NIH Public Access

Author Manuscript

Prison J. Author manuscript; available in PMC 2008 April 28.

Published in final edited form as:

Prison J. 2007 ; 87: 58–85.

Specialized Prisons and Services: Results From a National Survey

Karen L. Cropsey,
Virginia Commonwealth University, Richmond

Harry K. Wexler,
National Research Development, New York, NY

Gerald Melnick,
National Research Development, New York, NY

Faye S. Taxman, and
Virginia Commonwealth University, Richmond

Douglas W. Young
University of Maryland, College Park

Abstract

Findings from the National Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) National Criminal Justice Treatment Practices survey are examined to describe types of services provided by three types of prisons: those that serve a cross-section of offenders, those that specialize in serving offenders with special psychosocial and medical needs, and those that specialize in serving legal status or gender specific populations. Information is presented on the prevalence and type of specialized prisons and services provided to offenders as reported by wardens and other facility directors drawn from a nationally representative sample of prisons. Additional analyses explore organizational factors that differentiate prisons that serve specialized populations including staffing, training, other resources, leadership, and climate for change and innovation. Implications for expanding and improving services for special populations in correctional settings and the values of specialized prisons are discussed.

Keywords

specialized prisons; special offender populations; treatment services; violators

With more than 8 million offenders under correctional control (Taxman, Young, Wiersema, Rhodes, & Mitchell, 2006), the criminal justice system has become an ad hoc medical and social service delivery system. Offenders appear to have more physical, psychological, and substance-abuse disorders and social deficits than does the general population. Although the state is responsible for providing reasonable care for offenders who are incarcerated, as mandated by various Supreme Court decisions (e.g., *Estelle v. Gamble*, 1976), we know relatively little about the capability of the correctional agencies to address these needs. A recent survey of prison administrators sheds light on the capacity of a nationally representative sample of prisons to provide needed medical, psychological, and social services for offenders. The survey also allows for an analysis of the organizational factors that may affect whether a prison will provide the needed services. Findings from this survey are reported in this article with a discussion of the value of specialized prisons.

Medical and Psychosocial Needs of Offenders

As correctional populations have grown, they have been forced to confront the myriad of problems that the individuals bring into the system. Longer sentences ensure that the prison

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

population will age in prison, which is compounded by the poor health of many offenders. Drug abusers and individuals with mental illness are also disproportionately represented in prisons, which presents additional challenges of providing mental health, substance abuse, and medical treatment for these inmates (Mumola, 1999; Veysey & Bichler-Robertson, 1999). Furthermore, prisoners have other problems, such as histories of poor education and vocational training, that have generally limited their ability to financially support themselves through legitimate employment (Bureau of Justice Statistics [BJS], 2003). Finally, the rates of youthful, elderly, and female offenders have grown, which serves to diversify the prison population. This also complicates the management of the system because the array of populations creates the need to provide a greater diversification of services. These groups of offenders can be considered to be a subpopulation with "special needs" who are believed to require more intensive or specialized services to be successfully reintegrated into society. The following sections present an overview of the range of special needs of subpopulations of offenders.

Mental Health

According to a recent report to Congress released by the National Commission on Correctional Health Care (NCCHC) and the National Institute on Justice (NIJ) on the health of soon-to-be-released inmates, a large proportion of inmates suffer from mental illness (NCCHC, 2002). Prevalence estimates for specific mental disorders among state inmates were schizophrenia (2%–4%), major depression (13%–19%), bipolar disorder (2%–5%), dysthymia (8%–14%), anxiety disorder (22%–30%), and posttraumatic stress disorder (6%–12%; Veysey & Bichler-Robertson, 1999). Similar rates of mental illness prevalence estimates were found for jail inmates: schizophrenia (1%), major depression (8%–15%), bipolar disorder (1%–3%), dysthymia (2%–5%), anxiety disorder (14%–20%), and posttraumatic stress disorder (4%–9%; Veysey & Bichler-Robertson, 1999). These rates are 2 to 5 times higher than prevalence estimates of mental illness in the community (American Psychiatric Association, 1994).

