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A National Survey of Substance Abuse Treatment for Juvenile Offenders

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Abstract

Despite consensus about the value of substance abuse treatment for delinquent youth, information about its prevalence and availability is inadequate and inconsistent. This paper presents findings about treatment and other correctional service provision from a national survey of directors of 141 juvenile institutional and community corrections facilities. Educational/GED programming and drug and alcohol education were the most prevalent types of correctional and substance abuse services. Other common services included physical health services and mental health assessment, provided to about 60% of youth across facilities, and mental health counseling, life and communication skills, and anger management, provided to about half the youth. Substance abuse treatment, as with most other services, were more prevalent in large, state-funded residential facilities (where 66% provided treatment), than local detention centers (20%) and community corrections facilities (56%). More detailed data showed that the number of youth attending treatment in all types of facilities on any given day was very low.

Keywords

substance abuse treatment; juvenile offenders; correctional services; juvenile justice; delinquency

1. Introduction

1.1. Substance Abuse and Delinquent Youth

Many youths involved with the juvenile justice system experience multiple personal, education and family problems (Dembo & Schmeidler, 2002; Winters, 1999); often high rates of drug use are found among these youths. Many justice-involved youths use substances on a “regular” basis (Crowe, 1998; Dembo, et al., 1999; Feucht, Stephens, & Walker, 1994), some of whom have also demonstrated heavy usage levels and substance use disorders (Atkins et al., 1999; Gray & Wish, 1998; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002).

McClelland et al.(2004) found a high prevalence rate of multiple substance use disorders (SUDs) among Cook County juvenile detainees. Nearly half the detainees were found to have

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one or more SUDs, with 21% having two or more. Among detainees with a SUD, nearly half had multiple SUDs, the most prevalent involving alcohol and marijuana use disorders. Recent studies have also indicated a high prevalence of comorbidity in mental health problems among justice involved youths (Teplin et al., 2002; Wasserman, McReynolds, Larkin, Fisher, & Santos, 2002). Teplin et al. (2002) found nearly two-thirds of the male youths, and nearly three-quarters of the female youths, met diagnostic criteria for one or more psychiatric disorders.

While juvenile arrests for most offenses declined between 1994 and 2003, the rate of arrests for drug abuse violations increased 19%, with the increase being far greater among females (56%) than males (13%) (Snyder, 2005). A strong positive association between youths' drug use and crime has been well established (Dembo, Williams, & Schmeidler, 1993; National Institute on of Justice, 1999; Dembo, Schmeidler, Pacheco, Cooper, & Williams, 1997; Ellickson & McGuigan, 2000; Snyder & Sickmund, 2006; Tubman, Gil, & Wagner, 2004). Data from the Arrestee Drug Abuse Monitoring Program (ADAM) indicate high rates of alcohol and drug use among juvenile arrestees; across 9 jurisdictions, from 42% to 55% of male, and 26% to 65% of female, arrestees were drug positive (Zhang, 2004). While the causal dynamics are unclear (White, Loeber, Stouthamer-Loeber & Farrington, 1999; Wagner, 1996), delinquent youths tend to be more drug involved than non-delinquent youths.

Involvement with drugs or alcohol increases the likelihood of continued and serious contact with the juvenile justice system (CASA, 2004; Belenko & Sprott, 2002). Higher levels of involvement with substance use increase the rate of offending, the severity of the committed offense, and the duration of antisocial behavior (Greenwood, 1992; Lipsey & Derzon, 1998; Sealock, Gottfredson, & Gallagher, 1997). Further, the earlier the age of onset of substance use, the greater the likelihood of severe and chronic offending (e.g., Loeber, Green, Lahey, Frick, & McBurnett, 2000).

Substance involved juvenile offenders, particularly minority and inner city youths, are at high risk of being infected by and transmitting HIV and other sexually transmitted diseases via injecting drugs or crack cocaine-driven sexual activities involving multiple sex partners (Inciardi, Pottieger, Forney, Chitwood, & McBride, 1991; Smith-Rogers, 2001). Justice-involved youths have more serious psychosocial functioning problems than youths in the community (Lyons, 2001; Cocozza, 1992; Friedman, Katz-Leavy, Manderscheid, & Sandheimer, 1996) and it appears that the more youths penetrate the juvenile justice system, the more serious their emotional/mental health problems are (Robertson, Dill, Husain, & Undesser, 2004). It could be expected that youths placed in commitment programs have higher rates of drug use than youths placed on probation or in diversion programs. A recent study of 203 youths in residential commitment programs in Pennsylvania, Ohio, and Delaware found they reported high one year pre-incarceration prevalence rates in the use of alcohol (77%), marijuana (80%), cocaine (22%), opiates (16%), hallucinogens (16%), PCP (15%), inhalants (10%), and the nonmedical use of sedatives (21%) and stimulants (19%) (Dembo et al., 2006).

1.2. Recent Responses

Several reviews of the field were completed in the late 1990s which identified important assessment and treatment issues relating to drug abusing adolescents (Weinberg, Rahdert, Colliver, & Glantz, 1998; American Academy of Child and Adolescent Psychiatry (AACAP), 1998; Winters, 1999). Perhaps the most significant recent effort at reform is reflected in the report of the American Academy of Child and Adolescent Psychiatry's Task Force on Juvenile Justice Reform (2001). The AACAP Task Force noted that many incarcerated youths often experience medical problems that, in the absence of systematic examination, remain undetected. The Task Force recommended that "detainees should have full access to all

assessment and treatment modalities that are medically indicated" (AACAP, 2001: 8; also see: Morris, 2001–in AACAP).

