31.2	0	100.0	50.0
Private non-profit	52.7	6.2	0	0	50.0
Volunteer/civic	0	18.7	0	0	0

patterns of those jails offering psychological services, it appears that jails are more likely to cooperate with non-jail agencies when the length of stay is shorter for most inmates [$\chi^2(2)=5.2$, $p < .07$]. That is, those jails holding most of their inmates over six months are less likely to use agencies to provide service than those jails which hold most of their inmates less than 30 days. This may be due to the fact that when a jail's population remains long enough to participate in therapy, jail administrators may feel it is worthwhile for the jail to provide its own service rather than to depend on community agencies.

Staffing

The personnel involved in psychological treatment services includes administrators, a variety of treatment positions ranging from psychiatrists to para-professionals, as well as social service support staff. Table 7.25 lists the types of personnel providing services for inmates.

Administrators. The individuals administering psychological services are in one of two categories. Either the administrator is a director of all jail treatment services or a chief counselor who is also involved directly in providing therapy. Most program administrators are

TABLE 7.25

Staff Providing Psychological Services

Staff Position	Jails Using Positions	
	Number	Frequency[a] (%)
Administrator	24	60.9
Psychiatrist/M.D.	8	19.5
Psychologist	16	39.0
Drug specialist	12	29.2
Counselor	31	75.6
Social service support staff	15	36.5
Correctional officer	9	21.9

[a] Columns total more than 100% because respondents could respond in more than one category.

employed by the jail. A third of those individuals administering jail treatment programs are employed by outside agencies (see table 7.27). Almost all administrators have at least a college degree, and most have educational backgrounds beyond the bachelor's level. Three of the program administrators were identified as ex-addicts, and these individuals are employed by outside agencies.

Psychiatrist/M.D. All psychiatrists providing service to the jail programs in the sample do so on a part-time basis; most spend less than 10 hours a week at the jail. None of the jails providing psychological treatment uses a part-time psychiatrist alone; the services of a psychiatrist are supplemented by other staff.

Psychologist. Of the 16 jails employing psychologists, nine have at least one full-time psychologist; seven jails use a psychologist part-time between 10 and 20 hours a week at the jail. Psychologists are

paid directly by the jail in half of the cases.

Drug Specialist. Twelve jails have a staff position called "drug specialist." About half are jail personnel, and the other half are on the staff of a community agency. The "specialist" title in some cases is assigned by a civil service job description, which varies by state. In other instances, experience with drugs is the only requirement. Seven jails using "drug specialists" as part of the counseling staff employ ex-addicts in these positions. Two of these jails also require a college degree, but at the remaining five jails an ex-addict status is the only formal requirement. Most respondents supplement the written job descriptions with the requirement of "the right personality for the job." Individual personality characteristics are stressed heavily for drug specialist positions. Drug specialist positions are usually full-time positions.

Counselor. The general position of "counselor" exists at 31 of the jails with psychological services. Sometimes this individual is called a mental health worker, a psychiatric therapist, a group leader, or just a counselor. Requirements vary from "no requirements" to "college plus" (which may be a master's degree or a bachelor's degree with added education and/or training). Counselors are involved in all types of treatment programs and are the primary staff for psychological treatment. Some counselors are employed by the jail; others, by outside service agencies. Two jails have only volunteer counselors.

Social service support staff. Although social services are, for the most part, a function separate from psychological services, some therapeutic programs include certain additional services as part of therapy. Many of the therapeutic communities and a few other programs include a structured recreation program and planned physical exercise.

A few treatment programs hire specialists to administer this part of rehabilitation. Similarly, a poetry workshop employed an English teacher part-time. In some jails, a "follow-up" staff member helps inmates who have participated in treatment readjust to living in the community.

Correctional officers. Officers were identified as staff of psychological services only when they served in a treatment function. At a few honor farms, many correctional officers were also trained as counselors. At several jails, correctional officers were trained to lead encounter groups, to teach Threshold (a decision-making program), or participate directly in treatment in some fashion.

Tables 7.26 and 7.27 summarize the educational requirements and the employers of the various personnel who provide psychological services.

TABLE 7.26

Educational Requirements of Personnel Providing Psychological Services

Position	Educational Requirements by Jails Reporting the Position						
	None (%)	H.S. (%)	Training/ Experience (%)	College (%)	College Plus (%)	M.D./ Ph.D. (%)	Data n.a. (%)
Administrator	0	4.2	8.3	12.5	41.7	20.8	12.5
Psychiatrist/M.D.	0	0	0	0	0	100.0	0
Psychologist	0	0	0	0	0	100.0	0
Drug specialist	0	0	41.7	25.0	8.3	0	25.0
Counselor	12.9	3.2	12.9	32.4	16.1	0	22.5
Social service	33.3	6.7	26.6	6.7	20.0	0	6.7
Corrections officer	11.1	22.2	44.5	11.1	11.1	0	0

TABLE 7.27

Employer of Personnel Providing Psychological Services

Position	Employer			
	Jail (%)	Agency (%)	Volunteer (%)	Data Not Available (%)
Administrator	62.5	33.3	0	4.2
Psychiatrist/M.D.	25.0	50.0	0	25.0
Psychologist	50.0	32.3	0	17.7
Drug specialist	50.0	41.7	0	8.3
Counselor	35.6	45.3	6.4	12.7
Social service	26.6	40.0	20.0	13.4
Corrections officer	100.0	0	0	0

Relationship Between Jails and Type of Psychological Services

As the preceding discussion has documented, there is considerable variation between jails in the type of psychological services provided for inmates. We examined those factors that may account, first, for whether a jail provides psychological treatment and, second, for some of the variation at those jails that do provide psychological services.

In general, the existence of some form of psychological treatment is indicative of a comprehensive level of human services at a jail. This is illustrated in two ways: (1) by the variety of different services provided by those jails which offer psychological treatment and (2) by the level of service provided by those jails when different levels of service have been delineated.

Table 7.28 illustrates the frequency with which psychological treatment is provided in conjunction with the other services we examined.

TABLE 7.28

Relationship Between Availability of Psychological Services and Other Services

Types of Services Available at Jails in Conjunction with Psychological Services	Frequency of Jails Providing Each Type of Service	
	Number	Frequency (%)
Full range of services provided	28	68.3
Psychological, social, and detoxification services	7	17.0
Psychological, screening, and detoxification services	2	4.9
Psychological and detoxification services	4	9.8

A "full range of services" refers to the four major categories of services examined: intake screening, detoxification, social services, and psychological treatment. Most (68.3%) of the jails that provide psychological services also provide screening, detox, and social services. All jails providing psychological services also provide detoxification services, although the reverse is not true. Thus, those jails with psychological programs may be expected also to provide other inmate services.

Jails providing psychological services also tend to provide higher levels of both intake screening and detoxification services than do jails which do not provide therapy. Table 7.29 illustrates the relationship between the availability of psychological services and the type of screening.

The types of screening are scaled as "levels" of service, from low to high. Various types of screening isolate different problems. In terms of identifying a need for psychological treatment, a personal psychological assessment interview can be more relevant and, therefore,a higher

level of service than a medical examination. When identifying a need for detoxification services, screening that includes a medical examination is more salient than an interview alone. Thus, when relating a type of treatment to the types of intake screening, the level of a screening activity may vary according to the service for which the inmate is being considered.

TABLE 7.29

Relationship Between Availability of Psychological Services and Type of Intake Screening

Type of Screening	Relative Frequency of Jails Within Each Type of Screening That Provide Psychological Services			
	Jails			
	Without Psychological Services		With Psychological Services	
	#	%	#	%
No screening	28	77.7	8	22.2
Booking with questions about drug use	23	79.3	6	20.7
Medical exam and/or interview	12	80.0	3	20.0
Assessment interview	17	68.0	8	32.0
Medical exam and assessment interview	7	30.4	16	69.6

$\chi^2(4)=21.04$, $p < .0003$

The information presented in table 7.29 illustrates that, in most cases, those jails with the highest level of screening to identify those in need of treatment, are also those that tend to offer psychological help.

A similar relationship exists between the availability of psychologicical services and the type of detoxification services. Table 7.30 reports the availability of psychological services in relation to the levels of detoxification. While few jails overall provide psychological

services to inmates, our findings show a positive association between those which offer detoxification and the availability of such psychological help.

TABLE 7.30

Relationship Between Availability of Psychological Treatment and Levels of Detoxification Services

Level of Detoxification	Relative Frequency of Jails Within Each Type of Detoxification That Provide Psychological Treatment			
	Jails		Jails	
	Without Psychological Services		With Psychological Services	
	#	%	#	%
No detox services	17	70.8	7	29.2
Emergency detox only	12	63.2	7	36.8
Medical detox only	46	68.6	21	31.3
Integrated detox program	2	25.0	6	75.0

$\chi^2(3)=6.4$, $p < .09$

Counseling is more often available in jails in which services are administered by corrections agencies than in law enforcement agencies [χ^2 (1)=3.6, p<.05]. Psychological services are provided in 46% of the jails where services are administered by a corrections agency, and in 27% of those jails where services are administered by law enforcement agencies.

Inmate movement, the degree to which inmates move about the jail with minimal constraint, is related to presence of psychological treatment [$\chi^2(1)=6.8$, p<.008]. Of those jails with low inmate movement, i.e., when inmates remain in their cells most of the day, only one out of five provide some type of therapy. On the other hand, when jails permit inmates out of their cells for activities, services, and work assignments

on a daily basis, one can expect to find some type of psychological services in one out of two of those jails.

A similar relationship exists between inmate movement and the provision of drug-related therapy [$\chi^2(1)=917$, $p < .001$]. Of those jails with low inmate movement, when they provide any psychological services, only 27% provide drug abuser-oriented counseling. On the other hand, those jails with high inmate movement which provide treatment services focus that counseling on drug users in almost three out of four instances (73%). Inmate movement is positively correlated with the number of types of psychological services available at a jail [$\chi^2(3)=16.09$, $p < .001$]. Inmate movement, then is a good predictor of the availability of treatment services. No relationship was found between the availability or type of psychological services and jail size, length of stay (LOS) pattern, or geographic region of the jail.

CONCLUDING OBSERVATIONS

Psychological services in jails are the least prevalent component of the treatment services available to drug abusing inmates. Only one-third of jails in our study reported any psychological counseling programs at all; less than half of these programs focused on drug problems. This limited amount of services refers only to their availability and not to their quality. We have also found an uneveness in delivery based on the ide range of competencies required to perform services.

The reasons for the scarcity of psychological help in jails are many--limited jail budgets, lack of demonstrated effectiveness, availability of competent staff, the lengthy nature of psychological assistance, the jail setting itself, official reluctance to do "anything" with or for detainees, and probably most significantly, the lack of acceptance by

jail staff of a rehabilitation orientation. However, if a rehabilitation philosophy is adopted by the jail, the jail is more likely to facititate connecting inmates with problems and programs of help.

In the few jails that are now providing psychological therapy, only a very small proportion of inmates--usually under 10%--actually participate. Not infrequently, inmates with the greatest need for treatment do not receive it. The most common reason given for excluding an inmate from a therapeutic program is behavioral problems, because most treatment services for inmates are not prepared to handle severely disturbed people. In some cases, these inmates are transferred to a psychiatric facility but, more often, for security reasons thay are placed in isolation in the jail and labeled as behavior problems. In other cases, inmates choose not to participate in treatment.

Assuming jail commitment to rehabilitation and recognizing current paucity of psychological programs in jails, we offer the following conclusions and recommendations in five areas: (1) accessibility of service; (2) types of therapy; (3) staff; (4) continuity of treatment; (5) use of community agencies.

Accessibility. Constraints on access to treatment are often subtle; a major one is the attitude of jail staff toward treatment. Officers are sometimes reported to "put-down" the treatment programs to the inmates, which frequently can make those in need hesitate to participate. When officers ridicule and sometimes physically prevent access to treatment, as was reported by both counselors and inmates, accessibility is a moot issue. Correctional officers must be thoroughly appraised of jail policy toward rehabilitation and trained to understand their role in rehabilitation and their responsibilities to therapeutic programs. Some jails, as noted earlier, actually involve correctional officers as counselors or

assign other rehabilitative activities.

Type of treatment. Ideally, an inmate's needs are diagnosed and then he or she is placed in the treatment best suited to those specific needs. No one type of therapy is inherently better than another (although each has its advocates); various techniques are more or less appropriate depending on an individual's problems and personality. The jail should, to the degree possible, make available appropriate treatment, suited to individual needs. The general types of psychological therapy are briefly described with the advantages and disadvantages for both the jail and inmates in figure 7.1.

Staff. Many programs exclusively for drug addicts use counselors who are former drug users. Advocates of this strategy argue that these counselors are best able to develop rapport with the clients. Depending on the approach to therapy this may be true, although the status of being an ex-addict alone is not enough to make someone an effective counselor. Some of the ex-addict counselors have college degrees and advanced degrees in therapy; others have some special training or are graduates of a therapeutic community. But whether a counselor is an ex-addict or not, the success of therapy depends on the development of rapport with the client and the ability to have consensus between therapist and client as to the goals of therapy. For this reason, the most important component of any treatment program is a competant staff. The staff directly involved with providing counseling must be the ones responsible for designing program content and accountable for its delivery.

Continuity of treatment. For most psychological treatment approaches to be effective, the individual must participate for a substantial period of time; the time varies but usually extends beyond the short periods that most inmates remain in jail. For an inmate to have the greatest chance

FIGURE 7.1

Advantages and Disadvantages of Psychological Service Systems

Type of Psychological Service Systems	Advantages	Disadvantages
General Counseling: Therapy with unstructured goals	1. Flexible; designed to meet a broad range of individual psychological needs	1. Inmates unclear as to advantages of participating; goals of the counseling program often vague. 2. Low levels of commitment were observed on the part of both staff and inmates. This does not appear to be inherent in the type of counseling, but a result of how it is implemented.
Special-Purpose Counseling: Therapy designed to deal with pre-determined problems, e.g., drug or marriage counseling, or alcohol, etc.	1. Programs focus on specific problems with identifiable goals. 2. Both inmate and jail administrators can be introduced to the content of the program before initiating counseling. 3. Specialists in particular problem areas can be employed.	1. Not flexible; deals only with specific pre-defined problems. 2. Limited to helping only those inmates with the "special purpose" problem.

FIGURE 7.1 (Continued)

Type of Psychological Service Systems	Advantages	Disadvantages
Therapeutic Community (T.C.): Isolated residential therapy; program of behavior modification using a variety of techniques	1. Can be effective in changing attitudes and life styles of those completing the program. 2. Goals and objectives of T.C.'s are very "middle class," stressing upward mobility, self-reliance, self-discipline and moral behavior; high level of espirit de corps among participants. 3. This is a low security treatment program; participants take care of themselves and other members; internal, non-violent discipline. 4. T.C. program graduates can be developed into staff for T.C. programs in some cases. 5. Program participants tend to identify with rehabilitative goals of the jail staff.	1. Only very few people respond to this type of therapy; there are many dropouts during early stages in the program. 2. Treatment methods conflict with traditional jail activities: (a) separate living facilities required (b) T.C. participants are separated from other inmate population for meals and work assignments (c) jail staff must permit T.C. to operate somewhat separately from the rest of the jail, likely to cause concern at the jail during program initiation 3. Treatment takes a relatively long time compared to the length of stay at most local jails; usual time for completion between six and eighteen months. 4. Good staff hard to find; often must develop own or acquire staff from another Treatment Community.

to benefit from treatment, the jail should see that there are provisions for treatment continuity following release from jail.

Use of community agencies. Since the availability of a variety of psychological services is more useful for effective treatment of inmates than just one technique, and since most local jails have high turnover/short stay populations, the use of existing community treatment services as part of "in-jail" services is recommended as the most efficient way to provide service. Most communities have agencies which provide counseling. Further, most of these agencies do not charge jails for providing services. These agencies are in a better position than most jails to provide a variety of counseling activities because the staff is present. Initiating inmate treatment with counselors from community programs also improves the chances for therapy to continue beyond release from jail. Those jails in particular whose population profiles (LOS) fall into the short or medium category, should consider using outside agencies to provide service to inmates. Jails holding most of their inmates for longer periods of time may find it programmatically sound to develop "in-house" programs. Those jails developing in-house psychological treatment services should make some provisions for continuity of service for the inmate upon release. Optimally, it should consist of either a follow-up program operated by the jail or an active jail program for placing inmates in community treatment. Even where the lack of time or money does not permit direct treatment, a local jail, nonetheless, has both the opportunity and the responsibility to identify problems and needs and, at a minimum, attempt to initiate treatment with the help of community agencies.