Substance Abuse

Overall, 75% of offenders in state prisons were involved with drugs or alcohol at the time of arrest, and 17% reported committing criminal acts to obtain money for drugs (Mumola, 1999). The relationship between the abuse of illegal drugs and crime has been well documented (Bradford, Greenberg, & Motayne, 1992; Goldstein, 1985; Tonry & Wilson, 1990; Wexler, Lipton, & Johnson, 1988; White & Gorman, 2000). Close to two thirds of the annual $168 billion social costs of illegal drug use are from drug-related crime and law enforcement (Belenko & Peugh, 2005). More than 80% of state inmates and 72% of jail inmates have used illegal drugs, and two thirds of jail inmates and state prison inmates reported regular lifetime illicit drug use (Belenko & Peugh, 1998, 2005). Martin, Buztin, Saum, and Inciardi (1999) reported exceedingly high rates of relapse; within 3 years, approximately 95% of state inmates released to the community with drug-use histories return to drug use. Recidivism for substance abusers is also very high, with 68% rearrested, 47% convicted of a new crime, and 25% sentenced to prison for a new crime (Langan & Levin, 2002). The high recidivism rates are also related to violations of parole or conditional release, as more than one third of state prison commitments are violators (BJS, 2002). Studies have found that these violations are frequently related to drug use (relapse).

Co-Occurring Disorders (COD)

Offenders who have both mental health and substance abuse disorders (referred to as COD) constitute a subpopulation that presents considerable challenges. The Center for Substance Abuse Treatment (CSAT, 2005) estimated that approximately 16% of inmates have a mental illness and up to 65% of mentally ill offenders have a co-occurring substance abuse diagnosis. Furthermore, some studies have found that offenders with a combination of substance use and

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

mental disorders are at a greater risk for committing violent acts by 2 to 3 times the level of individuals with mental disorders only (Monahan, Bonnie, & Appelbaum, 2001; Monahan, Steadman, Henry, & Robbins, 2005; Steadman & Veysey, 1998). Melnick, Sacks, and Banks (2006) found that the risk of violence among individuals with mental disorder increases as the level of drug use increases.

Medical Problems

Medical costs for inmates currently account for approximately 11% of the average correctional department's budget, and the resources needed are expected to double in the next 10 years (Lamb-Mechanick & Nelson, 2000). Approximately 40% of newly incarcerated inmates reported a medical problem at intake (Albrecht, 1993), despite the fact that 88% of inmates are younger than 50 years old (Lamb-Mechanick & Nelson, 2000). The most frequently reported medical problems included heart problems (1.1%), circulatory problems (2.4%), respiratory problems (1.4%), kidney and liver problems (0.9%), and diabetes (0.9%; Maruschak & Beck, 2001). These medical problems can, in part, be attributed to various factors including the overwhelming majority of offenders (nearly 70%–80%) who smoke cigarettes (Cropsey, Eldridge, & Ladner, 2004; Cropsey & Kristeller, 2005), the higher prevalence of alcohol and illicit drug use (including injection drug use) among the offender population that is double that of the general population (Substance Abuse and Mental Health Services Administration, 2004), and the lack of accessed preventative health care prior to incarceration (Conklin, Lincoln, & Tuthill, 2000). Offenders also have higher rates of infectious diseases such as HIV/AIDS, tuberculosis (TB), and hepatitis (Hammett, Harmon, & Rhodes, 2002).