1.3. Assessments of Drug Treatment in the Juvenile Justice System

One of the most well-known studies of drug treatment in the juvenile justice system was the meta-analysis conducted by Lipsey and Wilson (1999). This meta-analysis focused on intervention studies conducted with serious juvenile offenders (i.e., adjudicated delinquents with prior offenses involving person or property crimes). Most relevant to the current study, Lipsey and Wilson focused on program characteristics, treatment type, and amount of treatment, and the relationship of these variables to recidivism (operationalized as police contact or arrest). Among noninstitutionalized juvenile offenders, duration of treatment was associated with larger effect sizes, and, interestingly, treatment intensity (i.e., the number of hours per week of treatment) was associated with smaller effect sizes. Further, the strongest effect sizes were associated with treatments that focused on strengthening interpersonal skills, individual counseling, and behavioral interventions. Among institutionalized juvenile offenders, integrity of treatment implementation and duration of treatment were associated with larger effect sizes; and, likewise, treatments focused on strengthening interpersonal skills and the teaching family home program (which is similar to therapeutic foster care programs). Subsequent work has indicated that family therapy is also associated with larger effect sizes (Lipsey, 2005).

Prepared for the National Institute of Justice, a report by McBride and colleagues (McBride, VanderWaal, Terry, & VanBuren, 1999): (1) summarized existing knowledge on programmatic efforts to intervene in the drugs-crime cycle, and (2) presented intervention models with the greatest potential for breaking this cycle. The authors summarized the evidence for the effectiveness of a number of different types of treatment programs (e.g., support groups, outpatient, day treatment, and inpatient programs; therapeutic communities for adolescents; family therapy). They recommend a comprehensive service model targeted to youths' drug abuse treatment needs as they move through different parts of the justice system, and, for youths placed in commitment programs, community reentry. No information is presented on the prevalence of drug abuse treatment services at different points in the juvenile justice system.

An extensive review compiled by a panel of experts convened by Drug Strategies (2005) identified ten key elements of treatment program effectiveness (e.g., systems integration; assessment and treatment matching). A related study of 144 highly regarded adolescent treatment programs showed that even among these programs, most do not adequately address critical treatment elements (Brannigan, Schackman, Falco, & Millman, 2004). Reclaiming Futures, a national demonstration effort seeking to integrate evidence-based adolescent treatment practices in juvenile justice settings, has yielded a number of useful lessons about implementing practice and policy reform in this area (Nissen, Butts, Merrigan, & Kraft, 2006; Nissen & Kraft, in press). While very informative, these reviews and studies did not provide data on the prevalence of drug abuse treatment in the juvenile justice system.

1.4. Prevalence of Drug Abuse Treatment Services in the Juvenile Justice System

The Council of Juvenile Correctional Administrators (CJCA) produces a yearbook documenting the state of juvenile correctional services. The *CJCA Yearbook 2005* reported results of a survey on institutional services completed by 46 of the 51 (90%) contacted juvenile jurisdictions. Results indicated 36 of the 46 (78%) jurisdictions provided substance abuse treatment at one or more of their correctional facilities. Twenty-nine jurisdictions (63%) reported they provided substance abuse treatment at most or all of their facilities, a finding that seems surprisingly low in light of the established facts that most youths in juvenile commitment programs are drug-involved and there is a strong connection between drug use and delinquency.

The Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies has issued brief reports on substance abuse services in juvenile correctional facilities based on a 1997 survey involving 3,127 facilities nationwide. The survey found 36.7% of the juvenile facilities provided substance abuse treatment (defined as group and individual counseling, detoxification, and pharmaceutical treatments while excluding self-help and drug and alcohol education programs) (SAMHSA, 2000; SAMHSA, 2002). Similar, but more detailed and updated information, was reported recently in *Juvenile Offenders and Victims: 2006 National Report* based primarily on the Census of Juveniles in Residential Placement and the Juvenile Residential Facility Census (JRFC), conducted by the Census Bureau for the Office of Juvenile Justice and Delinquency Prevention (OJJDP; Snyder & Sickmund, 2006). While data from multiple sources are combined in the 2006 report, the information presented on service provision is based on responses from nearly 3,000 juvenile facilities to the 2002 JRFC. Of those facilities reporting information on substance abuse services, 67% reported providing group counseling by a substance abuse treatment professional, and 20% said all youth in the facility received ongoing, onsite counseling for substance abuse (p. 226). Other service delivery data in this report include the prevalence of substance abuse screening (of facilities reporting any screening information, 61% said they screened all youth and another 20% reported screening some youth for substance abuse problems), use of drug testing, and mental health evaluations (Snyder & Sickmund, 2006).

There is no ready explanation for the discrepancy between the 36.7% figure from the SAMHSA survey and the 67% figure in the recent OJJDP report, although the latter number may be inflated somewhat because facilities that do not provide substance abuse service data are excluded from the calculation (no data on the number of facilities not reporting these data are provided). These unexplained differences, as well as the piecemeal nature of information gathered to date on substance abuse services in juvenile corrections (notably, neither survey reports data for services provided by community corrections facilities), highlight the need for more systematic and comprehensive studies of treatment service provision throughout the juvenile justice system.