CHAPTER EIGHT

A VIEW FROM THE INSIDE: PERCEPTIONS OF JAIL PERSONNEL AND INMATES

ADMINISTRATORS AND TREATMENT STAFF

Although most administrators thought their jails and programs could be improved upon, in general, a sense of pride in accomplishments, many of which had occurred in spite of major obstacles, was evident. We asked key personnel to provide us with their best ideas for the creation of drug-related treatment programs. Some of the respondents talked at length and in detail, indicating they hoped their ideas might find their way into practice--if not in their own jail, then in some other place. Others had difficulty seeing beyond the overwhelming configuration of problems that they face on a day-do-day basis. What follows, then, is the advice respondents would give to their fellow jail administrators who are thinking about starting a drug treatment program at their facilities.

The responses dealt with what respondents saw as among the critical issues surrounding drug treatment, including causes of drug abuse and its relationship to criminal behavior, the role of the jail in dealing with drug abuse, the relationship between the community's treatment resources and the jail, treatment alternatives, and priorities. In addition, jail administrators pointed to practical issues like staffing, funding, and public relations. The responses of these informed informants reflect lessons learned through the development and operation of their drug treatment efforts. Their comments provide a realistic appraisal of some of

the pitfalls that may face an incipient drug treatment program. An analysis of their responses suggests that most administrators were able to identify needed areas for change. Their responses were influenced by a wide variety of reality factors and their personal philosophy about the mission of the criminal justice system. The more obvious reality factors include:

The current organizational and operational aspects of the jail

The nature of the jail population, in terms of transiency

The administrative focus, that is, law enforcement or corrections

The funding base and the availability of external funding sources

The quantity and quality of community-based human service resources

The nature of the interface between the jail and other units in the criminal justice system

The larger community attitude concerning punishment and treatment

The nature and quantity of the community drug abuse problem and, more particularly, the special features of the community (e.g., port city, border town, high unemployment, etc.)

The tradition of community volunteering in respect to service provision

The locus of jail control (city, county, or state level)

The experience, background, and information base of the respondent

It is apparent that administrators could not be of one opinion on these issues. As a result, conflicting advice is available to jails considering drug treatment efforts. For example, some administrators suggest direct treatment approaches such as group and individual counseling. Other administrators argue that the more viable answers lie in better vocational and educational programming. These differences of opinion are to be expected in light of the factors enumerated above and

the limited amount of available knowledge about the etiology and treatment of drug abuse. In addition, there are a variety of opinions concerning the appropriate role of the jail as a service delivering agency. While some jail administrators perceive jails as an integral part of "corrections," others view their primary function as custody, with treatment the responsibility of the community or other institution. Still other administrators are ambivalent about the jail's role and think that it should be up to an informed public to determine whether jails should be involved in treatment and rehabilitation.

The bulk of this chapter consists largely of the words of administrators and jail treatment people. Each quotation was recorded by this study and represents, to the best of our knowledge and interviewer skills, the voices of jail staff.

Drug Abuse

Defining the Problem. There are a number of questions that a jail may wish to answer before embarking on a major drug treatment effort. One jail administrator told us that before you can really do anything else you have to define "drug abuse." Another jail administrator indicated that in addition to the definition problem, it is important to determine what the inmates really want. According to that respondent, "Many inmates accept their fate and claim they don't want to be changed. Unless the population is evaluated and their needs taken into account, no program will work."

Related to the issue of problem definition is the process through which such determinations are made. In other words: "How do we find out what the problem is?" One administrator put it very simply when he stated that "you have to get good information about drug abuse problems of inmates." In addressing the question of how that information is to

be obtained, the predominant opinion was that knowledge about the drug abuse problem can be obtained from "experts." While this opinion was qualified by administrators who warned about "quacks" and "experts who don't know anything," many administrators pointed to a need for professional knowledge and seemed to have faith that this knowledge is available. For instance, one administrator said that the first step is "to talk to the top professionals in the field."

What Produces a Drug Abuser? While only a few administrators commented on the causes of drug abuse, their statements are of interest. The remarks of one administrator reflect some thought into the causes of abuse and enabled him to justify a series of programs and services. He said, "Detoxification for the drug abuser is not enough. You must change the culture. Drugs are a cultural problem and a dependent personality has a hard time coping with his environment." Another administrator, in suggesting a need for vocational and educational programs, pointed out that drug abusers are "poorly trained," which is their "real" problem. Without locating the causes of drug abuse, another administrator cautioned against the common practice of associating drug abuse with criminal behavior.

Community Resources. There is a significant division of opinion on the extent to which the jail should rely on resources available in the community. One position expressed in a number of jails is that utilization by the jail of community resources is absolutely vital to the drug treatment effort. One small-town sheriff said, "Use everything and everybody available. You need personnel. Everything from the Ministers' Alliance, Alcoholics Anonymous, the county bar association, and the county medical society should be used." Another highly pragmatic administrator confided, "if someone is doing something to help at no charge

to the jail, take advantage of it. Try to stay flexible." Another response, but one also favoring utilizing community resources, sees the use of these resources as a way of getting inmates out of jail and back into society through community-based corrections. For example, an administrator suggested, "Get the program out of the jail and back into the community." Others made practical suggestions for working with outside organizations. One administrator pointed out that the jail can "use local and state government agencies to coordinate service and to act as intermediaries for the jail with the community." It was also suggested that the time to look at the community's resources is during the assessment process; the jail should "look at what facilities are available from outside sources--federal, state, and local" before developing a program.

A number of respondents took an opposing view, expressing serious concerns about working with community agencies. A typical comment was "if the drug abuser problem warrants attention, put someone on the staff half-time or more if necessary, because it's better than volunteers or an outside agency." More specifically, one respondent advised, "Don't start with community-based programs in which inmates are transported outside the jail because you'll have security problems, contraband, and inexperienced counselors." The issues of who should be in charge and accountability also arose: "Jails should have their own treatment center or program--or have control over one." Another jail administrator reflected on some basic issues of competency: "Stay away from using drug treatment programs as a diversion to a non-jail facility because drug counselors are being conned by inmates. Treatment can take place in the jail." Several jails made general mention of "accountability." Frequently, the comments took the following form: "Programs in the jail should be accountable." It would seem that some of the resistance to community programs can be

overcome if the jail is given assurance that agencies will do what they say and if the jail also has some contributing role in the program.

Developing Treatment Alternatives and Strategies

The Role of the Jail. It is important to consider treatment alternatives and the role of the jail simultaneously, because very often the jail's perception of its role will determine the kinds of programs which will be considered. For instance, one jailer who clearly perceived a need for treatment in the jail but was somewhat frustrated in attempts to provide rehabilitative services pointed out that "you need doctors and psychiatrists and time to work with the inmates." Several other jails mentioned the need for both medical services and counseling efforts. Other jails felt that the drug treatment effort should not be separated from other services in the jail. In a sense, the attitude reflected was that drug abuse is not a distinct problem in and of itself but may be a product of, or connected to, other problems which the individual exhibits. The following response articulates that point of view: "Don't separate drug treatment from general rehabilitation. Emphasize such services as work furlough and job counseling." Another administrator advises that "you should emphasize employable skills, training, and community resocialization." A few jails pointed out that a base level of medical service is needed, but it should be the only direct service dealing specifically with drug abuse. For example: "Limit it [drug treatment] to medical detoxification and improve general jail programs for vocational, educational, and psychological counseling."

One of the respondents who wanted to see more community-based corrections suggested that when the inmate returned to the community there should be a "variety of treatment models tailored to individuals in the

community" available to pick up where the jail program left off.

There was a mixed reaction to the utilization of group counseling in jail. Several administrators gave specific arguments against group counseling. For example, a response of one administrator was "Don't go into group counseling--the addict is the responsibility of the community. About all you can do in the jail is ask the inmate what drugs have been given him." Another jail administrator expressed a strong negative opinion of group therapy, stating, "avoid group therapy because it will only arouse tension . . . use one-to-one counseling instead." These reactions to drug group therapy, in particular, reflect an opinion that was heard a number of times throughout the course of the study. It was succinctly stated by an administrator: "We gave up our drug groups because they turned into bull sessions where inmates sat around and told war stories. Now we have our groups keyed in on core issues, and we don't talk about drugs."

The type of facility can often determine the role of the jail. One administrator noted his belief that "if it is just a detention center, you should just provide detoxification and stabilization. He'll be out before you can do anything else." Another respondent noted that "it's not the function of this type of facility. All you can do is recognize the addicts and what you can do in the appropriate facility."

Finally, one administrator noted that "transient populations of addicts are not subject to much rehabilitation. Jails should open up to the community and have [their] role in rehabilitation determined by an informed public."

Priorities. Many jails noted that the number-one priority of a drug treatment effort is to provide medical detoxification. This is seen as the minimum amount of service that should be provided to the drug-abusing

inmate. As we have stated, a number of jails believe in expanded programs ranging from individual and group counseling to vocational and educational training. Others noted that crisis intervention and referral should be included in the jail's priorities. Some jail personnel did point out that their major priority was to get as many people as possible out of the jail (except for those that are a "serious threat to the community") rather than to provide extensive treatment in the jail. Some respondents noted that security considerations were top priority and, in those cases where custodial needs interfered with treatment, that the latter should be altered. A comment by one administrator, important in light of the years of neglect surrounding jails, was: "Drug abusers are only one part of the inmate population . . . The entire jail population needs services--not just drug abusers."

Staffing. Personnel in many jails stressed a concern for professionalism in staffing drug treatment programs. One administrator noted that training was especially valuable; another said it was important to have trained specialists. Education and work experience in law and with police were also listed as desirable qualities in drug treatment personnel.

Other administrators were especially concerned with "institutional considerations" in seeking staff. An administrator advised, "When hiring counseling staff, institutional limits must be dominant. Look for experience in an institution, working within the correctional setting. Don't get a lot of 'do-gooders' in." Another area of concern was staff-inmate relations; these were described as "critical to any jail program. Without good rapport here there'll be no confidence or trust on either side and, therefore, no effective delivery of services."

Because correctional staff and professional staff must get along

with each other, one administrator suggested that custodial staff and professional (i.e., treatment) staff be integrated. (Our study identified one jail where all custodial staff were trained probation officers in the county probation department). Other jails indicated that adequate security precautions are the source of much conflict between the two groups, and security must be established before the custodial staff will support programs. One jail administrator expressed this point clearly: "Make certain that security problems [both escape and protection for the staff] are well in hand first; otherwise, there will be no support from the custodial staff. The political liability of 'corrections' in the jail is that, if something goes wrong with part of the program, it may pull the whole house down. You have to satisfy your 'right-wing element' before you begin liberal programs."

Screening. Screening for various purposes was recommended by many jail administrators. Jails should "provide screening diagnosis procedures and information sources that would be available to the courts." This could facilitate the diversion of drug abusers to appropriate programs. This is reflected in the suggestion that a strong classification system "is a basic element in any good correctional system" and that it is necessary to appropriately assess inmate needs. Another jailer cited a community TASC program as most successful and recommended that TASC perform its screening work in all jails.

Evaluation. Several jails stressed the evaluation component of treatment programs. One jail executive suggested that all administrators should, "make provisions for research and development [keep records, data, recidivist rates] so that we can determine the effectiveness of such programs. If things don't look good, look for change."

Public Relations. Some jails recognize a need to convince the public that treatment programs are needed. One jail made the following suggestions for gaining public support: "Keep on top of what is going on. Know your program and start small. [You] need imagination to get resources. You must sell the program to the public. Keep talking to civic clubs. Try to develop strategies to introduce the community to the program."

Funding. A commonly recited fact was that additional financial resources are needed in many areas and thet the absence of these resources causes problems related to program effectiveness. Grant funds to the jails or to agencies serving the jails present problems because of the undependable nature of the resource in relation to long-term planning. More than any other area of concern, the issue of where the needed financial resources were to come from loomed large. One jail made the following observation: "You need funds for designing programs. We have a grant preparation office in the county so the director of treatment does not have to spend all his time being a grantsman."

To this point we have reported, using words of administrators and staff, suggestions and recommendations for developing treatment programs for inmates with drug problems. The resources needed for such programs, discussed below, based on actual experiences within local jails and, as such, should be of considerable interest to other participants in local corrections administration and service provision.

Resources Needed

Respondents were asked to identify the kinds of resources that they thought would improve their jail's own drug treatment effort. The range of responses was broad, and it reflects the differences in jail conditions (as pointed out earlier) as well as differences in priorities and

philosophy concerning custody and treatment in the jail.

Screening. Most jails saw screening as a very needed resource. Different jails had different reasons for screening. For example, it was noted that screening was needed to determine whether medical attention should be provided--this from a jail that did not have medical screening. Others said screening is needed on entry to channel inmates into a range of services including psychiatric, vocational, and medical. Others felt that screening is needed for referral. A number of jails simply mentioned that screening is needed to identify drug abusers without suggesting specific uses for the screening. Most comments, however, indicated that screening should be tied to some service to the inmate and is not an end in itself as the booking procedure often turns out to be. Among the respondents who identified screening as needed there was no general accord on the range and type of services that might result from screening.

Detoxification. Detoxification was seen by some jails as a needed resource. The locus of detoxification was not uniformly agreed upon. In one jail it was felt that the detoxification center for drugs and alcohol should be run by the sheriff's department. This sheriff felt that since public drunkenness and illegal drug use were crimes, detoxification should be under control of his department. We found that other jails were interested in a coordinated local detoxification effort and were not uneasy if detoxification was administered by an outside service provider. One jail administrator suggested that the community really needed a street detoxification program where people with drug abuse problems could go voluntarily. Several jailers felt that detoxification was not the responsibility of the jail and that anyone with a drug problem should be given treatment before entering the jail. One

noted that what was really needed was a detoxification program that included counseling to prepare the addict for court or for release. The question of responsibility for detoxification is, of course, exacerbated by the fact that many persons who are arrested for crimes not drug-related may also be in need of medical care for their drug problem. Some administrators viewed only the reason for incarceration as relevant to the issue of where the inmate is detoxified; others tended to view the whole person--hence, the differences in perception on this issue.

Counseling and Therapy. Approximately 25% of the respondents in our sample noted a need for more personnel for counseling and therapy, but the type of therapy desired varied. For instance, one jailer was interested in providing a residential therapeutic community and group therapy sessions in the jail; other jails were interested in additional psychiatric services. One such jailer wanted a psychiatrist to perform an extensive interview to determine why the inmate became involved in drugs so that preventive techniques could be devised. It was generally noted that counselors frequently dealt with day-to-day inmate problems. As a result, one jailer thought that counselors should be freed from these day-to-day inmate responsibilities to be able to concentrate on therapy. Some jailers noted a particular interest in additional counselors but stipulated that this additional service be provided by jail employees rather than outside agencies.

Medical Services. Commonly identified was a need for more medical staff, additional medical resources, and more medical expertise in the drug area. Other jails reported a need for an expanded medical staff ranging from additional nurses or paramedics to providing 24-hour coverage.

Space. Space for provision of treatment was commonly cited as a needed resource. In general, most respondents qualified this by stating

that "appropriate" or "properly designed" space for medical treatment, social service, and counseling is needed. The need for space for outside organizations to interview prospective clients was noted frequently.

Community Resources. Additional community services and more cooperation were needed by many jails. The respondents expressed a need for community detoxification programs and closer contact with state and local welfare and social services programs. Some jails want services to be provided on a partnership basis between the community agency and the jail. For example, a need was expressed for community drug abuse counselors from the health and welfare department to come into the jail. Other jailers were more concerned with referrals to community organizations. One jailer explained that he would like "more halfway houses to come into the jail, explain their programs, and provide some kind of orientation."

Money. Most jailers, not surprisingly, expressed a general need for more money. Some noted that funds were needed to begin drug treatment programs while others noted that existing programs were "operating on a shoestring" and needed greater financial support. Almost always, confusion and uncertainty were expressed about the reliability of outside funding, given the changing priorities of governmental funding.