HIV/AIDS—The HIV/AIDS epidemic in the United States coincided with a sharp rise in incarceration related to the "war on drugs," with the result that many substance-abusing individuals who are at risk for incarceration also are at high risk for HIV/AIDS. In 1997, 16% of individuals with AIDS and 22% to 31% of individuals with HIV passed through a U.S. correctional facility (Hammett et al., 2002). Between 1989 and 1999, 32.9% of all positive HIV tests in Rhode Island came from the state correctional institution (Desai, Latta, Spaulding, Rich, & Flanigan, 2002). Furthermore, the rate of confirmed AIDS in state and federal prisons is 3 times higher than in the overall U.S. population—0.49% for prisoners and 0.14% for the U.S. population. Confirmed HIV cases ranged from 0.8% of all prisoners in the West to 4.9% in the Northeast, and the HIV-infection rates are generally higher among female prisoners (Maruschak, 2004).

TB—In 1997, approximately 40% of all individuals with TB were in a correctional facility (Hammett et al., 2002). Rates of TB are approximately 6 times higher among prisoners than in the general population (Hammett, Harmon, & Maruschak, 1999), with overcrowding and HIV creating an ideal mechanism for rapid transmission among inmates (McLaughlin et al., 2003).

Hepatitis—Hepatitis C (HCV) is the most prevalent blood-borne pathogen in the United States, with an estimated 1.6% of the U.S. population infected with the virus (Centers for Disease Control and Prevention, 2005). These rates are amplified among the offender population, with an estimated 31% of correctional populations infected with HCV (Beck & Maruschak, 2004). Approximately 94% of state inmates were housed in a facility that tested inmates for HCV disease, although most facilities (88%) reported that they only tested on inmate request or clinical indication (Beck, 2004). About 67% of facilities reported a policy for hepatitis B vaccination, with the majority of these facilities providing the three-shot vaccination for high-risk inmates or those who request vaccination. Only 12.4% of facilities (encompassing 17.2% of the total offender population) provided hepatitis B vaccination to all of their inmates (Beck, 2004).

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Educational or Vocational Needs

Offenders generally have lower educational attainment than the general population. A survey by the BJS (2003) noted that approximately 40% of inmates do not have a high school degree or general equivalency diploma (GED). The educational deficits of the offender population are more than twice as high as individuals outside of prison (18%; BJS, 2003). During this same time, the number of inmates who reported receiving educational services during incarceration fell from 57% in 1991 to 52% in 1997 (BJS, 2003). Even inmates who obtained their high school diploma or GED have lower literacy skills compared to individuals outside of prison, with 70% of all inmates scoring in the lowest two levels on the National Adult Literacy Survey (NALS; National Institute for Literacy, 2001).

Similarly, inmates have poor employment histories prior to prison. Incarceration, coupled with this poor employment history, cripples their chances of obtaining jobs after imprisonment. Survey data collected in 1997 (BJS, 2002) showed that 31% of offenders were unemployed 1 month before arrest, compared to the national unemployment rate of 4.9% for that year (U.S. Department of Labor, Bureau of Labor Statistics, 2000). The BJS survey also reported that 5% of state prisoners had never been employed (BJS, 2002).

Special Populations

The offender population is not homogenous in that it represents a broad cross-section of the general population. Often, the offender population is characterized by their age (e.g., geriatric, youthful), gender, or legal status (e.g., pretrial, parolees, probationers, or revoked). The significance of the legal status is that it often defines the degree to which the individual's personal liberties are restricted based on whether the offender is incarcerated or remains in the community. Offenders in any incarceration status are covered by previous Supreme Court decisions that mandate community-based standard medical and psychosocial services in any incarceration settings. Offenders in the community are required to use the existing (and frequently shrinking) network of medical, psychological, educational, and social services.

Geriatric Offenders

Inmates 55 year or older (69,900 at end of 2004) compose approximately 4.7% of all offenders in prison (Harrison & Beck, 2006). Older inmates generally have more medical needs compared to younger inmates, including the services provided in prison settings. One study found that approximately 83% of inmates older than 50 had at least one chronic disease (Thorburn, 1995). Chest pain was the most common complaint reported by 61% of inmates in another study (Colsher, Wallace, Loeffelholz, & Sales, 1992). These health problems of older inmates result in dramatically increased costs of incarceration. For example, the Pennsylvania Joint State Government Commission found that the cost of housing an inmate at their specialized geriatric facility was $63,500 annually, slightly higher than comparable nursing home care in the community ($62,000; Report of the Advisory Committee on Geriatric and Seriously Ill Inmates, 2005) and more than double the cost of annual incarceration at most prisons.

