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Drug treatment services for adult offenders: The state of the state

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Abstract

We conducted a national survey of prisons, jails, and community correctional agencies to estimate the prevalence of entry into and accessibility of correctional programs and drug treatment services for adult offenders. Substance abuse education and awareness is the most prevalent form of service provided, being offered in 74% of prisons, 61% of jails, and 53% of community correctional agencies; at the same time, remedial education is the most frequently available correctional program in prisons (89%) and jails (59.5%), whereas sex offender therapy (57.2%) and intensive supervision (41.9%) dominate in community correctional programs. Most substance abuse services provided to offenders are offered through correctional programs such as intensive supervision, day reporting, vocational education, and work release, among others. Although agencies report a high frequency of providing substance abuse services, the prevalence rates are misleading because less than a quarter of the offenders in prisons and jails and less than 10% of those in community correctional agencies have access to these services through correctional agencies; in addition, these are predominantly drug treatment services that offer few clinical services. Given that drug-involved offenders are likely to have dependence rates that are four times greater than those among the general public, the drug treatment services and correctional programs available to offenders do not appear to be appropriate for the needs of this population. The National Criminal Justice Treatment Practices survey provides a better understanding of the distribution of services and programs across prisons, jails, and community correctional agencies and allows researchers and policymakers to understand some of the gaps in services and programs that may negatively affect recidivism reduction efforts.

Keywords

Drug treatment services for adult offenders; Outpatient therapy; Service integration; Prevalence; Access rates of services

1. Introduction

The last 35 years witnessed an increase in drug treatment services for criminal justice offenders. Much of the impetus began with the creation of the Treatment Accountability for Safer Communities programs in the mid 1970s, in which the goal was to link offenders to treatment services in the community as part of traditional supervision or diversion programs. Community and incarceration programs frequently evolved as special initiatives oftentimes tied to federally sponsored research demonstration projects that resulted in the creation of prison and jail treatment programs, boot camps, intensive supervision programs (ISPs), drug treatment courts, and the like. The push to create treatment services originated from the realization that most offenders are drug involved (Arrestee Drug Abuse Monitoring System [ADAM], 2003; Bureau

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of Justice Statistics [BJS], 1991; National Institute of Justice, 1991) and that more than half of those in public health drug treatment programs were referred by the criminal justice system (CJS; Etheridge, Hubbard, Anderson, Craddock, & Flynn, 1997; Hubbard et al., 1989). Thus, the accessibility and availability of treatment services for offenders have been part of the public policy arena within the criminal justice and public health sectors during the past three or more decades.

Although drug treatment services for offenders have been the subject of much discussion, not much is known about the variability and availability of treatment services. Different types of drug treatment programs can be offered in prisons and jails as part of probation or parole and in other local community correctional agencies. Drug treatment services can be offered as stand-alone programs or as part of other criminal justice programs, such as drug courts, boot camps, intensive supervision, day reporting centers, and work release. These can be in-house, contracted, and/or referral-based programs that vary in terms of their integration with the CJS (Taxman & Bouffard, 2000).

Knowledge about how the CJS provides drug treatment programs and/or services for offenders is limited and often program specific (e.g., studies on drug treatment courts Taxman & Bouffard, 2000, 2003a, prison-based drug treatment programs Harrison & Martin 2001, 2003; Inciardi, Martin, Butzin, Hooper, & Harrison, 1997; Simpson, Wexler, & Inciardi, 1999a, 1999b, diversion from prison Belenko, 2000 as well as probation Farabee, Hser, Anglin, & Huang, 2004, intensive supervision Petersilia & Turner, 1993; Taxman, 2002, and boot camps Coweles, Castalleno, & Gransky, 1995). However, more data about the nature of treatment services provided to offenders in the public health treatment system are available because of the large-scale surveys of drug treatment programs. The most recent survey, Drug Abuse Treatment Outcome Study (DATOS), found that more than 42% of the clientele enrolled in publicly funded drug abuse treatment programs were from the CJS (Craddock, Rounds-Bryant, Flynn, & Hubbard, 1997). Offenders tend to participate in traditional outpatient programs that consist of drug education and counseling services. Although the public policy arena has focused on increasing treatment services, there has been less discussion about how to provide such services. A nationally representative survey of correctional agencies was conducted in 2005 under the auspices of the Criminal Justice Drug Abuse Treatment Studies to understand the breadth and availability of drug treatment services in the CJS. This article provides estimates from the National Criminal Justice Treatment Practices (NCJTP) survey, including the programs and services offered in correctional programs and stand-alone drug treatment programs as well as the number of offenders in different correctional facilities who have access to and participate in drug treatment services. This article also discusses the implications of the survey results for the field of corrections and the debate on expanding treatment services for offenders.

1.1. Substance use or abuse disorders in the criminal justice population

The last several decades witnessed an escalation in the adult criminal justice population, with estimates ranging from 7 million (BJS, 2004) to 8 million (Taxman, Young, Wiersema, Rhodes, & Mitchell, 2007) adults under correctional control. A significant portion of this increase can be attributed to drug-related offenses. In 1986, drug law violators accounted for only 9% of the population in state prisons (BJS, 1990). Propelled by the "war on drugs" and the use of the CJS for offenders with substance use problems, this figure increased to approximately a quarter. From 1990 to 2000, the number of drug offenders in state prisons accounted for 20% of the total growth in the state prison population (Office of National Drug Control Policy, 2003). Drug offenders constitute an even greater share of the federal prison population, growing from 25% of the population in federal prisons in 1980 to an astronomical 61% in 1993 (BJS, 1995). In 2001, 55.5% of sentenced federal prisoners were drug offenders (Office of National

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Drug Control Policy, 2003). Statisticians from the BJS (2001) estimated that 72% of the growth in the federal prison system between 1990 and 1996 was caused by drug violations. Local jails show the same general trend, with the percentage of drug offenders rising from 9% in 1983 to 24.7% in 2002 (BJS, 1995; Harlow, 1998; Karberg & James, 2005).

Probationers accounted for 75% to 85% of all persons under correctional control in 2005. These represent approximately three times the number in prisons and nearly six times the average daily population (ADP) in jails. In 2004, a quarter (26%) of probationers were convicted of drug law violations, followed by drinking-and-driving violations (15%), and drug law violators also accounted for the largest percentage of parolees in 2004 (38%; Glaze & Palla, 2005). Nearly 50% of probation sentences include a court-ordered commitment to drug treatment or alcohol treatment services (Mumola, 1998).

A nationally representative survey of the incarcerated population in 1997 found that more than 80% of state prisoners and 70% of federal prisoners reported past drug use (Mumola, 1999). At the time of their offense, 37% of state inmates and 20% of federal inmates reported being under the influence of alcohol; in addition, illicit drug use at the time of the offense was reported by 33% of state inmates and 22% of federal inmates (Mumola, 1999). A nationally representative survey of jail inmates in 2002 found that two thirds were regular drug users and that more than half reported using drugs in the month before they committed the offense that led to their incarceration (Karberg & James, 2005). A 1989 survey found that 29% of the offenders were under the influence of alcohol and 27% were under the influence of illicit drugs at the time of their offense. The first nationally representative survey of adults on probation, which was conducted in 1995, reported that 40% of probationers were under the influence of alcohol and 14% were under the influence of an illicit drug when they committed their offense (Mumola, 1998). Even more direct connections between drug use and criminal offenses were evident from the findings of the 1997 Survey of Inmates in State and Federal Correctional Facilities, in which 19% of state prisoners and 16% of federal prisoners reported committing their offense to purchase drugs (Mumola, 1999). A representative survey of jail inmates in 1996 found that 16% reported such motivation, up from 13% in 1989 (Wilson, 2000).