Obstacles Preventing Jails from Using Outside Resources

Respondents were asked which, if any, of their needed resources already exist somewhere in the community. In about half of the jails, these resources were reported to exist in their community. Respondents were then asked about the obstacles which prevent the jail from using these community resources. Most of the responses centered on a theme of negative attitudes.

For various reasons, the jails or the courts of jurisdiction have negative views of existing community programs. Sometimes it was simply a matter of priorities and interest. One sheriff told us that the jail was "too busy to be concerned about working with community organizations." Other respondents expressed concern with the ineffective "track record" of organizations that had come into the jail in the past or the lack of "follow-through" on the part of the community services.

The tendency of community agencies in the drug treatment field to employ former offenders and drug abusers represented a problem for some jails. The ever-present concern about security in the jail serves as the focal point for the exclusion of certain agencies which were described as "flagrant" in their employment of "ex-cons." In other instances, the objectives of the community agency are seen as antithetical to those of the jail, and exclusion occurs on that basis. More commonly, however, there is a lack of initiative, both by the jail and the community agencies, to establish a service delivery partnership. In some instances, the jail has taken the initiative, but, in the words of one jail administrator, "we'd like to have them come into the jail, but a lot of these agencies are 'gun-shy'." In other situations, agencies may feel unwelcome and, therefore, do not seek out such a relationship.

Program Effectiveness

Jail administrators were asked to highlight the factors that contributed most to their program effectiveness. Three general areas were identified: staff, service availability, and a detoxification program.

Quality of Staff. Twenty-five percent of the respondents indicated that their program effectiveness came about as a result of "good staff." For example, one jail noted the availability of a qualified medical

staff at a local hospital that provides medical service to the jail. Another jail praised the counseling staff for being very "sensitive." One supervisor of treatment staff reflected on the high level of cooperation with custodial staff. A similar response was noted by a jail administrator who commented on the fact that "TASC treatment staff got along extremely well with jail personnel."

Availability of Services. A number of jails indicated that the availability of a full range of medical, psychiatric, and social services contributed to program effectiveness. Another respondent pointed out that the jail had no "drug program per se" but that "the wide variety of resources available and the intensity of the counseling are the major factors contributing to effectiveness." A jail, reputed to have a well-organized medical delivery system through an arrangement with a local hospital, reported effectiveness due to "a good medical staff and the availability of the hospital, which has a security wing with 80 beds, plus 22 psychiatric beds." About one in six jails pointed to a good cooperative relationship with community human services organizations as a program strong point.

Detoxification. Some of the administrators reported that a good detoxification program was one of the jails' strong points because the "response time is speedy." One jail with minimal services noted that having detoxification in the jail was an improvement, but reserved unqualified approval by noting that detoxification caused some problems "because you're bringing drugs into the institution." The degree of "conscientiousness" in the efforts to provide detoxification to withdrawing and overdosed inmates was mentioned. The fact that the jail cited conscientiousness in providing detoxification is of interest. During the study interviewers at some jails noted that while mechanisms for

detoxification were present, cavalier attitudes towards persons with drug problems were adopted by some staff members. Clearly, having a mechanism for detoxification does not in itself insure that drug users will receive adequate attention.

Problems Related to Program Effectiveness

Respondents were asked to identify those factors which create problems relative to program effectiveness. In many instances, the problems identified coincide with resources needed, e.g., money, qualified staff, etc. Inability to control intake, case disposition, resource control at levels unconcerned with the correctional mission, and low esteem of the jail by the community were also cited as inhibitors of program effectiveness. Respondents also noted problems which included the attitudes of staff, client problems, security problems, the attitude of the public, and cost. If one were to chronicle all of the potential impediments to successful programming, each was identified as existing at some jails. The universality of problems facing jails and their administrators was one of the key findings of this study.

Staff Problems. Probably the most commonly expressed problem relating to program effectiveness was the personnel area. Staff problems can be broken down into three major categories: staff attitudes, staff qualifications, and staff allocation.

Staff attitudes seemed to be a problem which pertains primarily (although there are exceptions) to custodial staff. Since respondents included treatment personnel in addition to general jail staff, one might expect that the responses would be more likely to indicate that custodial staff had attitude problems. However, in many cases the negative attitudes of custodial staff were also questioned by sheriffs, watch

lieutenants, and wardens. While some respondents simply noted that the attitudes of some individual guards reflect a bias against treatment, other respondents were much more specific. According to one sheriff, "There is misunderstanding of what roles each position has. Guards have certain responsibilities with relation to programs. They don't understand or care." This sheriff pointed out that it was the responsibility of the custodial staff to see that prisoners enrolled in programs actually showed up when they were supposed to. Occasionally, guards shirk this responsibility. In addition, it was noted by others that guards occasionally took ad hoc punitive measures against those enrolled in programs. For example: While visiting a classroom at one jail, our interviewer saw a class with enrollment of 15 that had only six persons in attendance. The teacher (who also handled social services for the jail) noted that her students seemed to end up in solitary confinement with alarming frequency. She attributed this fact to the open dislike which the custodial staff showed towards the program.

Another problem area is staff resistance to change. An administrator pointed out that there is "resistance to change from longtime employees who don't help even though they don't do anything directly to hinder things." Another sheriff pointed out that there is "hostility from a punitive, custody-minded staff." These comments do include, in some cases, treatment staff, and one administrator particularly noted the resistance to change from "longtime social service counselors."

Another jail administrator noted that small salaries attract lower quality people and that this results in guards with negative attitudes and limited skill. "You get smart-aleck guards and jailers when what you need is guards who can work with people."

Several jails pointed to the difficulty in hiring qualified staff,

attributed in some cases to financial problems. In other institutions it was noted that a lack of care in hiring, inadequate standards, a limited pool of qualified candidates, political interference, low salaries, undesirable working conditions, as well as a host of other factors, impinge on the quality of staff.

One jail offered extensive comments on allocation of staff time. According to the respondent: "Counselors are required to handle minimal types of extra responsibilities and handle minute details for inmates, i.e., telephone calls, making appointments, being the inmate's route to services. This reduces time for counseling activities." Others indicated that a variety of problems emerged from rapid turnover of counselors, which hurt program continuity, and also meant that many of the counselors were inexperienced. In many instances, the staff were allocated to daytime positions, but problems emerged around the clock. Thus, counselors are frequently burdened with a "catch-up" problem, rather than being able to initiate new or necessary services.

Custodial Convenience. There are a variety of different issues surrounding the type of clientele--e.g., drug of choice, diversion programs, length of stay--that may diminish program effectiveness. One jail pointed out that "diversion takes all the easy cases. The ones left in jail are harder to work with." Another respondent pointed out that "time is a factor because it takes about three months for an inmate to get settled and you can really start working with him." The high rate of inmate transience, therefore, defeats the jail treatment program from the outset in the view of some administrators.

The concept of custodial convenience describes the relationship between jailers and inmates as one in which "everyone who can takes the

easy way out and makes only the minimal effort. . . ." Custodial convenience, according to the National Advisory Commission on Criminal Justice Standards and Goals, (1973:277), "also dictates a solution for the multitude of social and medical problems entering the jail. Here too, inmates are left to solve their mutual problems. . . ." In this study, we interviewed jail administrators and service delivery personnel who were actively engaged in activities other than "custodial convenience." That is, they and the jails were providing direct medical, psychological, and social services to a definable population. It follows, then to ask: "Does this active stance make a difference to the management of the jail or to the interpersonal relationships between inmates as expressed in disruptive behavior or inmate fighting?" The information we obtained was largely impressionistic. In most instances, the opinion of the respondent was confirmed by another person at the same facility and, in some instances, by direct interviews with inmates. We were able to get useable responses from approximately 60% of the jails studied.

In general, the introduction of drug-related treatment in a jail was associated with either less (43.6%) disruptive behavior or no change (53.8%) in the amount of disruptive behavior by inmates in the jail. Less than 4% of the respondents indicated that inmate violence was worse as a consequence of new services. Staff morale was reported to have declined in 13% of the jails which initiated drug treatment, while it improved in 35%. Administrative problems were perceived as increasing in 15.6% of the jails reporting, with no change reported in 61% of the jails responding.

Indeed, an administrator could find supporting data to argue for the maintenance of the "custodial convenience" approach to jail management even when initiating drug treatment programs. Our data suggest that positive

changes occur in terms of inmate violence and only limited problems emerge in staff morale and administrative matters.

Program Evaluation. A number of jails told us that they were concerned about their programs because there was no adequate mechanism for evaluating its effectiveness. Comments include: "There is no evidence that our program is effective. Since there is no follow-up, there probably never will be any evidence"; "[there is] no real follow-up and, therefore, no evidence of true effectiveness"; and "we don't have any control groups."

Information Desired

We asked respondents what type of information they would like to have, as jail administrators, that is not currently available. The major need expressed was for measures of program effectiveness.

During the course of our research it became apparent that many of the jails in our survey are in need of considerable technical assistance in order to organize, upgrade, and evaluate the outcome of the human services delivery mechanisms which are part of their treatment effort. Our field interviewers continually received requests from the jails for assistance and information related to the development of community services relationships and devising additional strategies for improving the quality and performance of the jail's program. Other information desired included how to screen for drug abuse, how to get funds to support program development and retention, and how to control drugs in jail.

In addition, a number of jails attributed part of the problems they face to the community attitude regarding offenders. One jail lieutenant stated: "There is no community interest in rehabilitation. . . . they have a punitive philosophy. They are not willing to spend money to help

people--only to punish them." Another administrator reflected, "They don't give a damn what we do as long as we don't create any problems. There is a lack of direction from society." Finally, one outspoken treatment supervisor believes that there is a "lack of public knowledge, interest and support. 'Salt em away and I don't want to hear about it'. It's just a question of priorities."

THE INMATES' PERSPECTIVE

We asked inmates to comment on the strong points of the drug treatment program in their jail. Their comments were very sparse; most inmates indicated that they were dissatisfied with services in their jails. Negative comments were sometimes specific but were mostly general criticisms about the programs or lack of programs. Comments included are:

"Services are ------ [expletive deleted]. They give them ------ when they want to."

"What rehab program? There's no rehab program here. I've been in a lot of jails and this isn't a bad jail--but there's no rehab program."

"They do help [detox] once they recognize the need, but it's spasmodic."

"I've been going to groups [counseling] for years. The only place that had anything to offer was ------ [a therapeutic community]."

Favorable comments include rather outspoken approval of professionalism by one inmate who stated, "The groups with psychologists and psychiatrists are fine. Doctors have it together. Doctor ------ is really good, but he's leaving."

One inmate praised methadone detoxification even though he felt it was too short. He said, "at least they give me methadone for 21 days. . . . so I can get through court."

Treatment Programs Available

Inmates at the same institution generally reported similar information concerning what programs are currently available for drug treatment. In addition, at several jails there was agreement among inmates interviewed that there were no treatment programs for inmates with drug problems. Throughout our study we have considered general services to inmates like education, work release, and social service counseling as part of the drug treatment effort. It is significant to note that inmates frequently mentioned these services as part of the drug treatment program. In addition, the most frequently mentioned services were methadone maintenance and detoxification for those previously enrolled in a program and individual and group counseling. A few inmates noted that while there were few programs actually in the jail, community programs did come into the jail to screen for potential clients.

While most of the jails where inmates were interviewed had a detoxification effort, inmates rarely pointed this out as part of the drug treatment program. Inmates generally consider detoxification for all opiate addicts as necessary and obligatory medical care and are critical of jail efforts in this area.

Impression of Programs

One of the critical issues regarding methadone in the jail is that of of fairness. As one jail administrator observed, it is difficult to justify giving methadone to one addict simply because he is enrolled in a program and deny it to another addict in the next cell. Several inmates observed that methadone treatment is desirable but that it should be available to all opiate addicts rather than just those who are enrolled in a street clinic.

Changes

We asked inmates to suggest changes in the drug treatment program at their jails. Here we received the most comments. Some of the comments, however, indicated the "hidden agendas" of inmates, and frequently these concerns were only peripherally related to drug abuse. For instance, furloughs for married men is a somewhat questionable suggestion as part of drug treatment while it may indeed be a legitimate service that a jail might provide.

Many of the inmate concerns centered on better detoxification. Some inmates were concerned about the immediacy of the responses suggesting that "they attend to you the day after you come in with valium, methadone, sugar, and stomach pills. . . .at least you'll know they were trying to help." Other inmates suggested that methadone be available for all inmates withdrawing from drugs--not just those previously enrolled in a street clinic. A few inmates were concerned about the level of professional competence exhibited by medical personnel. As we have discussed earlier, nurses, paramedics, and others often administer prescription drugs. In addition, custodial staff is frequently expected to detect drug abuse. One inmate called for "a medically responsible person, oriented to drugs and able to recognize the various symptoms." Finally, inmates asked for medical checks for all newcomers to the jail. This is consistent with the concerns of some jail and treatment administrators who were interested in providing physical examinations for all inmates.

Inmates have picked up the rhetoric of community corrections. One inmate effectively articulated the philosophy of community corrections when he stated, "community-based programs would be much better. The jail atmosphere is poor, and inmates are all committed to different lengths of

time. The jail atmosphere is impersonal."

Environmental factors are often believed to be associated with drug abuse. One inmate recognized this explicitly and said, "What they should do is give you a good job in jail that would prepare you for release and job placement. When you get out you need something to motivate you on the job so that you don't go back to using drugs."

A few inmates presented a shopping list of services. One suggested "a special counselor who knows about drugs, detoxification for all that want it, a psychiatrist, and vocational training."

A number of inmates were concerned with staff considerations. Generally it was felt that the staff should be "concerned" about the inmate. According to an inmate, "staff should not be 'grudge-bearing' and prejudiced. They should give a damn." In addition, inmates felt that effective drug abuse counselors should be "people with some experience with drug problems."

One policy question raised by the inmates' impressions of programs concerns the responsibility of the methadone program for its patients even after they are arrested. One inmate who has been enrolled in street methadone programs since 1971 argued that methadone detoxification was too rapid. According to this inmate, "It [detox] should take longer than 21 days. To get me strung out for four and a half years and then bring me down in 21 days. . . ." It is clear that policies regarding methadone for patients in jail vary from place to place. Responsibility for determining whether an inmate will receive methadone detoxification or maintenance now depends on the discretion of both the jail and the treatment program and, occasionally, court order.

A number of inmates expressed a concern about methadone as a treatment modality. Administrators, we found, sometimes offered similar opinions.

According to one inmate, "Methadone is a mistake . . . the whole thing is political. The clinic is a good place to sell. . . Methadone shouldn't be compatible with heroin . . . but it is."

As we have stated, most jails offered some kind of detoxification service. However, inmates feel that time is the most critical element in the provision of detoxification. One inmate noted that detoxification of any kind is slow in his jail. "It was really bad. It took three days to get methadone. It took two days just to get a 'kick pack' . . . They just sign you off. They get you on it when they want you on it. If you bitch too much, they throw you in a rubber tank. When they refuse you, you get angry. Instead of helping you, they ignore you." Another inmate noted that "the schedule doesn't meet the needs of inmates. Medical skills aren't sophisticated and the whole thing takes too much time."

Not all inmates are convinced that detoxification is a pressing issue. One inmate notes that if you're not in a methadone program "all you get is Valium for five days. Basically, that's just abstinence . . . apparently it doesn't kill people."

Screening addicts for detoxification has been a consistent problem for jail administrators, one with which inmates are familiar. According to one inmate, "Everybody says they're hooked . . . even the guys that aren't hurtin'. They don't know how to find out who's addicted and sift them out. Three-fourths of the guys would take a fix if they could get it."

Inmates expressed a wide range of views regarding the usefulness of drug counseling. It has been noted by jail and treatment officials that one of the strong points of the drug treatment program was an individualized approach to the inmate. Inmates also seem to respond favorably to this approach. For example, "Counseling is good because of the attention

program or service because it was "too new to evaluate." In addition, many new programs or facilities have an incremental growth component in the sense that one change will lead to further changes in the jail. For example, jail administrators occasionally told us: "We're completing a new jail. When it's finished we are planning to hire more medical staff," or: "When our renovations are complete, we shall have room for private counseling services."

Many of the new programs are experimental, not firmly a part of the administrative structure, and/or funded with temporary "seed" money from various units of government. Since such programs often do not have a continuing commitment from jail administration, their future is often uncertain, and abrupt termination of activities is frequent. We were not able to find out in every case why a program ended, and usually it was only possible to get one side of the story.