Youthful Offenders

Youthful offenders are considered to be adult offenders between the ages of 18 and 25, although in some states the age limit can be as low as 16. A few states have developed separate facilities to house their youthful offenders separately from other adult offenders presumably based on the special needs or security concerns of this group. Although little information is specifically available in the literature regarding this subpopulation of 18- to 25-year-olds, extrapolating to the juvenile justice literature paints a grim picture. It is estimated that 60% to 80% of juvenile offenders suffer from mental illness (American Academy of Pediatrics, Committee on Adolescence, 2001). Specifically, juvenile justice adolescents had prevalence rates for the

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

following psychiatric diagnoses: anxiety disorders (30%–58%), mood disorders (17%–24%), psychotic symptoms (32%–45%), disruptive disorders (35%–52%), and COD (44%–75%; Cauffman, Feldman, Waterman, & Steiner, 1998; Marsteller, Brogan, & Smith, 1997; Shelton, 1998; Steiner, Garcia & Matthews, 1997). It is unknown whether the psychological needs of young adults mirror those of juvenile offenders, and additional research is needed to characterize these youthful offenders.

Female Offenders

The female inmate population continues to outpace the male population for new admissions to prison, increasing by 4.7% annually from 1995 until 2005, compared to 3.9% for male inmates during that same period (Harrison & Beck, 2006). Women offenders now constitute 7.0% of all incarcerated individuals (Harrison & Beck, 2006). Female offenders differ from their male counterparts in several key ways. First, female offenders are frequently incarcerated for nonviolent, drug- or property-related offenses, compared to male offenders who are more likely to have violent offenses (Greenfeld & Snell, 1999). Female inmates are also more likely to be the primary caregivers for their children, and incarceration often means that these children are placed with extended family members or in foster care (Mumola, 2000). Several studies have estimated that one fourth of the male inmate population (National Institute of Corrections, 2001) and one half of the female inmate population (Ditton, 1999) suffer from mental illness.

Female prisoners are more likely than their male counterparts to report having drug and alcohol problems. For example, 73.6% of female prisoners and 69.3% of male prisoners reported that they regularly used drugs. Furthermore, 62.4% of female offenders reported using drugs in the month prior to arrest (compared to 56.1% male offenders), and 40.4% reported committing their offense under the influence of drugs or alcohol (compared to 32.1% of male inmates; Langan & Pelissier, 2001). Female prisoners had almost twice the rates of opioid use in the 6 months prior to incarceration compared to male prisoners (Brooke, Taylor, Gunn, & Maden, 1998).

Transition From Prison to the Community

Discharge planning and reentry services for mentally ill and other special-needs inmates released from correctional facilities to the community appear inadequate. For example, about 30% of prisons, jails, or community correctional agencies provide minimal community referral services to offenders in a recent survey of the field (Taxman, Young, Cropsey, & Wexler, 2006). Discharge planning and transitional case management services are often complicated by the location of prisons, which tend to be far away from the communities in which offenders reside (Veysey & Bichler-Robertson, 1999). Transition from prison to the community is further complicated in that state prison facilities rarely have formal (or even informal) relationships with community providers, and case managers in prison often cannot provide referrals to community agencies to ensure continuity of care for mentally ill inmates after release (Veysey & Bichler-Robertson, 1999). Given these structural limitations, it is not surprising that many special-needs inmates fall through the cracks and do not receive adequate care during their transition back to the community.