Another study that aroused the nation's interest in drug abuse in the criminal justice population was the Drug Use Forecasting (DUF) study, which began in the late 1980s and continued through to 2003 as the ADAM. The study examined drug use among arrestees who were formally booked and charged in several major cities in the United States. In the 23 cities that participated in the DUF study in 1989, half or more of the arrestees tested positive for illicit drug use in 18 of the 23 cities (National Institute of Justice, 1991). Cocaine was the most frequently detected drug by a large margin (National Institute of Justice, 1991). A further iteration of the study (ADAM) included a more rigorous methodology to obtain a representative sample of arrestees. Data from 2000 showed a median of 67% of male arrestees testing positive for at least one drug (30% cocaine, 44% marijuana, and 5.8% opiates; Taylor, Fitzgerald, Hunt, Reardon, & Brownstein, 2001). Among female arrestees, the median testing positive for any illicit drug was 68% in 25 counties (35% cocaine, 32% marijuana, and 6.6% opiates). Twenty-three percent of male arrestees and 24% of female arrestees tested positive for two or more illicit drugs (Taylor et al., 2001). The results of urinalyses from the DUF/ADAM studies and findings from the BJS surveys of criminal justice offenders illustrate the extent of illicit drug use in the nation's criminal justice population.

Studies have shown—and continue to show—that without treatment, substance-abusing offenders will invariably repeat the same types of behaviors that led to their criminal justice status (Harrison, 2001). This is exemplified in statistics showing that among the nearly 300,000 prisoners released in 15 states in 1994, 67.5% were rearrested within 3 years and 51.8% were back in prison (Langan & Levin, 2002). Approximately half of those who ended up back in

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prison did so for technical parole violations (e.g., failing a drug test and missing an appointment with their parole officer). Drug offenders matched the national average, with slightly higher reincarceration rates evident among property offenders and slightly lower rates among violent offenders (Langan & Levin, 2002). Data from national inmate surveys in 1997 showed that 83% of state inmates and 59% of federal inmates were recidivists, with 54% of state inmates and 24% of federal inmates on probation, parole, or escape status when they committed the crime that led to their incarceration (Mumola, 1999). The high rates of recidivism in the nation's criminal justice population, coupled with the realization that most of those involved with the CJS are substance users, lead to the conclusion that addressing the treatment needs of drug-involved offenders is critically important in reducing the cost of crime, as well as other criminal justice and social costs.

1.2. Treatment services in the CJS

Data about drug treatment services for prisoners nationally are obtained primarily from two surveys: the national survey of inmates in state and federal prisons conducted by the BJS (Mumola, 1999) in 1997 and a survey of correctional facilities conducted by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) in 1997 as well. According to the SAMHSA survey, 40% of correctional facilities nationally provided some type of substance abuse (SA) treatment service onsite to inmates in 1997 (SAMHSA, 2002). Nearly all federal prisons (94%) and 61% of state prisons provided treatment (defined as detoxification, group or individual counseling, rehabilitation, and methadone or other pharmaceutical treatment). Jails and juvenile facilities lagged far behind, with only approximately a third providing treatment (SAMHSA, 2002). The survey did not include probation or parole agencies. The BJS survey of inmates found that approximately a third of state prison inmates and approximately a quarter of federal prison inmates reported that they had participated in drug or alcohol treatment or other SA programs since their incarceration (Mumola, 1999). Approximately 1 in 5 state and federal prison inmates reported participating in self-help or drug education programs in 1997, up from the frequency rates of 1 in 10 federal prisoners and 1 in 6 state prisoners in 1991 (Mumola, 1999). It appears that although drug offenders were increasingly being incarcerated during that period, there were few additional resources available for SA treatment. Professional drug treatment was reported by only 10% of state inmates and 9% of federal inmates in 1997 (Mumola, 1999). More recent estimates are that, among state prisoners released in 2001, only 1 in 5 drug- and/or alcohol-abusing individuals received treatment (Beck, 2000). Approximately 1 in 3 prisoners participated in self-help, peer counseling, or other education/awareness programs. Considering the depth of the typical inmate's addiction, self-help or drug education programs are unlikely to effectively address the needs of the population (Belenko & Peugh, 2005).

There were two major initiatives over the greater part of the last decade that provided core funding for SA treatment in the CJS, including prison treatment through the Residential Substance Abuse Treatment (RSAT) initiative and funding for drug courts through the Bureau of Justice Administration (BJA). The RSAT for State Prisoners Formula Grant Program, created in 1994, greatly increased treatment availability in the nation's prisons and jails. The RSAT initiative encouraged states to develop SA treatment programs for incarcerated offenders by providing funds for their development and implementation. With the RSAT program in operation, every state was exposed to and offered a carrot with which to expand its residential treatment capacity. The BJA (2005) estimated that in FY (fiscal year) 2002, nearly 40,000 inmates received treatment services through the RSAT initiative. As of July 2004, 300 RSAT programs were in operation, and, since 2000, 10% of RSAT funds could be used for the treatment of parolees for up to 1 year after their release (BJA, 2005).[1] The RSAT initiative promoted the development of modified therapeutic communities (TCs) of at least 6 months' duration in prisons that included drug testing and aftercare.

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A new movement in the provision of drug treatment occurred with the creation of the first drug treatment court in Miami, Florida, in 1989, a specialty court that provided treatment, drug testing, and sanctions for drug offenders. Drug courts have received federal support since 1994, with an ongoing program at the Office of Justice Programs that assists in planning and developing drug treatment courts. Currently, there are more than 1,000 drug courts in the United States (SEARCH, 2003)—or an average of 1 drug court for every two counties. Drug treatment courts use a variety of mechanisms to provide drug treatment to offenders, ranging from referral to community-based services and to drug treatment provided in-house. Models vary significantly in terms of the quantity and types of treatment services provided. The National Association of Drug Court Professionals (1997) recommended that drug treatment be of 12 months' duration, with treatment conducted in phases. Reviews of drug court studies found that the percentages of drug court clients participating in treatment services vary considerably from 35% to 80% (Goldkamp, White, & Robinson, 2001; Gottfredson, Najaka, Kearley, & Rocha, 2006; Harrell, Cavanagh, & Roman, 1998; Peters & Murrin, 1998; Taxman & Bouffard, 2002). The lengths of time in treatment also vary from less than 30 days to more than 2 years, with most programs lasting less than 90 days. Even with the proliferation of drug treatment courts, few studies have analyzed the treatment services provided to offenders, with the exception of a naturalistic study on 4 drug courts by Taxman and Bouffard (2003a, 2005). In that study, 4 mature drug courts were analyzed to examine the types of treatment services that they provided. Two of the courts had specialized treatment programs for drug court participants exclusively, whereas the other 2 drug courts used existing outpatient treatment services in the community that included offenders and nonoffenders. The study found that drug court program completion rates were generally low, ranging from 29% to 48%. Compliance with drug treatment requirements was modest, with slightly more than 60% of the successful graduates completing at least 75% of the required drug treatment sessions and 21% of the unsuccessful graduates attending the same percentage of sessions. One site had a formalized treatment curriculum, whereas the others allowed the counselors to develop their own sessions. Treatment consisted of a variety of services, including group counseling, social and coping skills, case management, and relapse prevention (later phases). Support services were often accessed through the local self-help community (Alcoholics Anonymous, 12-step programs). The study included a survey of treatment counselors as well as observations of treatment sessions and found a mix of therapeutic approaches, including cognitive–behavioral strategies, education and aftercare, safety and self-exploration, and self-help or peer support (all used in relatively similar proportions of meetings and for similar proportions of overall treatment time; Taxman & Bouffard, 2003b).