The list below documents by category the wide range of changes that were identified in the course of our visits to communities and their jails. These changes can be characterized as improvements relating to housing; provision of human services such as health, psychological, social, educational, and legal; staff training; re-entry assistance; and use of volunteers. Although our focus was on the drug abuser, it is apparent that most of the changes will impinge (hopefully for the better) on the lives of all incarcerated people in the particular facility.

Improved Facilities

--new jails under construction or additions or renovation in progress (Lawrence, Kansas; Louisville, Kentucky; New Orleans, Louisiana; Minneapolis, Minnesota; St. Louis, Missouri, Lawton, Oklahoma; Provo, Utah; Little Rock, Arkansas)

--a new jail building planned (Gretna, Louisiana)

--new recreation building, including air conditioning (Rockville, Maryland)

--facility renovated and services upgraded following change in administrative responsibility (Kansas City, Missouri)

Health Facilities and Screening

--an automated health screening unit acquired which should improve services and aid in detoxification (Clayton, Missouri)

--following renovation in progress, a new medical clinic to be opened and additional staff hired (Minneapolis, Minnesota)

--plans developed to open a methadone maintenance program in the jail (St. Louis, Missouri)

--increased medical staff with the addition of physician and nurse interns for intake and follow-up unit (Cleveland, Ohio)

--medical detoxification initiated following court order (Decatur, Georgia; Detroit, Michigan; Cranston, Rhode Island)

--experimental work in progress to develop medical placebo for gradual detoxification (Cleveland, Ohio)

--paramedics hired to serve screening function following court order (Indianapolis, Indiana)

--agreement with hospital to provide comprehensive diagnostic testing linked to the drug treatment effort (Birmingham, Alabama)

Psychological and Social Services

--sentenced inmates diverted to non-jail drug therapeutic community (Nashville, Tennessee)

--initiation of group counseling by permitting outside agency to serve jail inmates (Chesapeake, Virginia; St. Augustine, Florida)

--expanded social service counseling and referral with the addition of diagnostic and classification services (Doylestown, Pennsylvania)

--family counseling program established (Smyrna, Delaware)

--guards trained as group leaders for guided group-interaction programs (Smyrna, Delaware)

--expanded crisis intervention counseling with the addition of paid staff members (Omaha, Nebraska)

--an expanded psychological and social services program initiated as a result of a large LEAA grant (Riverside, California)

--counseling received by inmates on outpatient basis in the community (Provo, Utah)

--therapeutic community planned for the jail by community treatment agency (Salt Lake City, Utah)

--drug treatment group in county working with pre-trial inmates not otherwise eligible for diversion (Tucson, Arizona)

--comprehensive rehabilitation program established (Pontiac, Michigan; Wichita, Kansas; Philadelphia, Pennsylvania; Atlanta, Georgia)

--drug therapeutic community available to inmates (Winthrop, Massachusetts; Baltimore, Maryland; Miami, Florida)

--formation of self-help groups to attempt to deal with drug problems (St. Paul, Minnesota)

--extensive law libraries for inmates established (New York, New York; Newark, New Jersey; Houston, Texas)

--position of volunteer-services director created to coordinate volunteer program in the jail (Memphis, Tennessee)

Community Re-entry

--expansion of pre-release center capacity with focus on community re-entry services (Rockville, Maryland)

--initiation of a new program to refer inmates to cooperating community agencies for re-entry counseling (Los Angeles, California)

--program initiated by local YWCA to find housing for women released from jail (Buffalo, New York)

--job preparation program operated by women's community service organization (Albion, New York)

--pre-release employment training offered to upgrade inmate's record and enhance his employment potential (Kansas City, Missouri)

--establishment of a referral agency coordinating all drug abuse treatment agencies used by the jail to aid re-entry (Anchorage, Alaska)

--establishment of a residential halfway house program with counseling services inaugurated (Salt Lake City, Utah)

--development of an intensive pre-job orientation and placement program as part of community re-entry program (Doylestown, Pennsylvania)

The designation of a new facility frequently means the replacement of an old, inadequate facility with a more modern, and often larger, facility. At some jails, however, the building of a new facility was premised upon the implementation of new or expanded services for inmates. For example, Gretna Parish Prison in Louisiana was not only building a new facility, funded in part by LEAA, but the professional staff were planning major changes in inmate services and designing a building that would facilitate the operation of the new program as well. More recently, LEAA has provided funds to help the Rhode Island Medical Center

to create an intake, placement, and tracking system for persons who have entered the criminal justice system with drug abuse problems.

Often the institutions reporting changes were those that already provided a relatively extensive level of inmate services, but in some jails the changes reported represent a significant change in policy from little or no services to an attempt to provide a comprehensive program of services.

Most of the changes involve the addition or expansion of programs or services that had proved their utility or feasibility at other jails. At a few jails, however, the services being implemented represent services which have never been tried at jails. For example, St. Louis City has applied for a grant to initiate methadone treatment in the jail. Other changes represent the initial use of relatively new technology at jails, e.g., the automated medical screening and diagnostic equipment being employed at the St. Louis County and Los Angeles County facilities.

Not all changes involve the improvement or addition of services. For example, problems of cooperation between the jail and community agencies have led to the abandonment of some programs. Also some jails reported building new facilities which provided for either no service areas or less adequate service areas than in the previous structure.

In considering the numbers and types of change in jails, one is impressed by the extent and nature of new programs. It is important to repeat again, however, that our sample does not represent the universe of all jails, but, rather, represents jails that identified themselves as having programs for drug abusers. Without having comparative data, we might expect, nevertheless, to find jails which have attempted to provide or expand services for drug abusers to be, more change-oriented than jails which have done neither. Indeed,

from a human services delivery perspective, our sample was probably representative of jails which "were doing something" for inmates. We cannot claim these findings are representative of all jails, but we can report that positive things are happening--some reflect the recommendations of the National Advisory Commission on Criminal Justice Standards and Goals (though not necessarily a consequence of those standards), some due to the influence of federal funding through LEAA and NIDA, still others a result of the changing attitudes of jail administrators and the political sector, and some stem from the mandates of the courts.

CHAPTER TEN

ALTERNATIVE ORGANIZATIONAL ARRANGEMENTS FOR SERVICE DELIVERY IN JAILS

Formal Organization and the Criminal Justice System

The criminal justice system in America today consists of the operation of multiple formal organizations, each of which is a discrete but interdependent subsystem. Within the administration of justice system one finds police, prosecution and defense, courts, jails, probation, prisons, and parole (to name only the major components). All of these organizations are interconnected and, to a considerable degree, have the scope of their activities determined in part by the other agencies' activities. For example, police and court activity control the intake and flow of jail population. The presence of drug treatment program capabilities within a jail is largely dependent on whether the jail receives any inmates with a drug problem or whether, instead, another part of the criminal justice system diverts such individuals elsewhere directly into the community treatment. Thus, the population which the jail receives for treatment and the nature of that population's needs is determined elsewhere in the system. A change in bail practices, utilization of release on personal recognizance (ROR), TASC programs, summons in lieu of arrest, pre-trial diversion, and a host of other strategies initiated and operated by other elements of the criminal justice system affect jail admissions, service needs, and the variety of jail services provided. Thus, liaison between the jail and other subsystems is vital to the fulfillment of its mission.

In addition to interdependence, policy constraints affect organizational capability to perform specific functions. Depending on its basic organizational objectives, the jail will develop either internal capabilities or will work toward establishing cooperative arrangements for performing specific functions. For example, if the jail has defined its official goal as that of rehabilitation, there may be certain strategies developed to assist in the rehabilitation of specific categories of offenders. If the goal, on the other hand, is custody alone, it is unlikely that any human services related to rehabilitation will be offered.

As the jail attempts to meet its broadly conceived goals, it must also concurrently develop appropriate interagency relationships. To attain the objective of rehabilitation, jails must develop cooperation with the court so that appropriate dispositions (related to length of stay, sentencing conditions, etc.) are forthcoming. The jail may need to rearrange the structure of its own organization if it is to utilize resources of other community services. It may also establish a related objective, that of obtaining outside professional and political support. And further, public awareness that the jail is in the business of rehabilitating inmates, in addition to confining them, will affect some police practices and public expectations. The total interdependence of the criminal justice system becomes obvious from the perspective of the jail in terms of who comes into it, who stays, who leaves, and under what circumstances.

When the jail modifies its own objectives (such as the initiation of additional treatment strategies for inmates with drug problems), changes can occur in the organizational structure of the jail itself. This happens because goal changes alter the need for resources, modify the internal justifications of such matters as type and level of staff

commitment, affect staff morale, affect inmate attitudes and behavior, and, of course, have an impact on the actual activities which occur within jail. In our study of the treatment resources of local jails we have observed evidence of all of these effects.

Where the attainment of the jail's objective dictates the involvement of outside service delivery, the possibility exists that a new configuration of interactional elements will come into play. For the jail, this may involve a radical departure from historical precedents insofar as utilization of the community resources is concerned. For the community human services agency, the new interaction may require a broadening of its service delivery perspective to include incarcerated individuals and a "reaching out" approach to involuntary clients. Both the jail and the community agencies will be faced with the parameters of the other's goal expectations, which are mutually affected by their reputation systems and the disabilities or strengths that may have lingered from any prior interactive involvements.

Organizations in various interactive arrangements work most successfully when each unit perceives the combined efforts as furthering its own goals. For the jail, this means it must have one or more unattained objectives, such as providing specific services to inmates. Next, the jail must establish access to agencies which have the ability to provide services directed at resolution of the problem. For example, a jail administrator may want to reduce suicide among inmates. Having observed that suicide and "cold turkey" are potentially associated, the decision is made to provide detoxification in the jail. A medical agency response may be negative to the provision of detoxification in an unsupervised, cell-block environment, and thus the jail administrator is thwarted in

this service provision goal. On the other hand, for a community drug treatment agency, the provision of detoxification services may be one of its integral functions, and the jail population may represent an added potential source of clients. Therefore, the treatment agency may be anxious to establish a cooperative working arrangement with the jail in order to continue or expand its mission. These kinds of mutually interactive objectives can result in strong working relationships between organizations. However, there is evidence to suggest that such working partnerships are easier to describe than implement.

The Emergence of Jail Services

In the past, jails operating at the local level have provided few inmate services within the facility, even though such human services for the general population sometimes existed in the community. As jails have begun to redefine their role in the criminal justice system from one of isolation of inmates to retribution, deterrence, and, now, rehabilitation, they replicated some of the human services of the outside society inside the jail. Initially, clergy and physicians were invited into jails, and then, as other inmate needs were recognized, additional outside specialists began to provide services in the jail. In some instances, jails have added specialists to the full-time staff or developed specialists from among their own staff. In other cases, strategies have been developed to draw on resources from outside the jail organization. For example, contracting for specific services, utilizing voluntary organizations, actively seeking additional funds (by grant application) for special tasks, and allowing third-party diagnostic services and referral agencies into the jail to screen inmates for needed services are some of the techniques which have allowed for expanded jail services at one time or another.

These variations in interactions between the jails, local drug treatment programs, hospitals, drug addiction agencies, and mental health agencies have all been documented in this study. In many instances, we found that jails themselves provide most of the usual serivces including screening, detoxification, counseling, and social services. In other cases, we found that factors such as concern within jails to meet rehabilitation goals, external pressures from community agencies intent on expanding their client base, or court-mandated jail services have led to a complex of arrangements for the provision of services to inmates.

Another aspect of service delivery which must be considered is a description of the administrative arrangement of the jail as it related to local government. Many jails are under the administration of a sheriff; some are operated by administrative structures other than law enforcement units, such as a city department of corrections or a county department of health and welfare. In this study, 67% of the jails were under the administration of a law enforcement agency (typically, a sheriff's department); 25% were under a department of corrections administration; and 8% were under state control for the custody function. We found that jail orientations and provision of services vary significantly depending on the administrative arrangement under which the jail is operated. At one extreme, we found administrative postures which reflected a "we're in the custody business" or "we are not in the drug treatment business so there is no reason to go beyond what we're doing now" position, in which rehabilitative activities receive low or no priority. At the other extreme, we identified administrative postures which exhibited rehabilitative and inmate advocacy-oriented positions. In turn, these positions were reflected in the organization, staff, and tasks, as well

as, in many cases, cooperation with outside service providers.

A Typology for Service Delivery

In the course of the study it was observed that jails vary significantly in the range and scope of services provided to drug-using inmates. In-depth interviews conducted with jail administrators, treatment personnel, and some community agency personnel have provided the data from which we have developed a typology depicting the organizational arrangement for service delivery of drug treatment resources in local jails. The typology provides descriptively for four different organizational arrangements utilized by jails for the delivery of treatment to drug abusing inmates. From the model we can describe how the jail assembles resources to provide inmate services as well as describe the locus of the services. Through identification of administrative responsibility, the typology takes into account the jail's role in service delivery as well as that of non-jail organizations. The elements of the typology are classified as follows (see Figure 10.1):

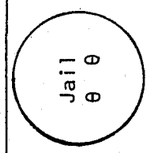
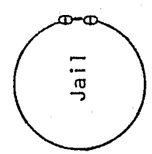
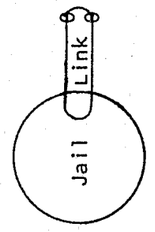
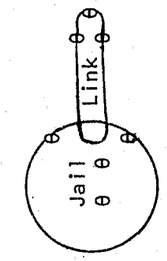
1. Internal System
2. Intersection System
3. Linkage System
4. Combination System

The Internal System

In the Internal System, all service delivery is administered and provided by the jail itself. There may be, for example, a social services unit, a hospital unit providing detoxification, psychological services with perhaps a therapeutic community, vocational training, education, and/or a work release program. Each of these programmatic activities in the Internal System is under the direct control of jail

FIGURE 10.1

A Typological Model for Jail Delivery of Services to Inmates

System	Primary Focus of Service Delivery System	Description	
Internal	Treatment while incarcerated	Jail Autonomous Service is administered and provided by the jail	
Intersection	Treatment while incarcerated, possible follow-up post release	Jail interacts with Outside Agencies. Service is provided by a separate organization which is in contact with the jail either by coming into the jail and providing services or by providing services at the outside agency's facility	
Linkage	Identification and referral for post-release treatment. Some service while incarcerated	Jail interacts with one Linkage Agency. A broker or linkage agency refers inmates from the jail to the service providers in the community	
Combination	Type varies depending on systems	Jail Interacts with Several Service Providers Concurrently. Two or more different conduits, including jail staff, outside resources, and brokerage arrangements provide services to inmates	

θ = Service Component

administration, and these services are provided directly by staff who are employees of the jail. The provision of service to the inmate in the Internal System is directed to the inmate while in the jail. The focus of service attempts to assist the inmate while incarcerated. In this system, there is minimal to no interface with community-based agencies for post-confinement service on any systematic and continuing basis. The range and quality of services provided is a direct reflection of the administrative mandate for a comprehensive program.

Several jails in the study can be classified as representing the Internal System.

Internal System: Example 1. An example of this system is a county penal farm serving a major southern city and its surrounding area. The farm jail has 500 inmates with sentences up to five years, although most stay between 9 and 12 months. The jail is somewhat unusual in several aspects. One remarkable feature is the large number of non-uniformed professional staff; another is the extensive screening and intensive diagnostic center in the jail. In addition, the jail offers a range of rehabilitative programs, some with a psychological and others with an overall human services orientation. Among these are therapeutic communities, individual counseling, and behavior modification programs, one with a token economy program. All programs are under the direct administration of the jail. This jail is an example of an internally run, autonomous unit providing custody and rehabilitative services to inmates.

Internal System: Example 2. Many jails have less ambitious levels of service for inmates but also typify the Internal System. A jail in northcentral United States, built to house 350 inmates and currently

overcrowded, serves as the initial intake facility for persons arrested in its county. The jail had been described as "little more than a human warehouse" prior to 1973. The jail had also been reluctant to work with outside organizations. Existing treatment programs in the past had been described as "ineffective, lacking in professional skill and too fragmented." With the exception of an education program run by a teacher from the board of education, no community agencies came into the jail. Prior to 1973, there were no social services at the jail. As a consequence of an LEAA grant, a social services program was established in the jail. The grant was given to the board of commissioners who preserved the jail's autonomy by naming the sheriff as project director. The social service program has three counselors for 509 inmates. Because of the overcrowding, social services are able to provide only a minimal amount of service, but the program represents a beginning. Its function is to deal with day-to-day problems caused by incarceration and to see that inmates don't get "lost in the system." In addition to social services, all medical services at the jail are internal with a staff of one full-time doctor, five full-time LPNs and three and one-half paramedics.