The NCCHC (2002) noted that 29 of the 41 (70.7%) state correctional systems that responded to the survey of treatment policies indicated that they had a policy to provide medications (usually a 30-day supply) to inmates with chronic medical conditions (including mental illness) at the time of discharge. After release, offenders are then expected to obtain the needed medication through the existing mechanisms in the community. Community correctional agencies, including parole agencies, are not required to provide medical care to offenders in the community. In this survey, several barriers were identified in assisting offenders in obtaining needed services, such as correctional or parole staff not communicating release dates

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

and times with health care providers, which results in some offenders being released without an adequate supply of medications. This failure to coordinate release information and planning can be devastating to individuals with chronic medical conditions such as HIV, HCV, psychosis, depression, asthma, diabetes, and a host of other diseases (NCCHC, 2002).

Violators of Probation or Parole

Of the prisoners who are released each year, only about 41% successfully complete supervision, with a large proportion being charged with a new crime or with violating the terms of their parole and returning to prison within 6 months (BJS, 2004; Glaze & Palla, 2004; Langan & Levin, 2002). About one third of recently released prisoners were arrested within 6 months of release, and more than two thirds were arrested within 3 years. Furthermore, 11.1% were convicted of a new crime 6 months after release, and about half were convicted on a new charge within 3 years (BJS, 2004). A major challenge for many correctional systems is that technical violators, those who fail to meet the conditions of release, place an additional burden on the system to address the offender's needs to prevent further involvement in the correctional system. For example, in California, almost 65% of all parolees were returned to prison on technical violations (MacKenzie, 2000). Many of these violations are the result of positive drug tests, failure to pay fines, restitution, or fees, failure to attend supervision or treatment sessions, and so on (MacKenzie, 2000). Some correctional systems have established special facilities for technical violators to address the programmatic failures that resulted in their reentrance to the prison system.

Summary of the Needs of Offenders

Prison facilities house offenders with a myriad of medical, psychosocial, and educational deficits. Correctional agencies are required to provide constitutionally mandated treatment (*Estelle v. Gamble*, 1976) for all offenders in their system, particularly to address medical and acute psychosocial problems. Offenders in most correctional systems are classified according to offense type, seriousness of crime, and other risk factors that determine the facility placement. This placement then affects the services that are available to offenders. Security concerns often supersede other special needs such as drug treatment or mental illness and may lead to placement in a facility that does not have the resources to address the needs of offenders, which affects their successful reintegration in the community. The existing literature does not adequately address how correctional agencies provide services in the context of the institutional environment. Although some states have developed specialized facilities (e.g., substance abuse, psychiatric/substance abuse, geriatric, youthful offenders, etc.) to provide more appropriate services to offenders with similar needs, it is unknown whether these specialized facilities differ in any substantial ways in the types of services that they are able to offer their population than the generic prison facilities. And it is unknown whether the specialized prisons provide services to a greater percentage of the offenders in the prison.

The purpose of this study is to examine the types of services available in facilities that self-identified as serving a special-needs population compared to prison facilities that may contain special-needs prisoners but were not designated as special-needs facility. Special-needs facilities were further classified in two different categories: facilities that addressed psychosocial needs (mental health, substance abuse, and medical treatment) versus other special population facilities (geriatrics, women, etc.). This was done to understand how providing services to address psychosocial needs that are fluid may differ from facilities that address special needs that are fixed or determined. Thus, this article addressed the following questions: (a) What services are available in different types of prison facilities? (c) What proportion of offenders are provided services in different types of prisons? and (c) What organizational factors differentiate prisons that serve specialized populations?

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Method

The National Criminal Justice Treatment Practices Survey (NCJTPS) provides the data used in this study. The survey is one study conducted as part of the National Institute on Drug Abuse's (NIDA) Criminal Justice Drug Abuse Treatment Studies (CJ-DATS), a national research cooperative (the survey is fully described in Taxman, Young, Cropsey, et al., 2006, and Taxman, Young, Wiersema, et al., 2006). Established in 2002 with support from several federal partners, CJ-DATS researchers from 10 academic research centers and NIDA are working together with federal, state, and local criminal justice partners to develop and test integrated approaches to the treatment of offenders with drug-use disorders (see Fletcher & Wexler, 2005, for a detailed CJ-DATS description). Information from the NCJTPS provides multilevel estimates of the prevalence of assessment and treatment programming for offenders in a myriad of correctional settings and characteristics of these programs.