1.5 The Current Study

As documented above, little is known about the prevalence of various types of substance abuse services throughout the juvenile justice system (local detention centers [jails], local community correctional programs, and residential facilities) and service availability in different components of the system. These concerns led to the development of a nationwide survey on these issues, conducted by Virginia Commonwealth University, University of Maryland, and partnering research centers within the National Institute on Drug Abuse's Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) cooperative. We report some results from the nationwide survey of juvenile justice agencies, including representative samples of juvenile residential facilities, local jails/detention centers, and community corrections offices and facilities. The results provide an informed picture of the current state of substance abuse treatment within the juvenile justice system, filling many important gaps in our understanding. Following a presentation of our results, their policy implications are discussed.

2. Materials and method

The survey of Juvenile Facility Directors (JFD) was part of a larger, multi-level survey of National Criminal Justice Treatment Practices (NCJTP) that gathered data from sources throughout the criminal justice and drug treatment systems. Information on the various samples and surveys employed in the NCJTP study and the JFD component, as well as details on survey frames, instrumentation, administration, response rates, and results of bias analyses can be

found in the survey methodology paper in this volume (Taxman, Young, Wiersema, Rhodes, & Mitchell, this volume).

2.1. Samples and Respondents

Two distinct sampling frames were required to address our goal of describing and assessing services in both institutional and community corrections. Residential facilities were selected from a sampling frame of 408 juvenile institutions listed in the 2003 American Correctional Association (ACA) national directory. This figure represents institutions identified from the total of 1,017 facilities listed in the directory (and an additional 19 facilities that were part of the 2000 BJS prison census and exclusively housed youthful offenders) after applying exclusionary criteria; facilities with a capacity of less than 25 were eliminated, as were diagnostic/reception centers, group homes, and community corrections facilities. As with the adult prisons, available funds dictated that a subset of the eligible institutions serve as the final survey sample. Sixty-seven of the 408 facilities were identified for this purpose using the same stratified (region and size), random sampling procedure employed with the NCJTP adult prison sample and federal Bureau of Justice Statistics surveys (see Taxman et al., this volume).

A two-stage strategy was used to identify the local juvenile jail and community corrections facilities. First, a stratified random sample of 72 counties were drawn from the 3,141 counties listed in the 2000 U.S. Census. These counties were selected to be representative of the country using stratification based on region and size of the county. The same counties were used for both juvenile and adult surveys. In the second stage, a purposive census of juvenile agencies was constructed using several information sources (the ACA Directory, municipal agency websites and directories, direct telephone inquiries, etc.). This included the primary juvenile corrections facilities (the largest juvenile jail or detention center, probation or parole offices) in these counties. Institutions included in the juvenile residential facility sampling frame were not eligible for the local sample. A total of 165 facilities in the 72 counties were identified for the local correctional sample.

Names, titles, and addresses of administrators responsible for operating the sample facilities were identified to receive the survey through phone verifications. Respondents were required to provide informed consent to take part in the research, which was approved by Institutional Review Boards at each of the CJ-DATS research centers involved in the study. Employing survey follow-up methods recommended by Dillman (2000) and others, we obtained an overall response rate of 59.5% (141 of 232), including 49 of 67 (73.1%) sampled residential facilities and 92 of 165 (55.8%) local correctional facilities and offices. This rate compares favorably with that found in most mailed organizational surveys, which average under 50% (Baruch, 1999), and particularly surveys of executives, which show rates of 20 to 30% (Cycyota and Harrison 2006). As explained in the accompanying NCJTP methods paper (Taxman et al., this volume), analyses indicated there were no differential response rates based on facility location, size, or type (residential facility, jail, community corrections) and further analyses using organizational data (resource and staffing factors, workplace climate and culture) suggested that there were no differences between respondents and non-respondents. Additionally, comparisons of JFD-derived weighted estimates of the juvenile population in residential facilities correspond with those reported by other sources (Taxman et al., this volume)

Although these findings suggest that the survey methodology employed in this Juvenile Facilities Director survey was successful, it involved a representative sample of facilities whereas the federal studies by SAMHSA and OJJDP were conducted of the national census of juvenile facilities and thus included much larger samples. The federal surveys also obtained response rates of over 90% (SAMHSA, 2000; Snyder & Sickmund, 2006). Nonetheless, the discrepancy in the federal surveys' findings on treatment prevalence as well as the lack of information on service access in these studies indicates the need for additional research.

Compared to the SAMHSA and OJJDP studies, enhancements in the present survey include the addition of community corrections facilities in the study sample (thus providing comparisons with residential and jail facilities) and more extensive queries about the types and duration of substance abuse and other correctional services, and youth access to those services. When comparing survey results it is also important to note that facilities that were exclusively devoted to providing substance abuse services were excluded from the OJJDP census (these accounted for about 10% of the juvenile correctional facility census used in the SAMHSA study), and that the JFD survey was aimed at facilities with the largest number of youth and excluded those that held fewer than 25 (these facilities accounted for more than half the facilities surveyed by SAMSHA and OJJDP).

2.2. Measures and Analyses

All of the organizational and attitudes scales used in the NCJTP and JFD Facility Director survey were either used directly or adapted from existing, psychometrically sound instruments. Survey sections addressing correctional services and treatment practice and policy areas were developed through a process of reviewing previously published large scale survey instruments (Chao, Sullivan, Harwood, Schildhaus, Zhang, & Imhof, 2000; Etheridge, Hubbard, Anderson, Craddock, & Flynn, 1997; Knudson & Roman, 2004), reviews by experts and practitioner stakeholders, and pre-testing in correctional facilities. Analyses were applied to weighted data to generate national estimates of service provision (see Taxman et al., [this volume] for a further discussion of the weighting procedures). Most analyses involved simple descriptive statistics used to assess measures of prevalence, access, and duration of specific types of programs and services. *Prevalence* refers to the percentage of respondents who report that their facility provides the service. *Access* was measured by the percentage of facility residents who could attend the service or program on any given day; typically, this was the program or service capacity divided by the facility's average daily population (ADP). In results tables, access is an aggregated average (mean or median) across all facilities reporting they provide the service. *Duration* refers to the percentage of facilities reporting that the provided service has a planned length of stay of 90 days or more, the suggested length of treatment for adults established in prior studies of substance abuse treatment (Hser et al., 2001; Simpson, Joe, & Brown, 1997).