Internal System: Example 3. A third example of the Internal System is found in a major northeast urban area jail. The jail consists of a complex of three adjacent buildings. While all services are provided and administered by the jail and its organizational arrangement can be categorized in the Internal System, it departs from the model to the extent that this jail has continuous contact with a range of community services for placement of inmates upon release. The jail's services, all internally administered, include opiate and methadone detoxification, and a post-detoxification program including

evaluation, therapy, social services, and referral to community agencies upon release. All of these activities are administered by the jail under an LEAA grant. This program differs from the other jails previously described as examples of the Internal System in that the primary goal of the entire jail drug treatment program is directed toward the enrollment of inmates, upon release, in one of many community drug rehabilitation programs. Thus the major burden of the rehabilitative effort is born by community agencies while the major jail effort is directed toward development of inmate motivation to utilize community services. In addition, the jail program provides services beyond referring inmates to community programs; it acts as an advocate to the court, requesting court transfers of inmates, both pre-trial and post-conviction, to community programs.

It should be clear from the jail programs cited that the Internal System can provide comprehensive integrated services to inmates, but it requires a major commitment on the part of jail administration.

The Intersection System

In the Intersection System, services are provided to inmates by human services organizations not a part of the jail, based in the community, independently administered, and working cooperatively with the jail. The outside organization provides services (by fee, contract, or without cost) either by staff coming into the jail or by having the inmates transported out to the agency. This latter arrangement is fairly common, particularly in small jails where need for service is irregular and discontinuous and where the number of inmates to be served is too few to justify full-time specialists based in the jail.

Two types of jails exhibit the Intersection System: The first type provides no programs or services other than medical; the second type

provides a fuller range of services. In the former case, the medical staff is hired by the county hospital or a government health department which, in turn, contracts with the jail to provide inmate medical care. Space is made available in the jail so that the doctors, nurses, and other medical staff can run a clinic. Some jails provide infirmary space. Alternatively, inmates requiring medical attention are transported to a hospital. Whether in-jail or out-jail provision of medical service occurs, each typifies the Intersection System because a non-jail organization independently administers medical services. A cooperative arrangement between the jail and the hospital is established to provide services to the inmate. This Intersection arrangement for health care is likely to remain the model for the foreseeable future, since the National Advisory Commission on Criminal Justice Standards and Goals has taken the position that "correctional facilities must have access to an accredited hospital" (Corrections, Standard 2.6).

In the second type of Intersection System, the jail utilizes multiple agencies outside the jail to provide either one or several services. Two examples of this organizational arrangement for jail services follow.

Intersection System: Example 1. The first example is a large county jail located in a western area where there is considerable drug abuse, including extensive heroin abuse, much of which is concentrated in the metropolitan center. The city operates an outpatient methadone clinic. There is only one jail in the area. It is a maximum security facility with a sophisticated system of television monitoring and remotely controlled gates.

The jail houses both male and female prisoners including misdemeanants, felons, federal prisoners in transit, military prisoners, and some

juveniles. By state law, the maximum sentence for convicts at the jail is one year, but some prisoners do remain up to three years.

The staff is divided into two groups. The correctional staff wear one color of uniforms; the guard staff wear another color. The former are professional correctional officers, each of whom is required to have considerable (considerable by jail standards) professional training in corrections. The latter staff are sheriff's deputies whose primary function is custody.

Almost no services are provided directly by the jail. Instead, except for jail-employed paramedics who meet minor medical needs, all services are provided by outside agencies. Medical services are supplied by the county hospital. Psychological services are provided by the three local community mental health centers, each of which serves those inmates who reside within their service sector. Two health centers currently operate at the jail. Detoxification services (for the more severe cases) are provided by the city detoxification center. The major service specifically for drug abusers in the jail is provided by a drug referral counseling program, federally funded and run by the county board of health. Finally, an additional group of services, consisting of a diversion and referral program, is operated by court services.

One member of the correctional staff suggested that there may be important advantages to having service provided by community-based agencies rather than by the jail. He observed that since orientation of outside agencies was toward service to clients instead of confinement, they may often make better decisions related to the helping of inmates.

Intersection System: Example 2. A second example of the Intersection System can be found in very small jails where support for special jail staff would not be fiscally sound because the number of inmates to be served is low. One small county jail in the South West serving its entire county as both the holding and sentenced facility is typical. The jail occupies a separate building in a new county criminal justice complex consisting of jail and county courthouse and county offices. The jail itself is very small with a resident capacity of twenty-five, but a daily average of eight or nine people. The inmate population consists predominantly of Indians and Hispanics. The jail, in spite of the small numbers of inmates, has been able to provide a fairly wide range of services by utilizing available resources in the community. In the small town in which the jail is located, the state operates a community-based social services agency. Its case workers provide inmates with counseling, referral services for serious psychiatric cases (including paying for private care), and transportation to the nearest detoxification center (a 90-minute drive away). There was a time when the town had its own detoxification center, but this has been closed. The state agency has been cooperating with the jail for over 17 years. Medical services are provided by the local hospital, including emergency detoxification. Problems are relatively limited from the jail's perspective in terms of tapping outside resources. The jail reported satisfaction with the availability of services for inmates by utilizing outside agencies and noted only limited difficulty with the various community agencies.

In practice, the Intersection System is a very practical way for small jails to gain access to specialists, and an expedient organizational

arrangement for larger jails able to work with agencies which have capabilities not found within the jail. Coordination of services provides the major drawback. In small jails the jail administrator can easily keep track of who comes in and whether agencies meet jail and inmate needs, but in the larger jails integrating services and coordinating activities must be planned and operated carefully lest some inmates receive some services, others none, and still others less than necessary.

The third type in the model is the Linkage System. The principle focus of the Linkage System is to initiate the service process to inmates in the jail through screening, with the objective of placing the drug abuser in a community-based treatment setting subsequent to release at either pre-trial, post-conviction, or sentence completion. In some instances, the linkage agency will also arrange for service such as counseling to be provided to the inmate inside the jail. The core feature in the Linkage System is its orientation to service outside the jail through existing community services. Basically, the linkage agency is an inmate case finding and referral system for the human services community. With this arrangement only one outside human services agency has direct contact with the jail. The agency acts as a "link" or "broker" between the jail, the inmate, the court, and the various other community-based service organizations which, in turn, provide services directly to the inmate.

The important feature of the linkage arrangement, from the jail administrative perspective, is that it requires limited jail involvement in terms of service content responsibility, commitment of personnel, or responsibility for funding. This is so because, in the first place, the jail need deal with only one agency; and, secondly, once the jail decides to permit the linkage agency into the jail and provides some space

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for its activities, the jail's own direct involvement with service delivery ceases. In contrast, with the Intersection System which also involves no direct jail provided services, the Linkage System reduces the need for extensive interaction between the jail and other non-jail service provider agencies. Then, too, in the Intersection System the jail must respond with coordination and often may choose to become involved in program content, funding, and logistics.

An example of the Linkage System will make clear the limited jail involvement in service delivery, primarily because the substantial aspects of service are not provided inside the jail. Only the initial contact involving the screening of inmates by the linkage agency occurs within the jail, although in some instances, that agency does provide some inmate services prior to release. We turn now to one such jail.

Linkage System: Example 1. This jail, which holds only pre-trial inmates in a midwestern city, occupies one floor of the city's police building. It provides limited general medical services to its population of 136 other than eight-day methadone detoxification for both opiate addicts and methadone dependent inmates. Some measure of the increased numbers of drug-abusing inmates over the years is suggested by a medical account of numbers detoxified. In 1966, the jail detoxified 50 addicts; by 1974, this figure was up to 2,700. No jail-operated services existed in the jail until an extensive screening program for service provision to drug-abusing inmates was provided by an outside agency. This comprehensive screening program and service referral links the jail and its inmates to community treatment agencies. Hence, this jail's organizational arrangement for providing service to inmates represents the Linkage System. The actual screening program consists of six full-time

counselors working in the jail to identify and evaluate all inmates who appear from arrest records to be drug abusers. If a person is charged with a drug-related offense or admits drug usage upon arrival, or if the inmate exhibits appropriate symptoms, he or she is interviewed by the screening counselors. After identification, a psychosocial evaluation of the inmate is conducted, and then, depending on the case and circumstances, recommendations are made to the court concerning disposition. Where the court rules that the inmate can be released to the custody of this linkage agency, direct treatment begins. An internal intake procedure of the agency takes over, further evaluation occurs, and assignment is made to a treatment program. Monitoring and periodic reports to the court continue as a linkage agency responsibility until completion of the treatment period.

The linkage agency, beginning in the jail and working with the inmate, directs the service provision program to its conclusion. The system has the potential for comprehensive, integrated, and highly professional service delivery to inmates while allowing the jail to concentrate its resources on the custody function.

Finally, the fourth category, the Combination System, represents a mixture of two or more of the foregoing three systems. Combination is generally found in very large urban jails, and frequently evolves ad hoc, due to a multiplicity of factors--outside funding support, court mandate, pressure from inmates, interests of community organizations, and staff-recognized needs of inmates.

Combination System: Example 1. A county jail in the South West, serving the capital of the state and surrounding area, exemplifies the

Combination System because the jail provides service concurrently through several different conduits including its own staff, outside agencies, and a linkage agency.

The jail holds one hundred detainees and convicted inmates. It reports offering a wide range of services through a special grant to the jail. This grant provides for a corrections services officer program which is jail administered; the program is designed to meet immediate needs of prisoners, make appropriate referrals, provide information to the courts, lawyers, district attorney, and other components of the criminal justice system. The program is actively involved in coordinating services for the inmates and assisting inmates in getting released to community programs. The program sees itself as being in an advocacy role on behalf of inmates. Through this special grant and the services described, the jail is a direct (i.e., Internal System) service provider.

In addition to the internally run program, this jail contracts for its medical services, including detoxification, and plans for an outside non-agency to provide psychiatric service. These two components represent the Intersection System. Further, a linkage agency operates in this jail. It consists of a TASC program of interviewers who screen inmates with a drug problem, evaluate cases, present treatment plans to the court, initiate treatment by enrolling released inmates in various community programs, providing tracking, follow-up, and liaison between rehabilitation agencies and the criminal justice system. This latter activity represents the Linkage System. Within this jail, then, are found jail-autonomous service provision, jail interaction with non-jail agencies, and linkage activities. The Combination System describes the jail's organizational arrangement for service provision. An additional observa-

tion on this jail is in order. While physically the jail was fairly old, dark, and dingy, occupying one floor in the court house building, the atmosphere was one of relatively relaxed activity, and good relationships between staff and inmates were evident. In fact, the director of the jail pointed out that the correctional staff is very pleased with the various services to inmates, especially those for drug-abusing inmates. In part, he attributed staff-inmate rapport to the common ethnic affiliation of guards and inmates. In part, we can speculate that the large number of programs available means that there is little unoccupied time for inmates and officers to think about discordant personal interactions and conflict-oriented encounters.

The Combination System has the greatest potential for multiple activities and services. While additional jail examples could be given from the study to describe the Combination System, it would serve only to document the abundance of activities which this system produces. Activities are limited only by a community's human services resources when the jail organizational arrangement is the Combination System.

Assessment of the Four Systems

The typology provides a useful analytical tool for describing variations in jail delivery of service. In order to anticipate the ability of the jail to provide services, however, one additional factor, the budget, must be considered. Several different funding arrangements have been observed. Services, in some cases, are financed from the regular jail budget. Often, other government or non-government agencies (such as a city hospital, mental health agency, etc.) provide no-cost services to the jail. In some instances, it is a part of the service provider mandate, or, in other cases, the outside agency may be a grantee from either

federal or state auspices to provide services. We have also observed funding through the creation of special units for the purpose of servicing the jail exclusively (e.g., TASC) or short-term project grants through federal, state, or local funding sources. While our study did not attempt to analyze the impact of funding source either upon service delivery or type of program, it is reasonable to assume that a relationship would be found to exist. Further study of that particular question is certainly warranted.

The study's findings indicate that the drug problem has been one of the significant forces in the past decade in moving local jails toward fuller and more sophisticated organizational arrangements for delivery of services to inmates. Specialization in delivery of treatment strategies and resources has both benefits and hazards. The benefits relate specifically to the characteristics of the formal organization such as increased division of labor, role specificity, goal establishment, and alternative funding mechanisms. The advantages of the Internal System are to be found in complete control remaining with jail administration. When the jail is the direct service provider, it has complete authority over what is done, how it is done, and by whom. Security risks are minimized and accountability is readily located. The Linkage System has the potential for bringing together the greatest amount of expertise, working in cooperation to meet multiple inmate needs with minimal jail administrative involvement. The Linkage System also has the potential, as noted earlier, for the greatest administrative efficiency because jail administration need deal with only one agency, rather than with many agencies as in the Intersection System.

FIGURE 10.2

SYNOPSIS OF ADVANTAGES AND DISADVANTAGES
OF FOUR SERVICE DELIVERY MODELS

System	Advantages	Disadvantages	Recommended Size and Type
INTERNAL: Jail provides all inmate services from within its own organization	1. Control and authority remain within the jail 2. Security risks--low 3. Accountability--high 4. Rehabilitative commitment on part of jail staff can be conveyed to inmate	1. For multiple services--administratively complex 2. Budget required--high 3. Jail may encounter problems in attempting to hire its own rehabilitation people 4. Two staff functions (custody and rehabilitation) may create internal friction	Relatively large (over 250 ADP); jail location inaccessible to outside service agencies; jails with long LOS profiles
INTERSECTION: Jail interacts with outside agencies to provide inmate services	1. Jail resources commitment--low 2. Provides accessibility to specialists 3. Staff agreement on goals (i.e. all staff in custody function) can contribute to internal harmony operationally and administratively	1. Difficult for jail to retain programmatic control 2. Increases security risks 3. Accountability--low 4. Duplication and/or conflicting services may be provided to inmates 5. Requires coordination between custody and outside agency staff	Small jails (ADP under 100); jails accessible to many and diverse community services; jails with short LOS profiles

FIGURE 10.2 (Continued)

System	Advantages	Disadvantages	Recommended Size and Type
LINKAGE: The jail interacts with only one agency which screens, identifies, evaluates, and refers to other outside service providers	1. Administrative efficiency potential for jail--high 2. Coordination of services--high 3. Collaborative aspect of service--high 4. Limited or no commitment of jail resources 5. Reduces duplication of services 6. Accomodates multiple services	1. Inmate service while incarcerated--minimal 2. Required level of coordination with custodial intake staff--high	Large jails over 250 with a maximum of 1000 (beyond that, multiple units would be necessary); ideal for jails with short LOS profiles
COMBINATION: Jail utilizes two or more systems of service delivery	1. Fosters high activity rate 2. Jail's specialist can increase accountability of outside agencies 3. Rehabilitative commitment on part of jail staff can be conveyed to inmate	1. Duplication of services risk--high 2. Administratively complex 3. Requires expenditure of jail resources (personnel and budget)--high	Very large jails (over 1000) where continuous service needs exist in quantity sufficient to justify commitment of jail resources, as well as substantial input from community agencies

However, the Intersection System can also work effectively. It is most suited to small or medium-sized jails where a member of the jail staff coordinates outside agencies so that a communication flow exists. A hazard of specialization and scale, whereby several organizations can be providing (often unwittingly) the same services to the jail population, is avoided in the Linkage System. Further, Linkage can accommodate and promote more discrete services than the Internal System while simultaneously attending to the collaborative nature of service delivery. By its design, the Linkage System is community-base oriented and, as a result, its acceptance and utilization will vary with the nature of offenders in the local jail and with community correctional policy. Duplication of services is most likely to occur in the Combination System, where concurrent operation of numerous activities and services can flourish. Integrated service delivery is most difficult to attain in this system. The Combination System is also most likely to foster the highest and fullest activity rate. Figure 10.2 presents the advantages and disadvantages of each of the four systems and offers recommendations as to optimal jail size and jail type for each system.