The present study is based on survey responses of prison wardens or administrators for adult institutions. The analysis could not be conducted with jails or community correctional facilities (e.g., probation, parole, etc.) because none of the survey respondents indicated that their facilities were designated as serving a special population or special needs. The frame for the NCJTPS sample of prisons consisted of the BJS most recent census (2000) of state prisons (N = 1,065). The sample frame has state facilities, of which 938 are general confinement prisons, 58 specialize in alcohol or drug treatment, 45 are boot camps, 14 are institutions for returned-to-custody inmates (parole violators), and 10 compose a wide variety of other facilities. A total of 150 adult prisons were selected for the study using a stratified proportional sampling technique without replacement. Prisons were allocated to 1 of 8 regional categories that included the four states with the largest correctional populations and four regions—South, West, Midwest, and Northeast. Within these strata, prisons were selected in probabilities proportional to the size of the facility. In accord with this strategy the census of 58 prisons that were designated as drug treatment facilities were selected with certainty. The remaining 92 prisons were selected randomly within each stratification cell. Nine prisons were found to be closed, leaving a final sample of 141, of which 98 (67.5%) returned surveys. Techniques used to improve response rates for the survey instruments included follow-up phone calls, postcards, and resending of the survey instrument (Dilmann, 2000).

Survey Procedures and Measures

The survey of prison administrators consisted of a 31-page mail survey. Questions covered the goals of the organizations, characteristics of correctional and treatment programs, average daily populations of the programs, characteristics of assessment and treatment delivery systems, and nature of the organizational climate and culture. Survey respondents were asked to indicate if their prison was a specialized facility serving a particular inmate population. Respondents who answered affirmatively were then asked to complete a second part to the question providing information about the population (specialization) of the facility. Other questions queried respondents about the services offered, providing a list of potential services and space to write in any additional services that the facility offered. The survey included a series of organizational measures including the size and number of staff at the facility, organizational culture and climate characteristics, sources of internal and external support, resources capabilities and needs, and networkedness. In this study, the following scales are used to elect complex organizational characteristics:

Internal support (three items, α=.66): This scale was designed to measure cooperation and coordination. An example reads, "The management style emphasizes teamwork."

Hierarchical consistency (three items, α=.72): This scale was designed to capture the consistency in approach and procedures and describes organizational cultures that are

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

stable and internally focused. An example reads, "There is a high level of agreement about the way we do things in terms of rules, policies, and procedures."

Staffing needs (two items, α=.57): This two-item scale was designed to capture the ability of the facility to hire and keep staff. An example reads, "We have trouble retaining highly competent staff in this facility/location."

Training needs (five items, α=.77): This scale was designed to measure access to training and ability to integrate new techniques. An example reads, "Opportunities are provided for staff to attend training or other developmental opportunities."

Program funding (three items, α=.63): This two-item scale was designed to assess the ability of the facility to maintain services and introduce needed services. An example reads, "We have funding available to introduce new programs and/or initiatives as they are needed."

Physical facilities (three items, α=.77): This scale was designed to assess the extent to which the physical space is maintained and is adequate to the program's needs. An example reads, "Our physical facilities are designed to meet the specific needs of most of the important services and programs we run."