To understand the differences in service provision in the different settings represented in the data, analyses were conducted separately for the three primary groups – juvenile residential facilities, local jails and detention centers, and community corrections (CC) offices and facilities. The survey did not include questions about security level or the number of detained (preadjudication) and committed youth in the facility, so we cannot be certain about these sample characteristics, but we expect the residential facilities are most comparable to the "long term secure" and "ranch/wilderness camp" facility types identified in the OJJDP National Report (where just 3% of the population are detained), while the local jails are comparable to the "detention center" facilities, in which 72% of the population is detained (Snyder & Sickmund, 2006, p. 202). As described by Taxman et al. (this volume), standard procedures for weighting based on differential probability of response were applied to present a national picture of the survey results. Weighted data on facilities, services, and youth are employed throughout the text and tables that follow.

3. Results

Survey responses showed three distinct facility profiles. As expected, virtually all of the residential units reported that they were directly funded by the state (1 facility reported no funding source), while jails reported receiving both county or city funding (92.1%) and state funding administered by the locality (82.9%). Community corrections agencies had an even greater mix of funding, as 55.7% reported some state support, 44.3% reported they received

state funds administered locally, and 63.1% had direct county or city funding (respondents could report multiple funding sources). The average daily population in the residential facilities was 180.8 (median = 98) youth, as compared to 33.4 (median = 30) in the juvenile jails and 278.3 (median = 85) youth in the community corrections facilities. The proportion of staff in clinical positions was greatest in the residential facilities, where they accounted for 30.3% of all staff compared to 25.3% in CC facilities and just 7.6% in the jails. This same pattern was evident when the number of clinical staff was compared to the facility census. The ratio of clinical staff to youth was 2 to 10 in the residential facilities, as compared to approximately 1 to 10 youth in the CC facilities and .8 staff to 10 youth in the jails/detention centers.

3.1. Correctional Services

In addition to detailed data on substance abuse services, the survey gathered prevalence, access, and duration information on other types of correctional programs that are found in both adult and juvenile justice settings. Table 1 shows the five most prevalent programs reported across all juvenile facilities in the sample. Other programs assessed in the survey include boot camps, which were in 8.9% of the facilities, and day reporting and work release programs, which were in less than 3% of the facilities (data not shown in table). As expected, educational programs were most common, and overall the number of youth estimated to attend these programs on any given day (106,325 nationally, using the weighted data) were more than three times the number attending the next most prevalent program (29,277, in intensive supervision programs). Although vocational services and therapeutic programs for sex offenders were fairly common (in 36.5% and 44.2% of the facilities, respectively), these were small programs accessed by only a few youth in most facilities.

Further inspection of Table 1 reveals that the low access figures reported in the “all facilities” column (represented by the percentage of the average daily population, or ADP attending the program) is dominated by the results reported by probation, parole, and other community corrections offices. The proportion of CC facilities offering any of the five programs compares favorably with prevalence data from the residential facilities and jails; however with the exception of educational programs, 7.5% or fewer CC youth participate in four of these programs. And while there are more CC youth attending education programs than youth in the other groups, these 45,272 juveniles represent only 22.9% of all youth in CC facilities offering educational programming. Intensive supervision programs, which involve increased monitoring and frequent contacts with supervision officers, have more participants than any program outside of education, but still serve just 7.5% of all youth and this same percentage of CC youth on a given day. The ADP attendance figures show relatively high access to education programs in residential facilities and jails (where the median figure of 100% indicates that half or more of directors in facilities that provided these services reported that all youth in their facility received education/GED services on a typical day). However, when data from all facility types are viewed in the aggregate, it is evident that youth in custody have very limited access to other kinds of correctional programs provided by juvenile justice agencies.

The pattern of service provision in the residential facilities and jails generally followed expectations. Because minor youth are mandated to attend school, nearly all the residential facilities and 62.6% of the jails provided education programs and virtually all youth in these facilities access these programs on a daily basis. In interpreting the relatively high “percent of ADP” figure for some programs in residential facilities (educational and intensive supervision) and jails (vocational and educational), it is important to note this is a median figure that applies only to those facilities reporting the service. Thus, while all the youth in at least half of the jail facilities that provide vocational services attend the program on any given day, only 17.3% of all the jails provide this well-attended service. Two-thirds of the residential facilities provide a vocational program, and in half of these facilities, the program is attended by 40% of the

daily facility census (i.e., in half of the facilities more than 40% attend, and in the other half less than 40% attend). Only 7.7% of the residential facilities provide transitional housing, and the program is only accessed on average by 12.5% of the ADP in these facilities. The 17.9% prevalence and 100% ADP median for intensive supervision in the residential facilities was higher than expected and may be attributable to some respondents interpreting this survey item literally, rather than its conventional referent (to intensive supervision probation or parole, which involves increased monitoring and more onerous reporting requirements for youth in CC settings).