The early 1990s witnessed the growth and expansion of boot camps, which represented the favored correctional program type during that period. Owing in part to the consistent meta-analysis findings that boot camps are not effective, they have declined in popularity (Mackenzie, 2000; Sherman et al., 1997). Treatment services and aftercare were viewed as important components of boot camp programs as evidenced by a study on boot camp programs which found that nearly all offered drug treatment programs, although 25% indicated that the services were mainly for drug education (Coweles et al., 1995). Most offered group counseling (86%), self-help groups (77%), individual counseling (64%), and milieu therapy (50%). The group counseling sessions tended to involve 12-step models, reality therapy, and stress management. Most programs reported using their own staff to provide treatment services, with 70% of staff having some type of formal training and 40% certified to provide treatment

[1]The original funding for the RSAT initiative was *$270 million for 1996–2000, representing the largest sum ever devoted to the development of SA treatment programs in state and local correctional facilities. The average award for implementing the RSAT treatment programs in states was *$450,000 in FY 1996, rising to approximately *$495,000 in FY 1997 and then to *$1 million in FY 1998. The RSAT program was continued after 2000, although funding in 2005 was reduced to a total of *$32.6 million for all 50 states and territories. The federal FY 2006 budget did not recommend further funding for the RSAT initiative.

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services. Coweles et al. also reported that 25% of the programs did not support postrelease programming and that the remaining 75% tended to have loosely configured mechanisms for continuing treatment after participation in the 90-day boot camp program. Several states had specialized facilities for boot camp graduates, but this was not a major trend (Coweles et al., 1995).

The provision of drug treatment as part of correctional programs has several challenges that researchers and policy-makers have observed over time. In addition to budgetary considerations, there are issues of treatment availability, quality of services, and staff training. Tension is natural in the merging of treatment goals within correctional programs, in which the emphasis is placed on behavioral change rather than merely adhering to requirements, and the same can be said for the merging of the philosophies of correctional and treatment agencies (Lockwood, Inciardi, & Surratt, 1997; Taxman & Bouffard, 2000). Other structural issues that providers wrestle with include selection criteria for placement in drug treatment programs, the use of reinforcement techniques to encourage treatment retention, the use of support mechanisms to increase offenders' participation in the community, the use of compliance measures to enforce requirements, and the time allocated for treatment within the correctional program (Farabee et al., 1999; Taxman & Bouffard, 2000).

1.3. Drug treatment for offenders in the community public health system

As part of the public health system, drug treatment is offered in the community in four major modalities: outpatient counseling (<5 hours per week), methadone-based outpatient programming (outpatient treatment with methadone), short-term inpatient treatment (<28 days), and long-term inpatient treatment (~6 months). Programs are licensed by the state, and counselors are generally certified by the state. Within each modality, program directors can provide treatment programs of varying clinical orientations and approaches.

In the late 1980s and early 1990s, two series of studies that were useful to understand the nature of treatment services provided in public health settings were conducted. One study focused on 476 private treatment programs and was conducted by Roman et al. from the University of Georgia. (It should be noted that most treatment programs were run by nonprofit organizations.) The other study was conducted as a cooperative agreement among teams of scientists and the National Institute on Drug Abuse (NIDA) to examine program types, client characteristics, treatment intensity, and treatment outcomes in typical community-based programs. The DATOS included 120 public and private treatment programs in 96 cities from 1991 to 1993 and collected information on 10,000 clients in 96 cities, with follow-up interviews of nearly 3,000 clients (Flynn, Craddock, Hubbard, Anderson, & Etheridge, 1997). The study on private treatment providers by Roman and Johnson (2002) found that nearly 23% of the referrals were from the legal system, more than 55% of the treatment providers offered outpatient programs (which tended to be group counseling), and 8.2% of the treatment providers also had programs for prisons. Over the last decade, more of the programs were offering services for specialized populations (e.g., women, relapsers, HIV/AIDS patients, and methadone maintenance patients), concurrent with a reduction in inpatient programs over this same period. Staff working in private treatment organizations tended to have masters degrees, and, overall, the programs tended to employ a number of part-time or contractual staff to run individual programs. The DATOS findings indicate that typical out-patient programs were similar to the drug court treatment programs described earlier in that they included a mix of approaches with a focus on psychosocial education group counseling sessions (Etheridge et al., 1997) and tended to be eclectic in the therapies that they provided (Simpson, Joe, Fletcher, Hubbard, & Anglin, 1997).

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2. Methods: The NCJTP survey

The NCJTP survey helps fill a void by identifying the nature and types of services available in correctional systems through all of their venues. It also provides information on the nature of correctional systems to determine the degree to which they have incorporated research findings into practice.

Most of the analyses discussed in this article are of simple descriptive statistics used to assess measures of prevalence, access, and duration of specific types of programs and services for offenders. *Prevalence* refers to the percentage of respondents who reported that their facility provides treatment programs and/or services. *Access* refers to the percentage of facility residents who could receive the services or participate in the programs on any given day (i.e., the percentage of offenders in a facility who could attend the program/service divided by the ADP). Point estimates are provided in terms of the percentage of the ADP involved in the program/service. An estimate of the number of offenders nationally involved in a program/ service on a daily basis, which is the sum of the number of offenders in the program/service, is provided (i.e., point estimates of the percentage of the ADP are converted into a number by summing across all facilities that offer the services).

Another series of measures was used to assess the quality of services as determined by whether the facility (1) uses a standardized risk assessment tool, (2) uses a standardized substance use assessment tool, (3) provides programs/services that are of at least 90 days' duration, and (4) incorporates some SA treatment as part of its correctional program. (Note. Although the literature on TCs suggests that effective programs should be of 9 to 12 months' duration, we used the 90-day measure in this study as a benchmark for all programs.) These measures were selected based on a review of the criminal justice and SA treatment literature that identified service delivery system issues that have empirical support for improving offenders' outcomes. For example, a series of articles by Lowenkamp and Latessa (2005) and Lowenkamp, Latessa, and Holsinger (2006) and a recent edition of *Crime & Delinquency* (Taxman & Marlowe, 2006) highlighted how the use of actuarial risk screening tools can be used to identify offenders who are more likely to benefit from placement in structured correctional and/or SA treatment programs. Research had found that programs and services lasting 90 days or longer increase the likelihood of effectiveness and promote lasting change for offenders (Hser et al., 2001; Hubbard et al., 1989; Simpson, Joe, & Brown, 1997), making it another useful measure of quality. The inclusion of SA as part of correctional treatment was selected because of the prevalence of substance use and/or abuse among offenders. Other measures could have been used, but we believed that these cited measures were the most salient to describe benchmarks for the correctional programs and services.