CONCLUDING OBSERVATIONS

It is clear that despite a long history of distinctly segregated arenas of operation, jails and community service agencies have begun to find elements of mutual benefit in collaborating in the treatment of drug-abusing inmates in jail. One of the major findings of the National Jail Resources Study is that drug treatment needs of inmates and the associated pressures for service have provided a strong impetus for the development of new and innovative organizational arrangement between jails and community human service organizations and government. It can be

expected that, in time, these arrangements and interdependencies will respond not only to the needs of inmates with drug abuse problems, but also will affect the general availability of medical, social, and psychological services to all inmates in local jails.

By analyzing service delivery from an organizational perspective, we find that jail orientations toward rehabilitative service provision vary significantly depending on the administrative arrangement (law enforcement or department of corrections) under which the jail operates. Further, jail service delivery arrangements can be categorized into four organizational interaction systems: (1) Internal; (2) Intersection; (3) Linkage; (4) Combination. For jails considering initiating or modifying present inmate services, the advantages and disadvantages of each system as well as the jail's LOS profile, jail's size, desired level of service emphasis, and numbers of staff and budgetary resources available should all be carefully considered prior to making changes in services.

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CHAPTER ELEVEN

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

Most jails are extremely busy places. The burden of numbers, particularly in large jails, is severe enough to tax any social institution. The noise and confusion of high turnover of inmates, blaring radios and televisions, the loud and angry voices reverberating off concrete and steel, the clanking gates and grinding locks add a continuing assault on auditory senses. Pressed by the handicap of knowing little more than names, numbers, and charges, the jail spawns an aura of suspicion reinforcing a lock-up frame of reference. Controls are justified as a way of keeping track of people and dealing with those who are "unknown."

Jail problems are compounded by the fact that these facilities serve a dual role: maintaining secure custody for those charged--but unconvicted--with the commission of illegal acts, and rehabilitating those convicted and sentenced. By necessity, the continuing process of admissions and discharges means that much of jail activity is reactive to the criminal justice system. People (inmates, lawyers, and visitors) coming and going, the continuing expectation of impending crisis (escape, assault, riot), merge to place low priority upon the correctional mission, if it ever existed in the first place.

In the course of our visits to jails, we spoke with staff who are optimistic about the potential of the jail to promote constructive behavior either through internally operated programs or in a partnership with the community's human services network. Others are less hopeful, born of

fatigue, cynicism, the reality of seeing involuntary clients not responding to available services, or having observed the frequent inability of current treatment technologies to effectuate change. Whether hopeful or not, almost all concur that the jail cannot stand as the sole community correctional resource. There is widespread agreement that jails are unable to alter the increasing drug or crime problem, or to modify the community structure or individual shortcomings which lead to incarceration.

But jails can provide a variety of resources, both during the period of incarceration and upon release, which may be conducive to changing patterns of behavior. It is our contention that to accomplish a sound correctional effort, four elements must exist concurrently. These are: (1) Planning, (2) Program, (3) Personnel, (4) Physical plant.

Planning

In large measure, jails have been bypassed in the current effort to upgrade the quality of criminal justice activities. This has, in part, been due to a lack of concern with that element of the justice system which holds unconvicted persons and minor offenders who are seen as unresponsive to change strategies or less in need of correctional intervention than serious longer term offenders.

The planning process in jails is frustrated by the lack of available data. Most jails are unable to generate any but the most rudimentary of statistics. Secondly, assessment of jail needs is handicapped by a lack of clarity as to organizational goals. Thirdly, projection of future populations is not predictable due to the ebb and flow of punitive community attitudes, the activities of law enforcement agencies, the propensity of prosecutors to prosecute,

judges to confine, bondsmen to assume risk, and the availability of alternatives to incarceration. Jails have limited control over their population movement, and as an agency of county or local government, have limited access to resources to carry forward sound planning mechanisms which will allow them to respond to future needs. In other words, the planning process is rejected because of limited information documenting needs and limited opportunity to carry out that which is perceived as necessary.

Interestingly, the current correctional rhetoric, which opts for community-based correctional resources does not usually include the jail either as a central or peripheral element in the spectrum of resources. In part, this may be due to the fact that the rhetoric is addressed to alternatives to imprisonment rather than jail incarceration. Or it may be due to the fact that prisons and parole are state-operated services, and jails are not usually part of that governmental network. Whatever the case, however, jails must be brought into the total correctional planning effort, and included in the configuration of resources available. Planning for jails, without consideration of the total network of criminal justice services, is neither technically sound nor operationally productive.

The problems enumerated above, however, demand resolution. Few state planning agencies have taken leadership either to encourage system-wide planning within the confines of a unit of government or to fund activities which would lead to a coherent criminal justice system rather than a series of segmented, discontinuous activities related to the accused or sentenced offender. Yet, the development of a coherent system is inseparable from reform both of the parts and of the jail specifically. Leadership is needed but lacking. Without direction, the problems of

jails, courts, prisons, probation, and parole will be compounded in the decades ahead.

Program

Most commonly, when thinking about "program" one conjures up a recipe book of intervention strategies. Included are such activities as social services, education and vocational training, work release, individual and group therapy, legal assistance, religious advisement, etc. Many jails offer such activities. Yet, for the most part, the services which are offered exist without the benefit of any meaningful screening process at admission in order to target in on those individuals who would benefit from specific rehabilitative activities. This is due to the fact that the dual mission of the jail is weighted towards the custody process which tends not to be treatment oriented. Even when services are offered to sentenced inmates, the jail tends to shy away from active intervention with detainees because of their legal status.

Most existing treatment technologies are based on a long-term involvement of the participant. Given the fact that many inmates do not stay long in jail, it is critical that new interactive mechanisms be developed between jails and outside service providers to assure the continuity of help. Equally important, however, is the need for the development by the behavioral sciences of new short-term treatment technologies which will encourage efforts toward the attainmant of self-fulfilling and law-abiding life styles after release from jail.

Personnel

While the last decade has seen a remarkable growth in the number of individuals either participating in, or graduated from, university and

college programs in the administration of justice, jails have not tended to be employers of such people. Hiring standards, particularly at the custodial level, do not encourage job application by college graduates. Nor in many institutions do jail administrators encourage their personnel to upgrade their skills either through in-service training or participation in educational programs.

Staff at all levels (custodial, social service, medical, vocational, educational, and psychological services) must have both a thorough understanding of the organizational mission and an ability to implement those objectives. Unless the personnel mutually share objectives, inmates can become trapped in the conflict between rival correctional forces. A disinterested or divisive custodial force can accelerate the demise of soundly conceived rehabilitative efforts. Conversely, a treatment effort which is unmindful of the security requirements of the facility can seriously jeopardize the safety of all personnel and inmates. What is critically needed is well-structured, adequately financed, and accessible training for jail-based personnel, bringing together diverse groups of staff representing various duties and responsibilities. Such training can enhance skills and understanding of the system, the offender, and the needs of the community. At the least, jails should make available to their personnel those self-instructional materials available through the U.S. Bureau of Prisons.

Physical Plant

There is general agreement that the physical plant which makes up most jails in unconducive to rehabilitative efforts. Space for treatment (social, educational, vocational, psychological) is, for the most part, scarce or non-existent. Broom closets and barber shops become converted

to counseling offices. A corner of a dining hall is used as a classroom, while the clatter of food preparation and clean-up activities competes for the inmate's concentration.

Many of the jails are obsolete, built in an era when the fortress facade, thick walls, and small cells constituted the ultimate in correctional architecture. Treatment was not perceived as part of the jail's function and, therefore, space was not allocated for that purpose. Modern jail architecture is not, by itself, any guarantee that the jail will be any less obsolete unless there is a conscious staff effort to make it rehabilitative, but adequate facilities are basic to the jail mission.

What Can Be Done?

As we have noted in this study, local jail populations throughout the nation have several important features in common. In planning for the kinds of services which can reasonably be provided in a local jail, these special features need to be considered. Jail resources are limited, and hence, cannot do everything that the jail, the public, or its inmates would like. It is useful, therefore, to examine those findings which point up commonly found features of local jails and suggest the kinds of services most critically needed by the jail.

The findings which follow are directed to jail administrators who are responsible for planning, program development, and allocation of resources. New jail services should be initiated only after a careful consideration of these findings.

Inmates arrive directly from the community. The fact that most inmates in local jails are processed directly into the jail following arrest means that crisis type needs may exist to which the jail should respond. These include medical care for wounds and recent injuries, assessment of

immediate medical problems such as drug withdrawal, epilepsy, diabetes, dangerous psychological state, etc. In addition to medical needs, a lawyer, immediate family and other individuals involved in the inmate's problems may need to be contacted. Thus:

> *The jail should provide short-term crisis intervention--medical, legal, social, and psychological services.*

Many inmates processed through the local jails remain for very short periods of time. While inmate problems may often be identified, particularly if screening strategies exist, very little progress can be made toward meeting those needs because of the limited time that counselors have with inmates. However, the jail usually has sufficient time to identify inmate medical, psychological and social service needs and develop a case plan with realistic goals. In some instances, the jail can initiate selected services for some inmates, but in all instances it should provide information at intake about the availability of services. As a routine part of the release procedure, the jail should enroll or put inmates in contact with appropriate human services and programs in the community because some social service needs of the inmate with short-term confinement can only be met in the community. Thus:

> *The jail should provide comprehensive referral services for inmates upon release.*

Most inmates in local jails are people with multiple problems. Inmates in local jails are generally lacking in the basic tools and social skills necessary for self-sufficiency in today's complex, industrialized

society. Deficiencies include lack of education, job skills, basic good health, positive self-image, ability to get along with others, and a limited awareness of the help available to deal with problems. Law-breaking behavior, often chronic, is frequently symptomatic of an inability to cope legitimately within the social system. It follows, then, that any assistance which the jail can provide to improve the many shortcomings found in inmate populations potentially can contribute to the reduction of recidivism. Thus:

> *The community must provide for the allocation of adequate resources to the jail for it to achieve its rehabilitation goal.*

Most jails keep minimal amounts of information on their inmates. There is no uniformity from jail to jail even within the same state in the collection of inmate data. Many jails do not have information on such a basic item as the average length of stay of their total population. Thus:

> *If jails are to plan for and provide necessary services, they must develop and be able to access information on the unique features of the population. As part of intake screening and social service follow-up, jails should develop basic information on the inmate such as:*
>
> 1. *Age, sex*
> 2. *Residence and pattern of residential mobility*
> 3. *Education level at commitment, including ability to read and write English and/or native language*
> 4. *Occupation, pattern of employment, skills, trade, etc.*

> 5. *State of health, including results of physical examination and problems identified*
> 6. *Marital status, including pattern of family support, stability of family relationship*
> 7. *Reason for commitment, including whether release on recognizance or diversion was considered*
> 8. *Abuse problems related to drugs and alcohol*
> 9. *Current and prior enrollment in community-based human service programs*
> 10. *Prior record; length of past commitment*

Few jails which have collected data on their populations analyze that information in a fashion which is useful for planning. Jails should develop aggregate population data which will assist in analysis of trends, identification of changing service needs, and determining professional staff needs to carry out jail programs. Many jails are located in areas which permit collaboration with college-based researchers who, in partnership with the jail, can assist in the design and operation of jail research and planning activities. Thus:

> *Jails should collect data which will enable them to develop:*
>
> 1. *Detainee-sentenced inmate ratios*
> 2. *Length of stay profiles based on multiple time periods*
> 3. *Male-female inmate ratios*
> 4. *Crowding level, showing the ratio of average daily population to official resident capacity of the jail*
> 5. *Educational patterns of inmate population*
> 6. *Occupational patterns (for job training and work-release*

programs)

7. Residence pattern (to assist in locating after-care facilities)

Almost half of the jails hold most of their inmates including those with drug problems for less than 30 days. Thus:

Jails should provide for service continuity and help upon release of the inmate through local community service agencies. Without this help and cooperative services after release, drug dependent individuals are likely to return to the same kinds of behavior which resulted in their arrest and confinement.

Few jails have written procedures to guide interaction between jail and community human services agencies. If services are to be operated effectively by outside agencies working in the jail, then procedures to cover the cooperative relationship need to be delineated to avoid problems and foster productivity. Thus:

1. Standardized procedures should be developed and formalized so that expectations as to role of each agency and [illegible] be detailed, including accountability for meeting mutually agreed upon objectives.
2. Standards which apply to the individual jail should cover requirements concerning:
   a) orientation of community agency personnel to jail procedures and responsibilities so that breaches in security and institutional safety are not

inadvertently incurred

   b) training for jail personnel as to community agencies' service capacity so that jail staff understand agency objectives and [illegible]
   c) security guidelines, including [illegible]
   d) evaluation guidelines, [illegible]
   e) jail policy on [illegible]

While most jails have accurate accounting of their population flow in and out of the facility, the average daily population data is not very helpful in planning for program development and staff requirements. Most jails do not have an accurate profile of the length of stay of their population. The length of stay profile measure developed by this study offers a useful method by which jails can analyze the time available for service delivery to inmates, and organize appropriate treatment resources consistent with how long discrete populations of inmates remain in the jail. Thus:

1. Jails should develop length of stay data for each inmate.
2. Planning for new services or reorganization of services in the jail should not begin until the nature of the inmate population by length of stay is fully known.

Some form of diversion is available to selected inmates in two out of three communities, but the guidelines for eligibility are frequently vague and utilization is erratic. Every jurisdiction should have available a sound system which is capable of diverting from the criminal justice system those persons who can safely be allowed to remain in the community as an alternative to continued processing through the criminal justice system. Thus:

Diversion programs should be formally established in jails with the active participation of all elements of the criminal justice system. Following appropriate screening mechanisms, the diversion effort should require the participant to attend a meaningful rehabilitative service in the community. There should be a clear understanding by all concerned that failure to participate in the diversionary rehabilitative activity will result in formal criminal justice processing.

Two-thirds of the jails with services to drug-abusing inmates have a screening procedure to identify these inmates; one-third do not. Even when there is screening, intake procedures frequently fail to inform inmates about programs of help which are available. Thus:

Screening procedures at time of intake should operate in all jails and should be designed to reach incoming inmates within twelve hours of arrival. At a minimum, screening should consist of:

1. *A diagnostic process in which physical examination by medical personnel occurs, and a personal assessment interview is conducted*

2. *The dissemination of information to the inmate about the availability of services within the jail and in the community*

All jails have general policies to detoxify rather than to maintain drug dependent inmates. The form of detoxification varies from gradual medical withdrawal to no-help "cold turkey." Guidelines on detoxification treatment (except for the duration of medication) are generally nonexistent. Thus:

1. *Treatment guidelines for detoxification should be developed and standardized. These should offer direction rather than merely listing constraints. For example, the definition of "drug abuser" needs to be clarified.*
2. *Jail medical detoxification services should be available around the clock*
3. *Guidelines pertaining to the handling of methadone maintenance patients in jail should be established so that incarceration in itself does not become the reason for ending treatment*
4. *Programs should be oriented toward treatment of the whole person with follow-up counseling so that an integrated process of psychological and social service assistance is available*

Psychological services are the least prevalent of the basic human services found in local jails. The lack of such clinical assistance affects all segments of the jail population: detainee, convict, drug-abuser.

Jails should utilize existing psychological services in the

community both for in-jail counseling and for ease of initiating psychological assistance after release from jail. In general, the development of jail-operated psychological services should be limited to those instances where community mental health resources are insufficient to respond to jail-based needs.

Jails cooperate extensively with community agencies to provide inmate services. Of the 118 jails studied, 83% indicated that some, if not all, inmate services are provided by non-jail agencies. There are wide variations, however, in the scope and frequency of the services provided.

It is appropriate that community agencies provide a variety of rehabilitation services to inmates in local jails since most local jails have primarily short stay/high turnover populations. Usually, inmates come from the community where the services and the jail are based. Rehabilitative assistance for these people can, for the most part, best be provided by community organizations since:

1. *They have the ability to deal with the individual both in and out of jail*
2. *They can provide a variety of different services with expertise not otherwise available to the jail*

A constraint on interagency cooperation is the mutually negative evaluations both the jail and the service agencies often have of each other. Service agency staffs question whether or not the jail really wants to provide services; they complain that jail decision-makers are unsympathetic to inmate service needs. At the same time, jail staff bluntly question the competence of outside agency staffs to deliver

quality services. These negative evaluations may in some cases be well founded, and thus, the following recommendations, in part, will assist in reducing barriers to cooperation.