3.2. Substance Abuse Treatment and Related Services

The survey assessed the same kinds of prevalence, access, and duration data on a range of substance abuse services and treatment programs (see Table 2). As expected, the least intensive service models were widely reported by respondents, with three-quarters of all facilities providing drug and alcohol education. Questions about case management were also in this section of the survey, and while only 21.2% of all facilities provided case management (including a surprisingly low 27.4% of the CC facilities), 94.4% of youth in CC facilities that provided case management were in the program, and the total estimate of 43,883 attendees was second only to the number in drug and alcohol education. Mirroring ongoing surveys of the national treatment delivery network (SAMHSA, 2004), the survey found that the most common treatment modality for juvenile offenders was brief (1–4 hours) weekly substance abuse group counseling. About 40% of all facilities provided this standard weekly “outpatient” treatment and 21.3% provided the equivalent of intensive outpatient treatment (5–25 hours weekly). As with the correctional programs, the aggregate access data showed that both of these modalities were available only to small numbers of juveniles, with 13.6% of the average daily population attending outpatient counseling and less than 1% attending intensive outpatient on a typical day. At 18%, the reported prevalence of therapeutic community (TC) treatment was larger than expected. In the substance abuse treatment literature, and as intended in the survey, TCs are a distinct modality involving intensive, behaviorally-oriented long-term residential treatment for drug-dependent clients. The TC figure in the Facility Directors survey may be inflated because some respondents interpreted the term literally, or sought to present a positive view of their facility as providing a therapeutic environment for youth.

Differences observed in the correctional services data between the three facility types were also evident in the substance abuse services findings. Both prevalence and access to services was highest in residential facilities. Additional analyses showed that 66.4% of the residential facilities offered at least one of the three primary treatment modalities (1–4 hours/week counseling, 5–25 hours/week counseling or TC treatment), compared to 55.7% of the CC facilities and 19.7% of the jails. Residential facilities also had the highest proportion of programs that met the 90-day duration criterion. Just under two-thirds of the outpatient counseling programs in these facilities had lengths of stay of 90 days or more, while less than 20% of the jail outpatient programs were of this length (it was not possible to calculate and report continuous duration figures since these survey questions used a categorical format, i.e., less than 90 days, 90–180 days, etc.). The high caseloads of the CC facilities again dwarfed the number of youth attending treatment in these offices, yielding very low access figures for the CC group.

3.3. Screening, Assessment, and Other Services

The Juvenile Facility Directors survey included a series of questions about the extent to which various screening, assessment, and other specialized services were provided to facility youth, either directly or through a referral made by facility staff. Detailed questions were asked about use of standardized substance abuse, mental health, and risk assessment tools. Just under half (47.6%) of the facilities reported using a standardized substance abuse tool, and the Substance

Abuse Subtle Screening Inventory (SASSI–A or SASSI-A2) was by far the most common tool, used in about half of the residential facilities (50.5%) and somewhat fewer jails (44.6%) and CC facilities (38.1%). The more comprehensive Addiction Severity Index (and companion tools for adolescents) was used in 16.5% of all facilities and about one-fourth (26.1%) of the CCs. Use of standardized mental health assessments was reported by 36% of the residential facilities and small numbers of CC facilities (13.5%) and jails (7%). Risk assessment is the standard means for determining levels of supervision in community corrections settings, so it was expected that CC facilities would report higher rates of use of these tools (36.0%) than residential (15.1%) or jail (8.0%) facilities. Nonetheless, the finding that almost two-thirds of the CC facilities did not report using any standardized risk assessment instruments was not anticipated. The rates of use of standardized family assessment instruments was similarly surprisingly low, at just 6.7% overall and a high of 7.5% in CC facilities.

On more general queries, respondents indicated the proportion of youth that were provided the service along a five-point scale ranging from “none” to “all.” To simplify presentation of these prevalence data (see Table 3), the responses were assigned quartile values of 0 to 100%. Given the diversity of practices represented in these data, it is notable that across all facilities their use ranges only 30 to 40 percentage points, generally between 20 and 60%. TB screening, which was provided to 56.1% of youth in all facilities, and physical health services (58.6%) were the most frequently reported somatic health services assessed in the survey. Similar proportions of youth were administered mental health assessments across all facilities (62.3%), while assessment for co-occurring disorders was conducted on less than half (44.1%) the youth. Across all facilities, mental health counseling was provided to 52.5% of the youth, and nearly as many youth (45 to 50%) were reportedly provided various kinds of behavioral development interventions involving communication, social and cognitive skills, and anger management. As was found with reported use of family assessment instruments, family counseling was provided at lower rates, averaging 40.9% of youth across all facilities.

The provision patterns among facilities for these services differ somewhat from those presented previously. While intensive and long-term correctional and substance abuse services appear largely limited to residential facilities, several of the services listed in Table 3 are common to jails as well as residential facilities. TB screening and physical health services were provided in jails at nearly the same high rates observed in the residential facilities. Just under three-fourths of youth in jails were administered mental health assessments, and assessments for co-occurring disorders and mental health counseling were provided to more than half the youth in jails. Similar proportions of the jail youth (54.3% to 73.3%) were provided the various behavioral and skill interventions assessed in the survey. The comparatively high rates of service provision reported by the jail facilities on these survey questions are comparable to the more detailed jail results for educational services and drug and alcohol education, suggesting that the counseling services assessed here (for mental health and co-occurring disorders, life skills, social skills, anger management, etc.) may be provided to large groups of youth in classroom-like settings.

Other than mental health assessment, which was provided to 51.2% of youth in the community corrections facilities, no service was provided to more than half of the CC youth. The same services that were prevalent in the institutional facilities were most frequently reported by CC respondents, but at roughly half the rate, ranging generally from 30% to 40%.