This survey was conducted on representative samples of prisons and counties, as discussed in the article on methodology included in this edition. The prison sample used the BJS 2000 census of prisons in which specialized drug and alcohol prisons were selected with certainty (n = 58) and a stratified sample of 92 prisons was chosen based on probabilities proportional to size and region as per the BJS strategy. A response rate of 70% was achieved. We used the most recent available census of prison facilities in the United States conducted by the BJS in 2000 (Stephan & Karberg, 2003) for the prison sampling frame. Of the 1,668 correctional facilities nationwide (private, state, and federal), 1,317 were state prisons, 3 were District of Columbia facilities, 84 were federal prisons, and 264 were private facilities. Federal prisons were excluded, as were facilities classified as community correctional agencies (n = 426) and specialized prisons (e.g., short-term hospitals and facilities serving individuals with a mental illness or those providing geriatric care). (The community correctional institutions were included in the local community sampling frame subsequently described.) Facilities categorized as targeting alcohol and/or drug treatment (n = 58) were sampled with certainty

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because of the nature of the present study, and the rest of the facilities were sampled according to the methods used by the BJS in its national surveys of prisons (the United States is divided into eight categories: South, West, Midwest, Northeast, and the four states with the largest correctional populations).

The county sample included jails, probation and/or parole offices, and community treatment programs. Again, using size of the jurisdiction and region as stratifying criteria, 72 of 3,141 counties or county equivalents were selected. Because there is no complete directory of local correctional programs available, we used a two-stage stratified cluster sampling strategy (Kish, 1965) in which the first stage was the selection of counties or county equivalents as defined by the U.S. Census Bureau and the National Institute of Standards and Technology. The selection also uses probabilities proportional to the size of the county's population, which was divided into three categories (small = <250,000; medium = 250,000–750,000; large = > 750,000), with counties with a population of 3 million or greater being sampled with certainty. Twenty-four strata were created by taking this three-category size measure, crossed with the aforementioned eight-category region variable used by the BJS in its prison sampling frame.

The second stage was the census of criminal justice facilities or programs offered within the counties. A list of 644 respondents in the 72 counties was established after determining the structure of facilities and agencies in the counties (e.g., jails, community correctional facilities, and probation and/or parole offices). A purposive sample of up to five of the largest adult SA programs included in the 2003 National Survey of Substance Abuse Treatment Services file was also taken to garner a more comprehensive view of the community-based services available to offenders. The total target sample for the community treatment programs was 243.

Targeted respondents were facility administrators (e.g., wardens, chief probation/parole officers, and agency directors) who were responsible for the daily operations of the correctional facility. A 32-page survey instrument was sent to the respondents through mail. The survey contained basic agency-level questions on, for example, the ADP of the facility and funding for the facility; questions about the background and personal opinions of the respondents (i.e., sex, age, education, work experience, and personal value systems); questions on the size of the facility and types of programs and services offered in the facility; and questions on the structure of the services, use of standardized instruments to screen and assess offenders, program components (e.g., drug testing, sanctions, and incentives), and networking with others in the community to provide treatment services. Respondents were asked to return the survey instruments within 2 weeks, but the actual response period varied from several weeks to several months after the distribution of the instruments. After receiving the instruments, researchers contacted the respondents to clarify responses and address any missing item. A response rate of 70% was achieved for the prison sample, whereas that of 71% was achieved for the community sample.

This article's focus is on the services available for and provided to adult offenders. A separate article in this edition is devoted to the provision of services to juvenile offenders (Young, Dembo, & Henderson, 2007).

3. Findings: Overview of SA treatment for offenders in the CJS

The NCJTP survey examines the treatment and other services provided by or through the CJS, as well as referrals by the correctional system to other services (e.g., drug treatment programs). The results focus on two issues presented in the first set of tables: (1) the prevalence of SA treatment services in correctional settings as well as the estimated number of offenders who participate in these programs on any given day and (2) the quality of the SA treatment services as offered in specialized and general/generic prison facilities.

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The second set of tables examines the nature of the correctional programs offered in various settings. Again, we report on the prevalence of the services and the estimated number of offenders involved on a given day. We also included in the data whether the facilities indicated that they provide SA treatment services as part of the design of their correctional programs. The quality of the programs was measured as a function of two parameters: (1) the use of standardized risk and SA assessment tools to screen offenders for the program and (2) the duration of the program. Regarding duration, correctional programs that lasted 90 days or longer were considered to be sufficient to change offenders' behavior based on the research literature, as discussed earlier.

Nearly all of the prisons (96%) reported that states funded their facilities. Community-based facilities reported much more diverse sources of funding, with 77% being funded by states, 27% being funded by county or local governments, and 13% being federally funded (respondents could have reported multiple funding sources). In addition, the funding for 14% of these facilities comes from states and is passed along to counties or local governments (pass-through). Jails also receive their funding from a variety of sources. Whereas 97% of jails are funded by county or local governments, 47% are funded via pass-through and 27% are state funded. Regardless of venue, roughly the same median percentage of the staff is dedicated to clinical services. On average, 11% of the employees in prisons, 10% of those in community-based facilities, and 7.3% of those in jails work in a clinic-related position (e.g., social worker, assessor, or clinician).

3.1. Prisons

The survey of adult facilities covered 98 prisons (74 general prisons and 24 special drug treatment facilities) administered by state correctional systems. (Nationally, 94% of all prisons are classified as generic facilities and 6% are classified as specialized drug treatment facilities.) As discussed by Taxman et al. (2007), these are representative of the 1,018 prisons in the United States in 2003. The ADPs of the prisons in this sample ranged from 15 to 7,400 prisoners, with a mean of 1,045 inmates and a median of 800 inmates. Table 1 provides an overview of the SA services available in prison facilities. The first column shows the percentage of prisons that offer a service, whereas the second column shows the estimated number of offenders who receive a service (sum of all offenders offered the service on an average day). Columns 3 and 4 show the results for specialized prisons regarding the median percentage of the ADP to whom a service is made accessible and the percentage of programs lasting more than 90 days, respectively. Columns 5 and 6 show the same information for generic prisons. (A specialized prison is that which has been designated for SA offenders, whereas a generic prison is that which serves offenders with an array of needs.)

As might be expected, drug/alcohol education is the service most frequently provided, with 74% of prisons offering this service. This is similar to the proportion found in the 1997 SAMHSA survey. It is estimated that more than 75,000 inmates receive drug/alcohol education on a given day. The other most frequently provided treatment services in prisons are group SA counseling (55% of prisons offer this service for up to 4 hours per week, and 46% offer it for 5–25 hours per week) and relapse prevention groups (45%). More than 52,000 inmates are receiving 5–25 hours of group SA counseling per week, and more than 39,000 are participating in relapse prevention groups. It should be noted that many prisons likely offered multiple (counseling and relapse prevention) or overlapping (TC and 5–25 hours per week of group counseling) SA services. Segregated TC programs are offered in 19.5% of prisons and serve more than 39,000 offenders at any given time.

Overall, approximately 170,597 individuals are offered SA treatment in generic prison facilities and 9,975 individuals are provided with services in specialized prisons. Generic prisons house a median of 860 offenders, and the percentages of the ADPs involved in SA services range

from 4% (relapse prevention groups) to 19% (≥ 26 hours per week of group SA counseling). Fifteen percent of the ADPs in prisons are served in a segregated TC unit within the general prison population, nearly the same percentage of those served in nonsegregated TCs (14%).

As expected, specialized drug treatment prisons tend to offer more services to offenders as compared with generic prisons. The median ADP in a specialized prison is 770. Low-intensity group counseling and case management are provided to nearly all offenders, which is not the case in generic prisons. The services provided in generic facilities are less likely to meet the 90-day duration measure as compared with specialized treatment facilities. Eighty-five percent of the services provided in specialized prison facilities are of at least 90 days' duration, whereas only 63% of the services offered in generic facilities surpass the 90-day threshold. The services most likely to surpass the 90-day threshold in both generic and specialized SA prisons are TCs (both segregated and nonsegregated) and group SA counseling for 5–25 hours per week, followed by drug/alcohol education and relapse prevention groups.