1. *To assure mutual understanding of both the service to be provided and the conditions for implementation, jails should require that the type, range and scope of service be identified in writing. A working "contract" agreeable to both organizations should be promulgated.*
2. *Ongoing assessment of service delivery by representatives from the jail and the service agency, with the assistance of university-based behavioral scientists, ought be an integral part of the process. This review should assist in retrospective analysis of productivity and serve to identify needed changes in service delivery and jail policy.*

Jails and the various community service agencies do not traditionally have contact with the same information network. Hence, they fail to communicate effectively with each other.

There are several ways to close communication gaps and increase interaction between corrections and human service agencies.

1. *Jail management level personnel should participate in community human service coordinating councils to insure a greater community understanding of jail service needs*
2. *Regular meetings with those agencies supplying services to the jail should include line-level jail personnel. These meetings can serve to inform both groups of the various activities being provided and to work out operational problems.*

JAILS AND COMMUNITY AGENCIES: PARTNERS FOR SERVICE

The first responsibility of jails is to hold individuals securely and safely. Most local jails hold more pre-trial than sentenced individuals. Pre-trial inmates who cannot be released pending trial must, of course, be presumed innocent and not be co-mingled with convicted inmates. Beyond the jail's basic custody function of providing safe, secure housing, jails should offer additional services including drug and alcohol abuse treatment. The objective of these additional services should be to help the inmate to develop work patterns and interpersonal skills to cope in a complex society.

Drug abusers are human beings and, like most, have a wide range of personal problems. In the addict's case, however, the problems also include the illegal use of drugs. Treatment, therefore, must deal with controlling the addiction. In most cases, elimination or control of the addiction means finding the underlying causes. This is often a protracted process, one which the jail cannot complete on its own.

Because drug treatment is a lengthy process and the current level of behavior change technology is such that few satisfactory short-term techniques exist, jails should develop those objectives which realistically can be met. Two possible treatment objectives which any jail can be organized to meet are: 1) identifying inmate treatment needs and 2) referring inmates to in-jail and community services.

The service responsibility directly administered by the jail can and should, in most cases, be limited to intake screening, evaluation and referral to outside-operated services, both in jail and upon release. During the screening process, a detailed evaluation of necessary services should be made for each inmate arriving at the jail. Initial screening

should be followed by meeting emergency needs and, later, referral to services provided by the appropriate community agencies. These agencies should have jail-based facilities and staff. For example, a community mental health agency could assist with psychological screening and introduce the inmate to counseling which could be continued by the same agency in its community center after release. This procedure assures continuity of service to the inmate who frequently is released before completion of a jail-based program.

Inmate participation in programs should not be restricted to convicted offenders. If the detainee requests assistance, it should be provided. Decisions as to disposition of detainees, other than those entering formal diversion programs, should not be related to participation in jail-based programs. Sentenced inmates should also have the same decision options to participate in services while serving sentences. They should be given explicit information and assistance in contacting appropriate service agencies at the time of release.

The interorganizational arrangement we have described with jail responsibility for screening followed by community agency responsibility for services in jail and on referral upon release is appropriate for local jails from the very smallest to the largest. Organizationally, the potential is great for positive working relationships between jails and community human service agencies. These positive factors include common clients, overlapping goals, low levels of interagency competition, and a joint need for resource exchange.

The first and most obvious reason for jails and community service agencies to cooperate is that they already serve some of the same people. For example, an inmate who is a methadone maintenance patient is a client

of the jail because of legal problems and a client of a drug treatment organization because of heroin addiction. Once in jail, the inmate still requires drug treatment, which the jail can provide either directly or through the community treatment organization.

Secondly, the goals of the jail and the service agencies overlap in that both have a rehabilitation orientation. Although there may be varying levels of commitment to this goal and many different approaches to the task, the fact that the common objective exists means that there is a strong foundation for cooperation.

Thirdly, although the organizations have many of the same clients and some of the same goals, because of the unique position of a jail, there is little reason for competition between jails and service providers. There is a very low probability that the activity of the one will detract from the chances of the other achieving its goals. Neither the jail nor the human services provider need fear loss of control of its primary functions. A jail is unlikely to absorb the activities of a service agency, and the service agency is not likely to assume the role of the jail.

Finally, there is a common need to exchange resources. The high level of resource needs of the jail are most apparent. Jail inmates require a wide variety of services, but usually not on a scale that warrants extensive internal program development. Local jails have low levels of internal resources, such as discretionary budget and specialized competencies, from which to draw for the provision of human services. But the jail can draw on external resources, that is, community service agencies.

In exchange, community agencies have needs that the jail can help

meet. In some localities, there is a proliferation of human services organizations competing for clientele. In this situation, if the jail provides clients, it is keeping the service agency "in business"; this is at its simplest a mutually benefiting exchange. In other communities, services agencies are overburdened. The resource exchange in this case may be money, but not necessarily from the jail. A considerable proportion of jail services are provided by outside agencies receiving federal and/or state grants. Some community service agencies are funded by local government which requires that service be provided to other local institutions including the jail. For example, in some large jails medical services are obtained from public hospitals which provide all care including intake health examinations, clinics and infirmaries within the jail. The consequences of cooperation result in reciprocal (but not necessarily equal) benefits to both the jail and the community services network.

In conclusion, we recommend a model for provision of inmate services which can respond to all inmate service needs (not only drug-related services) during incarceration as well as upon release. The proposed model is economical and administratively uncomplicated because the only jail provided and administered rehabilitative services are screening and referral. All other services are provided by appropriate community agencies working directly in the jail and with the jail referral staff. To restate, jails should:

1. *Develop comprehensive intake screening to deal with immediate inmate problems and identify other inmate needs*
2. *Become conduits for treatment, motivate inmates to seek help by offering crisis assistance, and by having an array of*

services in the jail conducted by outside agencies

3. *Provide information and assistance for continuing service and enrolling in rehabilitative programs upon release*

In general, inmates are interested in only two questions: "How did I get here?", and "How can I get out?". Beginning with the screening process, an additional question should emerge for the inmate to ponder: "How do I stay out?".

A partnership between the jail and the community human services network can provide help toward answering that question.

AN ANNOTATED BIBLIOGRAPHY OF SELECTED WORKS RELATING TO JAILS, THE DRUG PROBLEM AND HUMAN SERVICES

The bibliography is divided into four sections:

1. Monographs and special studies
2. Articles and essays
3. Reports
4. Handbooks and training materials

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Danzig, R. "Toward the Creation of a Complementary, Decentralized System of Criminal Justice." *Stanford Law Review* 26, 1 (1973): 1-54. [NCJRS]

Describes community correctional program involving counseling juvenile delinquents.

DeLong, J.V. "The Methadone Habit." *New York Times Magazine* (March 16, 1975).

Explores a variety of issues surrounding methadone maintenance as a treatment for heroin addiction.

Dupont, R.L. "The District of Columbia Experience Treating Heroin Addicts." *Public Management* 54, 3 (1972):7-9.

Describes the reorganization of the District of Columbia's heroin treatment programs into the Narcotics Treatment Administration.

English, G.E., and Monroe, J.J. "A Comparison of Personality and Success Rates of Drug Addicts Under Two Outpatient Supervisory Systems." *International Journal of the Addictions* 7, 3 (1972): 451-460.

Concludes that there is an interaction between personality type and type of outpatient supervisory system on "success rates" in addicts.

Friel, C.M. "Jail Dilemma: Some Solutions." *American County* 37, 10 (1972):9-11. [NCJRS]

Offers alternatives to jail construction programs as solutions to the jail overcrowding problem.

Goldstein, T. "Why the Prisoners Are Looking to Federal Courts." *New York Times* (December 3, 1974):39.

Deals with the increasing federal role in supervising state and local institutions which house individuals not yet convicted of a crime.

Goshen, C.D., "Evaluation of Drug Treatment Programs: Unrecognized Variables." *Adolescence* 8, 32 (1973):521-532.

Cites some of the more common mistakes made by evaluators and discusses the variables affecting "success."

Hess, A.G. "Deviance Theory and the History of Opiates." *International Journal of the Addictions* 6, 4 (1971):585-598.

Focuses on labeling theory in discussing the historical changes in interpretations of drug use.

Jaffe, J. "Drug Abuse: A National Overview." *Public Management* 54, 3 (1972):3-6.

Gives a short history of the federal response to the drug problem in both control and treatment areas.

Klapmutz, N. "Community Alternatives to Prison." *Crime and Delinquency Literature* 5, 2 (1973):305-337.

Considers various community alternatives to incarceration including probation, nonresidential community intervention, and residential community programs.

Kozel, N.J., Dupont, R.L., and Brown, B.S. "Narcotics and Crime: A Study of Narcotic Involvement in an Offender Population." *International Journal of the Addictions* 7, 3 (1972):443-450.

Reports demographic data and history of drug use and analyzes the results; cites the finding that approximately one out of every two offenders entering the District of Columbia jail is a heroin addict.

Langrod, J., Joseph, H., and Lowinson, J. "Treating the Addict-Probationer: Experiences of a Methadone Probation Clinic." *Drug Forum* 2, 4 (1973):367-370.

A discussion of the potential misuse of methadone as a form of legal control of the patient; suggests that methadone maintenance should be employed only on a voluntary basis.

Levin, G., Hirsch, G., and Roberts, E. "Narcotics and the Community: A Systems Simulation." *American Journal of Public Health* 62, 6 (1972):861-873.

Endeavors to show how systems analysis and computer simulation can aid in the study of the narcotics problem; recommendations for community action are made.

Liebson, I., Bigelow, G., and Flamer, R. "Alcoholism Among Methadone Patients: A Specific Treatment Method." *American Journal of Psychiatry* 130, 4 (1973):483-485.

Deals specifically with the problem of alcoholism among methadone patients.

Looney, M., and Metcalf, S. "The Fatigue Factor in Drug Addiction: Insufficient Motivation for Treatment." *Hospital and Community Psychiatry* 25 (1974):528-530.

Describes the fatigue factor, the pressures on an addict built up over time that may lead to enrollment in a drug treatment program.

Lowinson, J., Langrod, J., and Alperin, L. "Legal Services as a Tool in Treating the Addict." *American Journal of Psychiatry* 130, 5 (1973):592-595.

Suggests that initiating treatment (methadone) followed by an interruption of imprisonment is "futile and destructive" to the treatment process and that patients respond better to treatment when legal problems and concomitant anxieties are resolved.

Mattick, H. "The Contemporary Jails of the United States: An Unknown and Neglected Area of Justice." *Handbook of Criminology* (ed. Glaser). Chicago, Ill.: Rand McNally, 1974:777-848.

Examines the critical issues surrounding jails, describes practices in U.S. jails, and includes an extensive list of specific recommendations for reform.

National Association of Counties. "Jail Inmate Rehabilitation Program." *American County* 37, 10 (1972):11-12. [NCJRS]

Describes a Michigan County jail program which provides education, post-release follow-up, and other services including medical and drug treatment.

New York Times. "Inmates and Guards Lament the Imminent Death of the Tombs." (December 3, 1974):39.

Describes the marked change in conditions at the Manhattan Detention Center for Men in light of a court order closing the facility.

Noland, P.D. "Case Study/Los Alamos County." *Public Management* 54, 3 (1972).

Deals with a small middle-class community's approach to the drug problem.

Pew, M.L., Speer, D.C., and Williams, J. "Group Counseling for Offenders." *Social Work* 18, 1 (1973):74-79.

Discusses a community-based group counseling program for offenders in St. Paul, Minnesota, designed to combat feelings of isolation that make it easy to revert to earlier familiar behavior.

Platt, J.J., Scura, W.C., and Hoffman, A.R. "Heroin Addiction Incidence Among Youthful Offenders, 1968-1972." *Journal of Community Psychology* 1, 4 (1973):408-411.

Deals with the problems of the increasing incidence of heroin usage among youth committing criminal offenses. The study documents an increase in heroin use in the prison population of the New Jersey Reformatory Complex over and above increases in incarceration for drug-related offenses.

Robertson, J.A., and Teitelbaum, P. "Optimizing Legal Impact: A Case Study in Search of a Theory." *Wisconsin Law Review* 3 (1973):665-726.

Discusses the impact of law on actual behavior patterns among affected actors; examines the Massachusetts Comprehensive Drug Rehabilitation and Treatment Act, which deals with diversion of persons charged with drug offenses.

Sheeter, R., Newman, C.L., and Case, J. "Systems Analysis of an Information System for a County Jail." *Law Enforcement Science and Technology II* (ed. Cohen). Chicago, Ill.: IIT Research Institute, 1968:273-277.

Provides a systems model for the organization and development of an information system in a county jail.

Tropman, J.E., and Gohkle, K.H. "Cost/Benefit Analysis: Toward Comprehensive Planning in the Criminal Justice System." *Crime and Delinquency Journal* 19, 3 (1973):316-322.

Postulates that the main function of correctional institutions is change. As custodial concerns give way to changing priorities, there is a shift to community-based programs.

Waldorf, D., and Reinarman, C. "Addicts--Everything but Human Beings." *Urban Life* 4, 1 (1975):30-53.

Discusses some of the implications of ethnographic studies on addicts in their own environment.

Winick, C., and Bynder, H. "Facilities for Treatment and Rehabilitation of Narcotic Drug Users and Addicts." *American Journal of Public Health* 57, 6 (1967):1025-1033.

A systematic review of facilities available to drug addicts in the United States. Concludes that services are available where the need is greatest and that a substantial portion of the known drug users receive some type of treatment.

REPORTS

American Bar Association, Commission on Correctional Facilities. *Medical and Health Care in Jails, Prisons, and Other Correctional Facilities*. Washington, D.C.: American Bar Association, 1974.

Presents a compilation of standards and materials that contains summaries and excerpts of most major studies in the area of health care service delivery in the correctional setting.

------. *Summary Report--Pre-trial Intervention Strategies: An Evaluation of Policy-related Research and Policy Maker Perceptions*. Washington, D.C.:American Bar Association, 1974.

Reports the responses of nearly 400 policy makers who responded to a questionnaire on policy and research-related concerns.

------. *Compendium of Model Correctional Legislation and Standards (2nd ed.)*. Washington, D.C.: U.S. Department of Justice (LEAA), 1975.

Contains models, standards, policy positions and informational charts on a wide range of criminal justice activity.

------. *Survey and Handbook on State Standards and Inspection Legislation for Jails and Juvenile Detention Facilities*. Washington, D.C.: American Bar Association, 1974.

Provides data on state inspection and standards, legislation, enforcement and regulatory agencies. The appendix includes model legislation, selected state legislation, Advisory Commission on Criminal Justice Standards and Goals material, United Nations Standards, and excerpts from LEAA Jail and Juvenile Detention Census Reports.

American Bar Association, Correctional Economics Center. *Resource Needs of Correctional Administrators: A Survey Report.* Washington, D.C.: American Bar Association, 1974.

Reports on a survey of seventy-eight administrators of state-level juvenile and adult correctional agencies. The study attempted to measure the severity of various resource problems facing correctional administrators.

Boston College Law School. *Metropolitan Boston Detention Study.* Boston, Mass.: Massachusetts Joint Correctional Planning Commission, 1972. [NCJRS]

Assesses needs for the Boston area in order to develop and present alternatives to existing places of confinement.

Bull, J.L. *Long Jail Terms and Parole Outcome.* Sacramento, Calif.: California Department of Corrections, 1967.

Compares success of reinstated parolees who had served short terms with those who served lengthy prison sentences.

Cressey, D.R., and McDermott, R. *Diversion from the Juvenile Justice System.* Washington, D.C.: Law Enforcement Assistance Administration, 1974.

Explores the theory behind juvenile diversion as it applies to diversion programs in three different cities. Intake procedures and intake options are studied with an emphasis on specialized diversion units and informal probation.

Dehlin, D.J., and Millan, V.D. *Jail Survey of City and County Law Enforcement Agencies.* Washington, D.C.: Law Enforcement Assistance Administration, 1969. [NCJRS]

Reports survey responses of 181 jails on types of facilities, programs available to inmates, jail personnel, meals, inmate services, etc.

Drug Enforcement Agency. *Drug Abuse and the Criminal Justice System: A Survey of New Approaches in Treatment and Rehabilitation.* Washington, D.C.: U.S. Department of Justice, 1974.