3.4. Continuity of Care and Reentry Services

Practices aimed at fostering juvenile offenders’ reintegration in the community after release from incarceration are critical correctional service components. The survey assessed the frequency with which facilities provided reentry services to youth with substance abuse problems using the same five-point response scale described above. For reporting purposes the

"none" to "all" responses were again assigned quartile values of 0 to 100%. About half (51%) of substance abusing youth in residential facilities were provided with a referral to a community-based treatment provider at discharge, while 31.2% of jail youth with substance abuse problems were given a referral. The residential facilities further reported that they also arranged for a post-release appointment with a community-based program with over half of their substance abusing residents (55.1%), while appointments were made for just 24.5% of youth leaving jails. Contact with a community-based treatment provider prior to release was reported for high levels of substance abusing youth in both residential facilities (88.1%) and jails (86.2%).

CC facility respondents were instructed to answer this series of questions in terms of the frequency with which youth with substance abuse problems appear to have received these transitional services upon their entry to the community corrections office. Consistent with the responses from the residential facilities, CC respondents reported that 47.1% of youth entering the CC facility came with a community-based treatment referral. CC respondents, however reported low rates of pre-release contacts between youth and treatment representatives or parole or probation officers. This likely reflects these respondents' knowledge about youth contacts with specific treatment staff and probation/parole staff with which they are familiar. Residential and jail respondents likely report higher rates because they are including contacts with any community-based providers and institution-based probation/parole staff that meet with youth in their facilities.

4. Discussion

As the first national survey to gather data on substance abuse service provision from directors of facilities for juvenile offenders in institutional and community settings, the Juvenile Facilities Director survey fills important gaps in knowledge that have been left by previous research efforts in this area. Findings presented here update and expand on the few prior studies that have reported national data, which have focused primarily on service prevalence in institutions (SAMHSA, 2000; SAMHSA, 2002; Snyder & Sickmund, 2006).

The JFD findings, however, also come with limitations. Unlike the census studies undertaken by SAMHSA and OJJDP, the JFD survey employed representative samples and while response rates were typical of mailed surveys and there was no evidence of response bias, higher rates would engender more confidence in the generalizability of the results. More generally, inconsistencies in terminology – prevalent in substance abuse services and pervasive in juvenile corrections – make interpretation of the survey responses inevitably imprecise. A perusal of the ACA directory reveals that, in addition to using terms such as detention unit and correctional center, states may variously refer to a long-term, medium-secure residential facility as a training school, development campus, or recreational camp. One survey respondent's therapeutic community may be another's wilderness camp. Using nomenclature from the national Census of Juveniles in Residential Placement, OJJDP reports that some portion of adjudicated, court-committed youth are held in facilities that census respondents identify as detention centers, while a small proportion of detained, pre-adjudicated youth are in what is identified as long-term secure facilities (Snyder & Sickmund, 2006, p. 202). Although there is a general consensus regarding the meanings of these various terms, variations in their use make any presentation of survey findings involving facility types and services inexact. And in the present case, obtaining consistency or confirming the accuracy of respondent answers through file review or other procedures was fiscally prohibitive (and in many facilities and systems, no supporting documentation exists).

Within the constraints of these limitations, the JFD provides new information on a range of treatment-related services, including counseling, assessment, and continuity of care practices,

as well as other correctional program offerings. Perhaps the most notable JFD survey results involve data not previously available on service access – the proportion of youth in a facility that take part in the service on any given day. By sampling relatively large, state-sponsored residential facilities, as well as local juvenile jails/detention centers and community corrections offices, the survey also provided an opportunity for comparative analyses that revealed distinct service profiles for these different settings. Findings in each of these areas is discussed below.

4.1. Service Prevalence

Survey results on the proportions of facilities providing various services were generally consistent with expectations and comparable to prior study findings. School, GED, and other educational programs were by far the most common type of service provided in surveyed facilities. The aggregate prevalence figure of 73.8% for all facilities is similar to that reported in the SAMHSA survey (77.1%). Intensive supervision programs were predictably prevalent (76.4%) in CC settings; between approximately one-half to two-thirds of the residential and CC facilities also provided the other two most frequently reported correctional services, vocational training and therapy for sex offenders.

Across all facilities, use of standardized substance abuse assessment tools was reported by 47.6% of the respondents, which corresponds with the 61.6% figure for any substance abuse assessment (standardized or not) in the SAMHSA survey. At 44.6%, the overall JFD figure for substance abuse treatment provision (ranging from 1–4 hours weekly of group counseling to TC treatment) is comparable to the 37% figure reported by SAMHSA (2002). Our survey data also reinforce a finding reported in the SAMHSA study about differences in the treatment prevalence rates associated with facility size, as 66.4% of the larger, state-funded residential facilities reported providing treatment compared to 19.7% of the smaller, local juvenile jails and detention centers.

4.2. Service Access

The survey assessed service access in two ways. One, relatively conventional approach that has been used in some previous surveys (CJCA, 2006; SAMHSA, 2000) queried respondents about the proportion or number of youth in the facility that are provided the service. Across the three facility types, several core services (mental health counseling, life skills, communication skills, anger and stress management) were reportedly provided to about half of the youth under custody, and 60 to 90% of youth in residential facilities and jails. Physical health services and mental health assessment were provided at higher rates, with about 60% of youth across the facilities and 96% or more residential facility youth and 72% or more youth in jail facilities. While the presentation of data in the CJCA and OJJDP reports does not permit direct comparisons with these JFD findings, they appear consistent across these various juvenile facility surveys.