Substance abuse treatment services are often available within other types of correctional programs offered within prisons. Correctional programs are specific programs often designed to punish offenders and change their behavior. The average prison offers 2.2 correctional programs. Table 2 provides an overview of the types of correctional programs offered by prisons and the number of inmates involved in such programs, as well as the proportion of these programs offering standardized SA assessment and treatment, the number of offenders receiving services, the proportion of programs using other risk assessment tools, and the proportion of programs lasting 90 days or longer. The most frequently offered programs in prisons are education/GED (General Educational Development) preparation (89%) and vocational training/job readiness (71%); boot camps, day reporting, and transitional housing are infrequently provided (4%, 5%, and 2.6%, respectively). As shown in Table 2, access is an issue with correctional programs in that few inmates are involved with any program. The median percentage of offenders involved in intensive supervision is 6%, whereas that of offenders involved in day reporting is 15%. Although education/GED preparation and vocational training/job readiness programs are offered in most prisons, these programs tend to have a relatively small percentage of the ADP involved (only 7%–8% of the ADP), for estimated national averages of 139,362 and 107,262 offenders, respectively, on any given day.

The survey found that approximately 15% of the correctional programs administered by prisons are offered in community settings. Most likely, these prisons administer back-end release or transitional programs for offenders who are nearing their reentry to the community. Of the 1.2 million offenders in prison, the national estimate of offenders involved in back-end release programs (40,982 in ISPs and 5,022 in work release) is relatively small. Transitional housing programs are infrequently provided (~3%) and tend to be in stand-alone prison facilities where all of the offenders are in the program. They also serve a small number of offenders nationally (~6,847).

As shown in Table 2, many of the correctional programs include SA treatment services, most likely as a strategy to integrate services for offenders. The work and education programs (e.g., education, vocational training, and work release) are less likely to offer drug treatment services, but more than half of the day reporting, sex offender therapy, and ISP services provide them. All of the boot camps reported offering SA services.

This study used several measures of quality to examine the correctional programs, with the two main measures being the availability of SA as well as risk assessment standardized tools to determine the offenders' need for a program and the duration of each program. Substance abuse assessment tools are more widely available in prisons as compared with risk tools (Taxman et al., under review). Most prisons that offer correctional programs tend to use some

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type of SA tool to screen and select for the programs. Overall, 54% of prisons use at least one SA assessment tool and 25% use a standardized risk assessment tool. The most frequently used standardized SA assessment instrument is the Addiction Severity Index (27%), whereas 38% of prisons reported using an assessment tool of their own design. The most frequently used standardized risk tool is the Level of Service Inventory–Revised (20%). Prisons, particularly those that have boot camps and day reporting programs, indicated that they use the risk assessment tools after offenders have been selected to participate in the program instead of as a mechanism to identify offenders in the prison who are suitable for the program. Sixty percent of facilities offering vocational training/job readiness use a standardized SA screening tool, whereas 51% of facilities offering education/GED preparation and day reporting use such tools. The same is true for back-end release programs, with 84% of facilities providing work release programs, 64% of those offering transitional housing, and 59% of the ISPs using standardized SA tools to screen inmates.

Most prison setting programs and back-end release programs are provided for more than 90 days. Overall, 68% of all in-prison programs and 83% of all back-end release programs last for more than 90 days. Boot camps are less likely to be of 90 days' duration as compared with other programs, with the exception of transitional housing. Most transitional housing programs are of 30 days' duration, although 36% of these are offered for at least 90 days.

3.2. Jails

The NCJTP sample consists of 57 jails, of which 74% are locally operated facilities, with the remaining 26% being state operated (either a regional jail or a regional facility). Jails range in population on a daily basis from 4 to 53,000 individuals, with a median population of 65 inmates. The median state-operated facility has a population of 405, whereas the median locally run jail holds that of 65. None of the jails defined themselves as specialized facilities.

Most local counties have a jail or detention facility for offenders who are awaiting trial or serving short sentences (generally ≤ 12 months, although offenders can spend up to 24 months in the local jail/detention facility in some states). The annual flow through jails in the United States is 9 million, and 70% of the population are released within 72 hours (Beck, 2006). According to the survey, jails had a standing population of 713,990 in 2005.

Table 3 describes the prevalence of SA treatment services in jails and the median ADP served. Drug/alcohol education is the most frequently provided treatment service (61% of jails), accompanied by up to 4 hours of group SA counseling per week (60%). Other services are infrequently provided, although 51% of jails offer relapse prevention groups. The treatment services in jail settings are provided to only a small portion of the ADP, ranging from 3% (≥26 hours of group SA counseling, segregated TCs, and relapse prevention groups) to 11% (5–25 hours of group SA counseling). Generally, the SA services provided in locally run facilities are even less accessible to offenders as compared with those in prisons.

Slightly more than half of all SA treatment services (56%) in jails are offered for more than 90 days. Segregated TC services (98%) and relapse prevention groups (94%) are more likely to be of 90 days' duration than other services, although each is available to only 3% of the ADP. Less than half of the two most frequently provided services (drug/alcohol education and group SA counseling for up to 4 hours weekly) last for more than 90 days (20% and 48%, respectively).

Table 4 presents the prevalence of various correctional programs in local jails, the estimated number of offenders in each program, the proportion of programs that include SA assessment and treatment, and the proportion of programs of 90 days' duration. Overall, 84% of the jails reported offering a work release program and 60% reported offering education programs. Less

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frequently offered are transitional housing, sex offender therapy, and vocational training, which are offered in less than 10% of jails (provided in 2%, 3%, and 7%, respectively, of facilities). Table 4 also shows the percentage of the ADP involved in correctional programs in jails, as well as the median daily population in these programs, and illustrates that offenders in jails have limited access to correctional programs. It should also be noted that locally run jails tend to offer more programs as compared with state-run or regionally administered facilities.

Correctional programs in jails are also less likely to offer SA treatment services as compared with similar programs offered in prison settings. Some type of SA treatment service is offered through 22% of correctional programs in jails. Facilities providing transitional housing offer these services most frequently (92%), followed by boot camps (75%). Far less than half (35%) of work release programs, the most frequently offered program, provide SA treatment services, and only a small number of offenders in jails are actually provided with drug treatment services as part of the correctional programs.

Roughly a third of jails (35%) reported using an SA screening tool. The most frequently used tool (by 30% of facilities) is the Drug Abuse Screening Tool, whereas 36% of jails use a screening tool of their own design. Jails that offer ISPs are the most likely to use an SA tool (56%), whereas those offering day reporting are the least likely to use one (3%). Few jails (1%) use standardized risk assessment tools, and, overall, such tools are used much less frequently as compared with SA screening tools. Jails that provide transitional housing are the most likely to use risk tools (23%), followed by those providing vocational training/job readiness (11%) and sex offender therapy (6%). Less than 2% of the remaining program types use standardized risk tools.

Owing to the turnover in population and shorter facility stays, jails are more likely to offer shorter durations of correctional programs. Approximately a third (36%) of the programs provided in jails are of at least 90 days' duration. Only 3% of day reporting programs are offered for this duration, whereas 65% of work release programs are provided for this length of the time. Close to half of all ISPs (45%) last for 90 days or longer, and approximately a quarter of transitional housing (29%), vocational training (29%), and boot camp (25%) programs last for this length of time.