Provides case studies on nine different drug treatment efforts around the country. The project provides information on development of models for drug abuse programs.

Federal Register (1974) "Drugs for Human Use [Reorganization and Republication], Department of Health, Education and Welfare, Food and Drug Administration's Special Requirements for Use of Methadone, Rules and Regulations (Title 21. Chap. 1, Subchap. D. Part 310. Subpart D. Sec. 302-304; Subpart E. Sec. 505)." Volume 39, 62, part II (March 29, 1974).

Gateway Houses Foundation, and Illinois Law Enforcement Commission. *Gateway's Success in the Rehabilitation of Drug Abusers.*

Gateway Houses Foundation, Inc., 1973.

Reports on the evaluation of the effect of therapeutic communities upon drug abuse in two cohorts of 186 and 157 individuals. The study involved a follow-up over approximately two years in which drug usage, employment, family life and school attendance were used as measures of success.

Law Enforcement Assistance Administration. *The National Treatment Alternatives to Street Crime Program [TASC] White Paper.* Washington, D.C.: Law Enforcement Assistance Administration, 1974.

Discusses the goals of the TASC program, which evolved as an attempt to overcome the tendency of "hard-core" addicts to avoid seeking treatment on their own.

Law Enforcement Assistance Administration and the U.S. Bureau of the Census. *Local Jails: A Report Presenting Data for Individual County and City Jails.* Washington, D.C.: Government Printing Office, 1973.

Reports results of inmate data, institutional data, expenditure and employment data for jails compiled from LEAA National Jail Census of 1970.

McGee, R.A., and Montilla, M.R. *Model Community Correctional Program: Summary Report.* Sacramento, Calif.: Institute for the Study of Crime and Delinquency, 1969. [NCJRS]

Discusses evaluation, proposed plans, and problems in developing a comprehensive community correctional program.

National Advisory Commission on Criminal Justice Standards and Goals. *Corrections.* Washington, D.C.: Government Printing Office, 1973.

Presents issues related to all components of corrections and a wide range of standards, with limited discussion of local jails.

National Commission on Marijuana and Drug Abuse. *Drug Use in America.* Washington, D.C.: Government Printing Office, 1973.

Deals with issues of definition of the drug problem, drug-using behavior, the social impact of drug independence and drug-induced behavior, and the development of coherent social policy.

National Council on Crime and Delinquency (U.S. Department of Justice, Bureau of Narcotics and Dangerous Drugs). *Proceedings of the Alternatives to Drug Abuse Conference.* Washington, D.C.: Government Printing Office, 1972.

Presents a summary of issues surrounding drug abuse and their implications for the criminal justice system, for education, and for the community.

National Criminal Justice Information and Statistics Service (U.S. Department of Justice, Law Enforcement Assistance Administration). *National Survey of Court Organization.* Washington, D.C.: Government Printing Office, 1973.

Provides information on the court structure in the fifty states.

------. *The Nation's Jails.* Washington, D.C.: Government Printing Office, 1975.

Provides a summary of the 1972 survey of inmates of local jails. This volume includes findings on the location, size, physical facilities, separation, meal services, medical and recreational facilities, employees, and social and rehabilitative programs.

------. *Survey of Inmates of Local Jails 1972 Advance Report.* Washington, D.C.: Government Printing Office, 1972.

Presents the major findings from the *Survey of Inmates of Local Jails* conducted by the LEAA as a follow-up to the 1970 jail census.

National Institute on Drug Abuse. *Quarterly Statistical Brochure, August 1974.* Washington, D.C.: Government Printing Office, 1974.

Includes data on the client-oriented acquisition process, Drug Abuse Warning Network Hospital Emergency Room Report, Drug Enforcement Administration data, and federal drug abuse prevention budget figures.

Platt, J.J. *Research and Evaluation Report, Wharton Tract Narcotics Treatment Program, Youth Reception and Correction Center.* Yardville, N.J., 1974.

Reports that successful completion of the Wharton Tract Narcotics Treatment Program leads to success on parole and that program participants change along a "number of personality and cognitive functioning dimensions." Parole success, according to the evaluation, can be predicted accurately from inmates' personality characteristics.

President's Commission on Law Enforcement and the Administration of Justice. *The Challenge of Crime in a Free Society.* Washington, D.C.: Government Printing Office, 1968.

Includes the work of the commission's task forces, including the corrections task force. A comprehensive view of the entire system, including recommendations for change.

Rudoff, A. and Esselstyn, T.C. *Jail Inmates at Work: A Study of Work Furlough, Final Report.* Sacramento, Calif.: California Department of Rehabilitation, 1971. [NCJRS]

Examines the effectiveness of an ongoing work furlough program.

Sarri, R.L. *Under Lock and Key.* Ann Arbor, Mich.: National Assessment of Juvenile Corrections, 1974.

Reports information on current juvenile jailing practices, demographic and other characteristics of the juvenile jail population, conclusions and recommendations about legislation, court practices, physical facilities, and programs.

Steinwald, Carolyn et. al. "Medical Care in U.S. Jails: A 1972 AMA Survey." Chicago, Ill.: American Medical Association, Center for Health Services Research and Development, 1973.

Presents findings of a survey to determine medical resources and care available in U.S. jails. Assesses the potential role of the medical profession in improving the care of inmates.

Strategy Council on Drug Abuse. *Federal Strategy for Drug Abuse and Drug Traffic Prevention.* Washington, D.C.: Government Printing Office, 1975.

Describes what the federal government is doing about the drug situation and indicates a continuing federal commitment to a multi-modality approach to coordinating and decentralizing treatment efforts.

Task Force on Federal Heroin Addiction Programs. *Federal Drug Abuse Programs: A Report . . . Submitted to the Criminal Law Section of the American Bar Association and the Drug Abuse Council.* Washington, D.C.: Drug Abuse Council, 1972.

Deals with the various strategies and agencies that make up the federal drug prevention effort and concludes that we need more research on methadone, more coordination among federal agencies and departments dealing with drug abuse, and more support for community-based treatment programs.

Task Force on Prison and Jail Health. *The Captive Patient: Prison Health Care in Kentucky.* Lexington, Ky.: Kentucky Public Health Association, 1974.

Reports the results of a study of Kentucky jails and prisons concerned with health and sanitation conditions, health problems of inmates, and medical and mental health facilities.

HANDBOOKS AND TRAINING MATERIALS

American Correctional Association. *Manual of Correctional Standards (3rd ed.).* Washington, D.C.: American Correctional Association, 1966.

Covers the full range of issues and problems associated with corrections programs including objectives, community corrections, administration, operation and services.

Blumer, A.H. *Jail Management: A Course for Jail Administrators.* Washington, D.C.: Bureau of Prisons, n.d. [NCJRS]

An independent study course covering management of jail operations, personnel and fiscal management, jail and community corrections programs, community relations, legal problems, and jail planning.

------. *Jail Operations: A Training Course for Jail Officers.* Washington, D.C.: Bureau of Prisons, n.d.

A programmed instruction course for jail officers, covering correctional history and philosophy, jail operations, jail climate, supervision, discipline, and special prisoners.

Deming, V., and Kilpack, R. *County Jail: A Handbook for Citizen Action.* Media, Pa.: Friends Suburban Project, 1973. [NCJRS]

Gives information gathering procedures, change strategies and goals, and the mechanics for effective community action.

Gottfredson, D.M., and McCrea, T.L. *Prescriptive Package: A Guide to Improved Handling of Misdemeanant Offenders.* Washington, D.C.: Government Printing Office, 1974.

Describes alternative methods for handling misdemeanant offenders at all levels of the criminal justice system.

McCartt, J.M., and Mangagna, T.J. *Guidelines and Standards for Halfway Houses and Community Treatment Centers.* Washington, D.C.: Government Printing Office, 1973.

Covers many of the problems associated with beginning and operating a halfway house.

National Sheriffs' Association. *Manual on Jail Administration.* Washington, D.C., 1970. [NCJRS]

Provides information on jail administration, from planning the actual facility to the development of community support.

------. *Guidelines for Jail Operations.* Washington, D.C., 1972. [NCJRS]

Gives a comprehensive, detailed description of recommendations for every phase of jail operations.

------. *Handbook on Jail Programs.* Washington, D.C., 1974. [NCJRS]

Presents, in the form of standards, the inmate programs that are designed to aid in the prisoners' rehabilitation as well as to facilitate smooth jail operations.

------. *Inmates' Legal Rights.* Washington, D.C., 1974.

Provides clear basic information on achieving healthful environment, inmates' personal safety and welfare, participation in programs, access to the courts, etc.

Newman, C.L., Goehring, S., and Pierce, E.S. *Drugs and Treatment Programs.* University Park, Pa.: College of Human Development, The Pennsylvania State University, 1975.

Presents a training module for probation and parole personnel which includes summary information on seven major treatment modalities, information on a variety of drugs and special problems related to drug abuse.

Newman, C.L., Parsonage, W., and Price, B.R. *Jails and Prison.* University Park, Pa.: College of Human Development, The Pennsylvania State University, 1969.

Discusses the history of punishment, its influence on current practice, and functions and goals of modern penology are presented as part of a training module series.

Richmond, M.S. *Classification of Jail Prisoners.* Washington, D.C.: Bureau of Prisons, 1971. [NCJRS]

Results of an experiment which tested the effectiveness of a prisoner data inventory form for determining the degree of required jail supervision and housing assignments.

------. *New Roles for Jails.* Washington, D.C.: Bureau of Prisons, 1969. [NCJRS]

Discusses trends and alternative ways of dealing with offenders as a background for planners of local jails.

Pappas, N. *Jail: Its Operation and Management.* Washington, D.C.: Bureau of Prisons, 1970. [NCJRS]

Sets forth principles to guide the jail officer and administrator in their job performance and procedures to be followed in the performance of specific tasks.

APPENDIX

Jails Participating in the Study

JAILS PARTICIPATING IN THE STUDY

Birmingham City/County Jail
Birmingham, Alabama

Alaska State System of Corrections
Anchorage, Alaska

Pima County Jail
Tucson, Arizona

Pulaski County Jail
Little Rock, Arkansas

Alameda County Sheriff's Department
Pleasanton, California

Elmwood Rehabilitation Center
Milpitas, California

Fresno County Detention Facility
Fresno, California

Los Angeles County Jail
Los Angeles, California

Orange County Jail
Santa Ana, California

Riverside County Jail
Riverside, California

Riverside County Rehabilitation Center
Banning, California

San Diego County Honor Camp
San Diego, California

San Diego County Jail
San Diego, California

San Francisco County Detention Center
San Francisco, California

San Francisco County Jail
San Bruno, California

San Mateo County Honor Camp
Redwood City, California

San Mateo County Jail
Redwood City, California

Denver City Jail
Denver, Colorado

Hartford Community Corrections Center
Hartford, Connecticut

Litchfield Community Corrections Center
Litchfield, Connecticut

Montville Community Corrections Center
Uncasville, Connecticut

Delaware Correctional Center
Smyrna, Delaware

Dade County Correctional and Rehabilitation Department
Miami, Florida

Dade County Women's Jail
Miami, Florida

Duval County Jail
Jacksonville, Florida

Hillsborough County Board of Criminal Justice
Tampa, Florida

Seminole County Jail
Sanford, Florida

St. John's County Jail
St. Augustine, Florida

Cobb County Jail
Marietta, Georgia

DeKalb County Jail
Decatur, Georgia

Fulton County Jail
Atlanta, Georgia

Halawa Community Correctional Facility
Aiea, Hawaii

Hilo-Hawaii Community Correctional Facility
Hilo, Hawaii

Maui Interim Community Correctional Facility
Wailuku, Hawaii

Bannock County Jail
Pocatello, Idaho

Cook County Department of Corrections
Chicago, Illinois

Winnebago County Jail
Rockford, Illinois

Madison County Jail
Anderson, Indiana

Marion County Jail
Indianapolis, Indiana

Johnson County Jail
Iowa City, Iowa

Douglas County Jail
Lawrence, Kansas

Sedgwick County Jail
Wichita, Kansas

Shawnee County Sheriff's Department
Topeka, Kansas

Hardin County Jail
Elizabethtown, Kentucky

Jefferson County Jail
Louisville, Kentucky

Jefferson Parish Prison
Gretna, Louisiana

Orleans Parish Prison
New Orleans, Louisiana

Penobscot County Jail and House of Corrections
Bangor, Maine

Baltimore City Jail
Baltimore, Maryland

Montgomery County Department of Corrections and Rehabilitation
Rockville, Maryland

Norfolk County House of Correction and Jail
Dedham, Massachusetts

Suffolk County House of Corrections
Winthrop, Massachusetts

Suffolk County Jail
Boston, Massachusetts

Detroit House of Corrections
Plymouth, Michigan

Oakland County Jail
Pontiac, Michigan

Wayne County Jail
Detroit, Michigan

City-County Workhouse
St. Paul, Minnesota

Hennepin County Jail
Minneapolis, Minnesota

Minneapolis City Workhouse
Wayzata, Minnesota

Ramsey County Jail
St. Paul, Minnesota

Clay County Jail
Liberty, Missouri

Jackson County Jail
Kansas City, Missouri

Municipal Correctional Institute
Kansas City, Missouri

Platt County Jail
Platt City, Missouri

St. Louis City Jail
St. Louis, Missouri

St. Louis County Adult Correctional Institution
Chesterfield, Missouri

St. Louis County Jail
Clayton, Missouri

St. Louis Medium Security Institution
St. Louis, Missouri

Silver Bow County Jail
Butte, Montana

Douglas County Jail
Omaha, Nebraska

Clark County Jail - Las Vegas Metropolitan Police Department
Las Vegas, Nevada

Belknap County Jail and House of Correction
Laconia, New Hampshire

Coos County Institution
West Stewartstown, New Hampshire

Essex County Jail
Newark, New Jersey

Monmouth County Jail
Freehold, New Jersey

Salem County Jail
Salem, New Jersey

Bernallilo County Jail
Albuquerque, New Mexico

Taos County Sheriff's Department
Taos, New Mexico

Bronx House of Detention
New York City, New York

Erie County Correctional Facility
Alden, New York

Erie County Jail
Buffalo, New York

Nassau County Corrections Center
East Meadows, New York

New York City Correctional Institution for Men
New York City, New York

New York City Correctional Institution for Women
New York City, New York

Orange County Sheriff's Department
Goshen, New York

Wilkes County Sheriff's Department
Wilkesboro, North Carolina

Cleveland House of Corrections
Cleveland, Ohio

Columbus Workhouse
Columbus, Ohio

Cuyahoga County Jail
Cleveland, Ohio

Franklin County Jail
Columbus, Ohio

Mahoning County Jail
Youngstown, Ohio

Montgomery County Jail
Dayton, Ohio

Comanche County Jail
Lawton, Oklahoma

Lawton City Jail
Lawton, Oklahoma

Linn County Sheriff's Department
Albany, Oregon

Tillamook County Jail
Tillamook, Oregon

Bucks County Prison
Doylestown, Pennsylvania

Delaware County Prison
Thorton, Pennsylvania

Philadelphia Prison System
Philadelphia, Pennsylvania

Allegheny County Jail
Pittsburgh, Pennsylvania

Rhode Island Department of Corrections
Cranston, Rhode Island

Spartanburg County Detention Center
Spartanburg, South Carolina

Minnehaha County Jail
Sioux Falls, South Dakota

Metropolitan Nashville/Davidson County Jail
Nashville, Tennessee

Metropolitan Nashville/Davidson County Workhouse
Nashville, Tennessee

Shelby County Penal Farm
Memphis, Tennessee

Harris County Sheriff's Department
Houston, Texas

Hutchinson County Jail
Borger, Texas

Travis County Jail
Austin, Texas

Salt Lake County Jail
Salt Lake City, Utah

Utah County Jail
Provo, Utah

St. Albans Correctional and Diagnostic Treatment Facility
St. Albans, Vermont

Chesapeake City Jail
Chesapeake, Virginia

Fauquier County Sheriff's Office
Warrenton, Virginia

Spokane County-City Detention Center
Spokane, Washington

Kanawha County Jail
Charleston, West Virginia

Men's and Women's Detention Center
Milwaukee, Wisconsin

Cheyenne Police Department Jail
Cheyenne, Wyoming

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