Another method used in the JFD survey to measure access involved asking first if the service was provided, and if it was, asking about the number of youth attending the program on a daily basis. Estimates could then be made of the number of youth provided the service on a daily basis across facilities, and the average percentage of the facilities' census or ADP that participated on a given day. This more precise approach was used to assess access to substance abuse treatment, and educational and vocational programs. Responses to these questions showed that, with the exception of the high numbers of youth attending educational programs (and to a lesser extent drug and alcohol education) in residential facilities and jails, relatively few youth were participating in these services on a daily basis. Because the "percentage of ADP" figures (in Table 1 and Table 2) do not account for the turnover in program participation – as individuals graduate, transfer, or terminate from the program, their slots are filled with other participants – they understate the total percentage of youth in a facility who are provided

the service at some point over the course of their stay there. Nonetheless, viewing service provision in this way makes evident that there are very large numbers of youth who are *not* attending treatment programs on any given day, and that juvenile justice facilities and their sponsoring agencies are making very small investments in substance abuse treatment provision on a daily basis. These results also illustrate the disproportionately high numbers of youth under community corrections custody and the extremely low rates of service provision in these facilities.

Service access results in two other areas deserve mention. Because there is very little published data on reentry services provided to incarcerated substance abusing juvenile offenders, it is not clear if it is good news or bad news that the survey found just over half the substance abusing youth in residential facilities are provided with referrals to community-based treatment providers prior to their release, and a similar percentage of these youth have been given a post-release appointment with a program. Nonetheless, there is considerable room for improving upon these modest referral rates, which likely reflect doubts held by facility staff about youth follow-through and the generally fragmented nature of service delivery in the juvenile justice system (Horowitz, Sung, & Foster, 2006). These findings also underscore the need for research such as the current CJ-DATS-sponsored studies of model strategies for facilitating reintegration from juvenile residential and detention facilities to community life (Jainchill, 2005; Liddle, 2006).

Perhaps the most urgent need for expanded programming identified in the survey concerns family-related services. Meta-analyses and consensus reviews of research on interventions for juvenile offenders and adolescent substance abusers in particular point to the importance of engaging and involving families in treatment (Brannigan et al., 2004; Lipsey & Wilson, 1998). It was thus disappointing to find that standardized family assessments were used at very low rates and that family counseling was only provided to 40% of youth in all facilities, and in the relatively service-rich residential facilities, family counseling was provided at only about half the rate of less proven programs on life skills or anger management. These findings at least suggest that agency decisions about service delivery may be driven more by the ease and efficiency of providing the service than the research evidence supporting particular interventions.

4.3. Service Profiles in Juvenile Justice Settings

Analyses showed there to be a number of major differences among the three facility types represented in the Facility Directors survey sample. Substance abuse treatment and correctional services of all kinds were much more prevalent and accessible in the large, state-funded residential facilities compared to the other facilities and offices. Responses by residential facility directors indicate that youth in these institutions are routinely provided with physical health services, mental health assessments, and classes in education, communication and social skills, anger and stress management, cognitive skill development, and drug and alcohol education. Substance abuse treatment in the form of group counseling or TC treatment is provided in two-thirds of the residential facilities. The most commonly provided treatment is in the form of brief (1 to 4 hours) weekly counseling sessions. More intensive treatment is provided in about half of the facilities; however, these tend to be small programs serving less than 15% of the residents on a daily basis.

The survey findings on juvenile jails and detention centers show low rates of prevalence and access on most services, and particularly substance abuse treatment. These results echo those found in surveys of adult jails, and evidence the challenges of providing meaningful services to a highly transient population, and the priority placed on security and efficiency in these facilities (Belenko, 2002). Other than education and GED classes, and screening and treatment for physical health problems, the only services provided to half or more youth in these facilities

are the kind that can be delivered in large, classroom-like formats, such as didactic sessions on life and communication skills, or drug and alcohol education. And, while these types of services are relatively prevalent in these facilities, it is notable that 36% of the juvenile jails did *not* provide any educational programming. Given that adolescents are legally required to attend school, further investigation into this finding is warranted.

Service patterns reported by community corrections facilities contrasted with both the residential facilities and jails. The kinds of correctional services that were most common in residential facilities and jails (life and communication skills, anger management, cognitive skill development) were provided by CC facilities at generally half to one-third the rates reported by these custodial facilities. The proportion of CC facilities that provided substance abuse counseling, on the other hand, approached the prevalence rates found for the residential facilities, and was three to four times the rates reported by the jails. It was in this service area with this population, however, that the differences between prevalence and access were most dramatic, as the proportion of youth participating in CC-sponsored substance abuse treatment on a daily basis was very small, at 2.5% or less. The CC data showed that even access to services traditionally associated with these facilities, such as intensive supervision, case management, and risk assessment, were employed with small proportions of CC youth.

Taken together, the allocation of service resources across the three facility types appears short-sighted. Research indicates that the most effective and efficient service investments are in interventions applied in the early stages of delinquency (Butts & Mears, 2001). The Juvenile Facility Directors survey showed the converse – comparatively high rates of service provision in long-term residential facilities and low rates in jails, detention centers, and probation offices, where youth are first likely to be exposed to the juvenile justice system, and potentially to treatment for the first time (Nissen et al., 2006). Survey findings indicating modest use of family counseling and widespread use of life skills and anger management classes further suggest that agencies' service decisions may be driven by immediate priorities (cost savings, security) over long range benefits (reduced recidivism). Like the man who chooses to look for his lost car keys under the streetlamp, rather than on the dark side of the street where he dropped them, juvenile justice agencies will get nowhere until they acknowledge and address the challenges that come with providing evidence-based treatment services.