3.3. Community supervision (probation, parole, and local correctional agencies)

The drug treatment services and correctional programs offered in the 134 agencies that supervise offenders in the community are described in Tables 5 and 6, respectively. More than 4.5 million offenders are under some form of supervised release, ranging from 20 to 95,000 individuals per agency (*Mdn* = 600 individuals). Seventy-seven percent of facilities are operated by states or through state-funded contracts, and 23% are run at a local or community level. Table 5 describes the SA services provided in supervision agencies. (Note. This does not include those services offered by other public health treatment services that may be accessed by referral from community supervision agencies. These are not captured because a pretest of the survey instrument found that community correctional agencies could not identify who they had referred to SA services in the community.) Only 2% of the supervision agencies indicated that they serve SA offenders only (classified to this point as specialized facilities), and 98% of supervision agencies are responsible for a broad array of offenders (classified to this point as general or generic facilities). The most frequently offered services, available in approximately half of the community agencies, are drug/alcohol education (53%) and low-intensity group SA counseling (up to 4 hours per week; 47%). Relapse prevention groups are offered by slightly more than a third (34%) of the supervision agencies. Group SA counseling lasting 26 hours or longer is the least frequently offered service (2%), although 21% of the facilities offer SA counseling for 5–25 hours per week.

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The survey findings confirm that services are provided less frequently in community settings than they are in incarceration facilities and that fewer offenders have access to the available services. Offenders who can access SA treatment services range in number from 190,906 for drug/alcohol education to 141,263 for group counseling of up to 4 hours per week and to 93,088 for case management. The survey found that 538,379 of the nearly 5.7 million supervision offenders participate in some type of SA treatment service in community correctional programs, which is slightly less than 10% of the supervision population.

Although the SA services offered through community supervision only benefit a small portion of the ADP, most are offered for 90 days or longer. Specialized facilities are more likely to provide services for more than 90 days. Eighty-nine percent of all services in specialized facilities are of at least 90 days' duration, ranging from 24% of the segregated TCs to 100% of the case management programs. None of the nonsegregated community-based TCs exceeds 90 days. In generic facilities, 65% of all services last for 90 days or longer, ranging from 24% (≥26 hours of group counseling) to 93% (5–25 hours of group SA counseling per week).

Community supervision agencies differ greatly from prisons and jails in terms of the availability of correctional programs and their accessibility for the nearly 6 million offenders on supervision. Table 6 shows that sex offender therapy is the most frequently offered program (provided by 58% of the agencies), followed by intensive supervision (42%) and transitional housing (24%). With nearly 6 million offenders on supervision (as compared with 1.2 million in prisons and 713,000 in jails), the median percentage of offenders in correctional programs is lower than the percentages in prisons and jails, ranging from less than 1% (transitional housing and boot camps) to 9% (intensive supervision). Nearly 321,000 individuals are involved in ISPs nationally. (Some states have a policy that all parolees are to be initially placed on intensive supervision. Others use risk tools to determine who should be eligible for ISPs.) If ISPs are excluded, less than 5% of the ADP are involved in correctional programs in community supervision agencies.

As noted, some supervision agencies are administered by state agencies and others are administered by local governments. Locally run facilities offer day reporting to 3% of the ADP and intensive supervision to 3% of the ADP, whereas state-run facilities offer day reporting to 19% of the ADP and ISPs to 9% of the ADP. However, the other correctional programs offered through locally run facilities (e.g., drug courts and sex offender therapy) are accessible to a greater percentage of the ADP as compared with programs provided by state-administered facilities. Sixty-five percent of all community-based programs are offered for more than 90 days, ranging from 20% (transitional housing) to 96% (sex offender therapy).

The community correctional agencies reported different patterns of using standardized assessment tools. Less than half (42%) of community supervision agencies use some form of standardized SA screening tool. The most commonly used tool is the Substance Abuse Subtle Screening Inventory (27%). Twenty-five percent of agencies developed their own tool. Agencies providing transitional housing are the most likely to use such tools (89%). Vocational training programs (75%) and boot camps (71%) also regularly use standardized SA screening tools, whereas those offering work release programs are the least likely to use them (29%).

Standardized risk tools are used by 50% of facilities, with a version of the Wisconsin Risk and Needs Instrument being the most frequently used tool (36%). Agencies that offer transitional housing are also the most likely to use risk assessment tools (88%), whereas those that offer boot camp programs are the least likely (33%). State-run services are more likely to use standardized risk assessment tools and SA screening tools (55% for risk assessment and 48% for SA screening) as compared with their locally run counterparts (32% for risk assessment and 22% for SA screening).

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Forty-two percent of all community supervision agencies offer some form of SA treatment service integrated into a correctional program. Work release programs are the most likely to include SA treatment services (82% of the programs), followed by drug courts (73%) and ISPs (69%). The community supervision program with the highest number of offenders receiving some type of SA service is intensive supervision, which provides SA services to nearly 10 times the population of the next highest total. Correctional programs offered through locally run facilities are more likely to provide treatment services as compared with programs offered in state-run facilities.

3.4. Other services provided in correctional settings

The last set of tables examines the prevalence of other services provided and the use of community referral strategies in prisons, jails, and community correctional settings. As discussed, other medical, social, and support services are more likely to be provided in prison settings than they are in jails or community correctional settings as these facilities are constitutionally mandated to provide psychomedical services because offenders are under the care of the state. Table 7 illustrates that prisons are more likely to offer all types of medical, psychosocial, and religious services. In general, fewer services are offered by community correctional agencies, likely because of the assumption that offenders can obtain such services from other organizations in the community, although studies have found that offenders may not always be welcomed by such organizations (Duffee & Carlson, 1996) and that waiting lists often prevent them from gaining access to services.

Community correctional agencies are more likely to have diverse referral strategies for SA offenders as compared with prisons and jails, as shown in Table 8. In general, nearly 60% of the parole and probation agencies reported that they make community-based treatment referrals for offenders, although less than half of them make an appointment with treatment providers. Roughly a third of jails make community-based referrals and establish contact with the offenders before their release, and prisons are less likely to make referrals or appointments to community-based organizations. Slightly more than a third of agencies reported using 12-step programs or establishing contact with service agencies for offenders before their release.

4. Discussion and conclusions

The National Survey of Criminal Justice Treatment Practices has provided a framework for capturing much needed information on the array of treatment services and programs provided to offenders in a variety of correctional venues. The survey adds to the existing literature through a comprehensive overview of services and programs provided in prisons, jails, and community correctional agencies. As expected, the survey confirms the finding from BJS surveys and other studies that there is a paucity of drug treatment services provided either as stand-alone programs or as part of other correctional programs for offenders. In addition, this survey expands the results from past studies by reporting prevalence rates, access rates, and a limited number of quality measures for the services or programs provided in facilities.

Although many correctional agencies report having programs or services for offenders (prevalence), the estimated percentage of the ADP involved in the services (access) is more telling. Substance abuse education and awareness is the most prevalent form of SA service, offered in 74% of prisons, 61% of jails, and 53% of community agencies, followed by group counseling for less than 4 hours per week (55%, 60%, and 47%, respectively). However, these SA education and low-intensity group counseling treatment services are offered to a relatively small number of the 8 million adults involved in the correctional system, with estimates of slightly more than 109,000 prisoners, 86,000 jail detainees, and 331,000 individuals under community supervision receiving these services each day. Together, they account for 42% of the SA services provided to prisoners, 63% of those provided to jail detainees, and 75% of

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those offered to offenders in the community. More intensive services are infrequently offered to offenders throughout the correctional system, although it appears that RSAT funding has achieved the intended goal of assisting agencies with providing clinical and intensive SA treatment services for offenders in prisons. The NCJTP survey illustrates that many correctional facilities attempt to provide SA treatment services for offenders but that the resources available limit the capacity of programs to a small percentage of their daily population. The available services tend to be more oriented toward educational awareness and minimal counseling, as opposed to intensive clinical services.

Similarly, other correctional programs are also difficult to access. Education is the most frequently available program in prisons (89%) and jails (60%), whereas sex offender therapy (57%) and intensive supervision (42%) dominate in community correctional programs. However, estimates of only 139,362 prisoners and 45,941 jail detainees receive education services while incarcerated (18,436 offenders are provided with such services in community correctional facilities). Again, these numbers illustrate how misleading the prevalence rates are unless one considers access issues; it appears that waiting lists for programs are a problem within correctional settings, much as they are in the community.

The survey also offers an enhanced understanding of the SA treatment services provided to offenders. The NCJTP survey found, similar to the reanalysis of the 1997 inmate survey data conducted by Belenko and Peugh (2005), that much of the drug treatment services offered to offenders can be more clearly characterized as educational or awareness building, falling at the lower end of clinical services; that is, drug treatment services focused on developing insight, skills to manage drug-using behaviors, and prosocial and (non-drug-using) social networks, among others, are less likely to be provided. The focus on education and awareness services and weekly group counseling will not address the substance use needs of offenders given that they are four times more likely to have a dependence problem as compared with the general population (SAMHSA, 2005a, 2005b). This finding is confirmed in various studies, including the latest ADAM study and the Belenko and Peugh reanalysis of the 1997 inmate survey data. In the ADAM study on arrestees in 30 cities, 35% of the male offenders and 50% of the female offenders met the clinical definition of being in need of treatment (ADAM, 2003) based on their drug-using behaviors. The Belenko and Peugh study revealed that offenders were more likely to have progressed from abuse to dependence and that the severity of the problem behavior requires more intensive therapeutic services than mere educational groups. The NCJTP survey findings add to the existing body of literature indicating that there is a gap not only in the availability of SA treatment services for offenders but also, and more importantly, in the types of services provided to offenders.

Substance abuse treatment is generally intertwined with correctional programs, suggesting that correctional programs are a critical component of the drug treatment delivery system for offenders. Approximately 54% of the drug treatment services for prisoners are provided within correctional programs, as compared with 59% for offenders under correctional supervision and 42% for those in jails. The importance of correctional programs in the provision of drug treatment services has been previously discussed in studies on drug courts (Taxman & Bouffard, 2003a, 2005), boot camps (Coweles et al., 1995), TCs (Harrison & Martin, 2003; Simpson, Wexler, & Inciardi, 1999a, 1999b), and ISPs (Petersilia & Turner, 1993). Correctional programs provide the link to drug treatment services using various forms of legal coercion, and treatment as part of correctional programs tends to improve outcomes, particularly programs that offer treatment, testing, and sanctions (Mackenzie, 2000; Sherman et al., 1997). However, a number of challenges to marry the punishment and treatment goals exist. Because many correctional programs are designed to be retributive (e.g., boot camps and day reporting programs) or incapacitating (e.g., intensive supervision and work release), the inclusion of drug treatment services in this framework forces the therapeutic components to

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compete with the correctional program components as a primary concern of the programs. Studies on drug treatment courts and boot camps that examined the nature of drug treatment services provided to offenders found that SA treatment was part of their programs but that correctional goals were often more important than the therapeutic goals (Coweles et al., 1995; Gottfredson et al., 2006; Taxman & Bouffard, 2000, 2003a). This may explain why drug and alcohol education and outpatient therapy (e.g., counseling for <5 hours per week) are frequently included in correctional programs. More intensive treatment regimens may require time that would interfere with correctional components such as increased face-to-face contacts, community service, and status hearings, among others.

Findings from this survey illustrate however that gains may have been made in the quality of services available in the system and that administrators in the correctional system are aware of the research-based program factors that affect quality. Roughly half of jails and community correctional programs and nearly two thirds of prisons reported that their drug treatment services last for 90 days or longer. Comparing these findings with those of other studies on correctional SA treatment programs over the last two decades suggests that this is a positive advancement for the field (Butzin, Scarpitti, Nielsen, Martin, & Inciardi, 1999; Coweles et al., 1995; Inciardi, Martin, & Butzin, 2004; Martin, Butzin, Saum, & Inciardi, 1999) as SA services are now offered for a longer duration. Longer duration of services helps ensure that treatment programs, if properly designed, have the potential for affecting offenders' recovery. In addition, it appears that roughly half of prisons and community correctional agencies and a third of jails use some form of standardized SA assessment tool; furthermore, nearly a third of community correctional agencies use a standardized risk assessment tool. Community correctional agencies are also using strategies for referring offenders to services in the community fairly regularly, although prisons and jails have not adopted such strategies to the same degree. These indicators suggest that the field is making strides to usher offenders into services based on their needs.

The current collage of services and programs provided to offenders varies across correctional venues. The survey findings illustrate that, compared with the 5.7 million offenders in jails and community correctional programs, a greater percentage of prison inmates can access programs and services as a result of their greater availability. The challenge of increasing the rates of services in jails, community supervision agencies, and community correctional agencies still lies ahead. Another challenge is to change the intensity of services offered to offenders, including providing more counseling to therapeutic interventions for longer durations. Although no controlled study on the merits of therapeutic programs to educational ones exists, consensus in the field is that cognitive–behavioral, TC, and other behavioral strategies are more likely to achieve reduced recidivism and drug use (Chandler & Fletcher, 2006; NIDA, 1999).

Another major issue is the appropriateness of services provided to offenders given their unique psychosocial needs (e.g., poorer educational attainment and higher prevalence of SA dependence as well as mental health issues). More analyses are needed to explore the nature of the treatment services offered to offenders, as shown in other articles in this edition and other analyses currently underway. It also appears that correctional agencies may make service and program decisions that are based more on reducing costs and providing minimal services to as many offenders as space provides rather than on providing effective services that are more likely to yield reductions in drug use and recidivism. Future analyses from this survey will examine these service decisions in the context of the sociopolitical environment of correctional agencies.

The survey has three limitations that are important to note. Although the survey provides estimates of the numbers and types of programs and services offered, it does not indicate when during the correctional stay can offenders receive the services. The point prevalence estimates

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could actually be altered if services for prisoners were offered during a specific period (i.e., the last 6 months) or only to offenders who have been diagnosed with an SA disorder (i.e., those who have been clinically assessed). The survey did not determine whether there was a pattern of offering services, but the current knowledge of the prison system is that most prisons do not have set policies that limit SA treatment services to offenders at the end of their stay. Furthermore, as shown by the survey data on the availability of SA assessment tools, few correctional agencies have the means to determine the offender pool actually in need of treatment.

The overall state of the state shows that existing services and programs provided by correctional agencies and their drug treatment agency associates will have a marginal impact on the desired goals of public safety and offender change unless there is a greater commitment to providing SA services and correctional program packages that are better suited to meet the needs of offenders. Along with this, such packages must also be made available to a greater percentage of offenders throughout the correctional system.