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Table 1

Prevalence of Correctional Services and Programs

Type of Program/ Service	Residential Facilities (N=49)	Jails (N=32)	Community Corrections (N=60)	All Facilities (N=141)
Education/ GED Program				
% with program	97.1%	62.6%	76.7%	73.8%
# in program	29,890	31,164	45,272	106,325
% of ADP (median)	100%	100%	22.9%	73.0%
Vocational Training				
% with program	67.7%	17.3%	42.9%	36.5%
# in program	13,246	4,641	8,935	26,822
% of ADP (median)	40%	100%	.6%	.6%
Sex Offender Therapy				
% with program	50.3%	8.4%	64.1%	44.2%
# in program	4,450	700	13,071	18,221
% of ADP (median)	12.6%	16.7%	1.6%	5.6%
Intensive Supervision				
% with program	17.9%	7.2%	76.4%	47.9%
# in program	3,117	2,945	23,216	29,277
% of ADP (median)	100%	10%	7.5%	7.5%
Transitional Housing				
% with program	7.7%	.1%	25.3%	15.3%
# in program	1,776	-	3,507	5,298
% of ADP (median)	12.5%	-	.4%	.4%

Note: Weighted data presented in all tables. “% in program” refers to the percentage of facilities that provide the specified program or service. “# in program” refers to the number of youth attending the program on a typical day in all reporting facilities. “% of ADP” refers to the median percentage of the average daily population in the facilities with programs that attend the program on a typical day.

Table 2

Prevalence of Substance Abuse Services

Type of Program/ Service	Residential Facilities (N=49)	Jails (N=32)	Community Corrections (N=60)	All Facilities (N=141)
Drug/ alcohol Education				
% with program	88.1%	63.2%	80.2%	75.2%
# in program	18,759	14,673	40,002	73,434
% of ADP (median)	30%	41.7%	8.2%	21.3%
% pgms >= 90 days	43.7%	9.7%	15.8%	16.5%
SA Group 1–4 hrs/ week				
% with program	50.7%	12.6%	54.0%	39.8%
# in program	8,484	4,360	10,588	23,431
% of ADP (median)	30%	30%	2.5%	13.6%
% pgms >= 90 days	63.7%	18.3%	36.9%	37.9%
SA Group 5–25 hrs/ wk				
% with program	42.2%	7.9%	25.9%	21.3%
# in program	4,339	1,600	4,844	10,783
% of ADP (median)	13%	70%	.9%	.9%
% pgms >= 90 days	67.2%	4.3%	98.5%	82.4%
TC - Segregated				
% with program	23.5%	43.8%	2.2%	18%
# in program	5,887	5,750	7,087	18,724
% of ADP (median)	18%	20.8%	100%	20.8%
% pgms >= 90 days	82.8%	87.9%	24.2%	82.6%
TC – Non-Segregated				
% with program	10%	5.5%	5.7%	6%
# in program	3,482	257	1,548	5,288
% of ADP (median)	100%	30%	.4%	11.6%
% pgms >= 90 days	95.3%	4.9%	90.9%	65.3%
Relapse Prevention				
% with program	51.2%	7.4%	43.6%	32.1%
# in program	8,044	1,652	5,751	15,448
% of ADP (median)	30%	58.5%	2.1%	5.7%
% pgms >= 90 days	56%	6%	87%	77.5%
Case Management				
% with program	35.2%	6.8%	27.4%	21.2%
# in program	10,090	2,164	31,629	43,883
% of ADP (median)	66.3%	66.7%	10.9%	10.9%
% pgms >= 90 days	67.2%	19.5%	94.4%	83.6%

Note: Weighted data presented in all tables. “% in program” refers to the percentage of facilities that provide the specified program or service. “# in program” refers to the number of youth attending the program on a typical day in all reporting facilities. “% of ADP” refers to the median percentage of the average daily population in the facilities with programs that attend the program on a typical day.

Table 3

Percent of Youth Provided Various Services

Service	Residential Facilities	Jails	Community Corrections	All Facilities
HIV/AIDS testing	64.3%	24.5%	20.3%	26.5%
HIV/AIDS counsel & treatment	55.9%	25.3%	19.9%	25.7%
TB screening	93.7%	87.6%	25.0%	56.1%
Hepatitis C screening	73.5%	18.3%	18.8%	24.3%
Physical health services	97.0%	95.7%	30.9%	58.6%
Assessment for MH	96.2%	72.3%	51.2%	62.3%
MH counseling	72.2%	59.7%	45.2%	52.5%
Assessment for co-occurring dis.	77.2%	51.2%	34.8%	44.1%
Counseling for co-occurring disorders	64.4%	45.5%	29%	37.1%
Family therapy/counseling	46.0%	34%	44.1%	40.9%
DV intervention	35.7%	22.3%	18.3%	21.3%
Communication or social skills development	90.4%	66%	34%	49.8%
Life skills management	81.5%	73.3%	31%	50.1%
Anger or stress management	87.1%	64.2%	32.2%	47.5%
Cognitive skills development	90.8%	54.3%	32.2%	44.9%
Job placement/voc counseling	48.7%	28.7%	26.6%	28.3%
Religious/spiritual sessions	87.8%	65%	17.8%	40.4%

Note: Percentages in table were derived from quartile values of 0 to 100% that were assigned to responses to a five-point scale ranging from “none” to “all.”