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Table 1

Prevalence of SA services in prisons

Type of program/service	Percentage with program[a]	Estimated no. of offenders[b]	Specialized facilities		Generic prisons	
			Percentage of ADP (*Mdn*)[c]	Percentage of programs lasting >90 days	Percentage of ADP (*Mdn*)[c]	Percentage of programs lasting > 90 days
Drug/alcohol education	74.1	75,543	8.8	92.1	9	65.3
SA group counseling						
Up to 4 hours/week	54.6	34,509	76.9	73.9	10	58
5–25 hours/week	46	52,293	8.8	92.9	8	72.9
≥ 26 hours/week	11.2	12,182	11.3	78.9	18.6	24.3
TC						
Segregated	19.5	34,776	8.8	84.3	15.5	74.8
Nonsegregated	9.2	10,710	5.7	91.6	14.4	66
Relapse prevention groups	44.5	39,493	13	74.3	3.8	62
Case management	6.9	10,761	100	91.1	9.1	40.7

[a]Percentages of facilities that indicated that they offer the service.

[b]National estimates of the sum of the number of offenders in the service on an average day.

[c]Percentages of the population involved in the service on an average day.

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Table 2

Offenders in correctional programs in prisons

Type of program/ service	Percentage with program	Percentage of ADP (*Mdn*)	Estimated no. of offenders in program	Percentage including SA treatment	Estimated no. of offenders receiving SA services[a]	Percentage using SA assessment	Percentage using risk assessment	Percentage of programs lasting > 90 days
Boot camp	3.8	8.2	6,749	100	6,749	28.1	71	28.1
Day reporting	4.8	15.2	1,637	50.8	832	50.8	53	97.8
Sex offender therapy	18.5	14	28,272	61.6	17,416	41.4	27.9	80.9
Vocational training	71	7	107,262	28.5	30,570	60.3	26.3	64.9
Education	89.2	7.8	139,362	36.3	50,588	51.3	21.6	70.5
Intensive supervision	13.4	6.2	40,982	53.4	21,884	58.5	25.7	79.6
Work release	15.8	6.3	5,044	20.1	1,014	84.5	19.5	99.3
Transitional housing	2.6	100	6,487	56.9	3,691	63.6	28	36.3

[a] National estimates of the number of offenders provided with SA treatment within the correctional program on an average day.

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Table 3

Substance abuse services in jails

Type of service	Percentage with services	Estimated no. of offenders in a service	Percentage of ADP (*Mdn*) for general facilities	Percentage of programs lasting > 90 days for general facilities
Drug/alcohol education	61.3	47,237	4.5	19.9
SA group counseling				
Up to 4 hours/week	59.8	39,943	7.4	48.1
5–25 hours/week	23.1	16,471	10.8	8.9
≥26 hours/week	1.1	1,185	3.4	92.3
TC				
Segregated	26.2	11,889	3	97.9
Nonsegregated	< 1	282	4.3	75.4
Relapse prevention groups	50.7	20,173	3	93.6
Case management or TASC	22.8	15,235	7.7	89.8

Note. TASC indicates Treatment Accountability for Safer Communities.

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Table 4

Correctional programs in jails

Type of program/ service	Percentage with program	Percentage of ADP (*Mdn*)	Estimated no. of offenders in program	Percentage including SA treatment	Estimated no. of offenders receiving SA services	Percentage using SA assessment	Percentage using risk assessment	Percentage of programs lasting >90 days
Boot camp	25.7	1.5	4,692	74.8	3,509	24.1	0	24.9
Day reporting	20.7	1.5	3,715	5.3	197	3.3	1.8	3
Intensive supervision	43.8	100	38,179	<1	305	56.1	<1	44.6
Work release	84.2	5.2	33,852	34.9	11,814	32.8	<1	65.2
Drug court	20.9	3.1	4,617	6.5	300	5	<1	4.9
Transitional housing	1.6	1.5	817	92	752	35.8	23.1	28.8
Sex offender therapy	3.2	2.5	2,367	29.8	705	50.8	5.9	35
Vocational training	6.9	14.3	14,332	32.7	4,687	48.5	10.8	29
Education	59.5	3.7	45,941	2.5	1,149	9.2	1.4	16.7

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Table 5

Substance abuse treatment services in community supervision agencies

Type of service	Percentage with services	Estimated no. of offenders	Specialized facilities		Generic prisons	
			Percentage of ADP (*Mdn*)	Percentage of programs lasting >90 days	Percentage of ADP (*Mdn*)	Percentage of programs lasting >90 days
Drug/alcohol education	53.1	190,906	7.7	78	8.6	56.9
SA group counseling						
Up to 4 hours/week	47.1	141,263	4.8	90.9	3.3	62.8
5–25 hours/week	21.2	37,090	1	87.9	2.7	92.9
≥26 hours/week	1.5	2,449	<1	71.8	1.1	24.2
TC						
Segregated	3.7	17,579	27	24.3	2.6	77.2
Nonsegregated	3.4	9,815	100	0	6.6	86.8
Relapse prevention groups	34.3	43,740	<1	91.5	1.3	57.4
Case management	7.1	93,088	1.9	100	18	88.4

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Table 6

Correctional programs in community correctional agencies

Type of program/ service	Percentage with program	Percentage of ADP (*Mdn*)	Estimated no. of offenders in program	Percentage including SA treatment	Estimated no. of offenders receiving SA services	Percentage using SA assessment	Percentage using risk assessment	Percentage of programs lasting >90 days
Boot camp	<1	<1	2,136	28.8	615	71.2	32.6	46.1
Day reporting	13.4	3.8	140,463	20.1	28,233	38.4	53	48.6
ISP	41.9	9.3	320,931	68.9	221,121	45.4	51.6	65.2
Work release	7.4	3.9	34,150	81.7	27,901	29.1	54.1	45.3
Drug court	20.2	2.3	39,718	72.7	28,875	44	55.7	94.9
Transitional housing	24.2	<1	27,355	25.4	6,948	88.6	87.8	19.5
Sex offender therapy	57.5	2	80,471	41.7	33,556	47.4	45.9	96.2
Vocational training	22.6	2.2	67,157	7.1	4,768	74.5	70.7	23
Education	14.9	1.5	18,436	18.6	3,429	41.1	48.6	63.7

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Table 7

Prevalence of other screenings, assessments, and services

Program/Service	Prisons	Jails	Community correctional agencies
HIV/AIDS testing	68.7	22.3	11.9
HIV/AIDS counseling and treatment	50.1	27.5	12.9
Tuberculosis screening	92	60.8	11.9
Hepatitis C screening	79.6	23.5	11.3
Physical health services	93.5	73.8	13.4
Assessment for mental health	86.5	40.6	19.2
Mental health counseling	58.9	31.5	18.3
Assessment for co-occurring disorders	66.8	32.8	19.6
Counseling for co-occurring disorders	49.1	31.1	17.9
Family therapy/counseling	38.6	10.7	12.8
Domestic violence intervention	32.6	31.8	19.4
Communication or social skills development	57.6	16.6	10.9
Life skills management	56.6	20.7	17.3
Anger or stress management	49.7	31.7	18.4
Cognitive skills development	50.7	18.1	17.5
Job placement/vocational counseling	51.2	21.5	19.2

Note. Values are presented as percentages.

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Table 8

Offender reentry services

Reentry service	Prisons	Jails	Community correctional agencies
Community-based treatment referral	38.3	35.6	60.4
Community-based treatment appointment	25	23.4	31.3
Community-based treatment prerelease contact	14.1	26.5	19
Twelve-step contact	24.5	24.7	32.5
Parole/Probation prerelease contact	14.2	31.2	33.3

Note. Values are presented as percentages.