We also included several measures of networkness or systems integration on key activities. These activities include (a) sharing information on offender needs, (b) using similar program eligibility requirements, (c) having written agreements providing space for substance abuse services, (d) holding joint staffing and case reporting consultation, (e) developing joint policy and procedures manual, (f) pooling funding for offender substance abuse services, (g) coordinating policies and procedures to accommodate each other's requirements, (h) sharing budgetary oversight of treatment programs, (i) sharing operational oversight of treatment programs, (j) having cross-training between organizations on substance abuse issues, and (k) having written protocols for sharing client information. The integration items have been shown to be important in transitioning the care of offenders in prior studies (Taxman & Bouffard, 2000). Two measures are used in this study, including:

Systems integration: Sharing information with substance abuse program (α=.89): This scale indicates the endorsed number of activities between the substance abuse program and the prison.

Systems integration: Sharing information with community corrections (α=.88): This scale indicates the endorsed number of activities involved between community corrections agency, such as parole, and the prison.

Analytic Procedures

The survey allowed the prisons to identify the types of offenders served by the facility. Prisons, as part of a strategy to attend to security and to assist with reintegration into society, should provide certain services or programs. The rationale for the categorization used in this survey is that the types of needs of offenders can be related to different areas: psychosocial needs and population demographic characteristics. Facilities that reported specialized programs that served prisoners with mental health, substance abuse, or medical needs were classified as psychosocial special needs ($n = 31$). Prisons that reported being a special population such as youthful offenders (18–25 years old), women, and technical violators were classified as other special populations ($n = 11$). Finally, prisons that reported that they did not have any one specific population but rather served the array of offenders were classified as nonspecialized ($n = 56$). This grouping scheme was developed prior to data analysis and was based on theoretical assumptions that prisons would target services based on the type of offenders housed in their facility and that these services would vary based on whether they were responding to

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

demographic characteristics or psychosocial characteristics. Analysis of variance (ANOVA) procedures were used to examine differences between the three types of facilities. Finally, organizational measures were examined among the three groups using ANOVA procedures. The Tukey honestly significant difference test was used for all post hoc comparisons. All alpha levels were set at $p < .05$, indicating significance.

Results

The following analyses respond to the three study questions: (a) What services are available in different types of prison facilities? (b) What proportion of offenders are provided services in different types of prisons? and (c) What organizational factors differentiate prisons that serve specialized populations?

Types of Services Provided in Prisons

Table 1 (column 1) shows the percentage of prisons that provide assessment and other services to inmates. Overall, all the prisons report providing assessment and other services at a fairly high range, 65.3% to 98.0%.

Assessments used—Table 1 shows that the nearly all prisons screen at least some inmates for mental health issues (96%) and TB (95%), followed by HIV testing (90%), HCV (89%), and COD and substance abuse, each at 89%. Among facilities that report conducting mental health assessment, 60.6% used a standardized assessment instrument such as Beck's Depression Inventory, whereas the remainder used their own (unstandardized) tool (9.6%) or no assessment tool (29.8%). Similarly, among facilities that reported COD assessment, 60.9% reported using a standardized tool, 9.2% an unstandardized tool, and 29.9% no assessment tool.

Services available—The most frequent services available to inmates are religious or spiritual (98%), followed by life skills management (95%), physical health services (94%), anger or stress management and cognitive skills development (each at 93%), and social skills training or mental health counseling (each at 90%). A slightly lower level of available services includes HIV counseling (85%), COD counseling and job placement (each at 81%), family therapy (72%), and domestic violence intervention (65%).

Proportion of Inmates Receiving Services

Table 1 (column 2) shows the mean score indicating the proportion of inmates receiving assessments and/or services, with a score of 1 indicating none, 2 less than half, 3 half, 4 the majority, and 5 all. Columns 3 to 5 in Table 1 show the differences in the proportion of inmates receiving assessments and services at our three types of facilities: nonspecialized facilities, facilities specializing in psychosocial treatment (substance abuse, mental disorder, and the single medical needs facility), and other specialized facilities.

Proportion of inmates receiving assessments—Overall, prisons indicated that they provided a TB assessment more than any other assessment, with a mean score approximately 4.5 out of a possible 5, followed by mental health assessment ($M = 4.3$). No other assessment had a mean score in this range (4–5). Of the midrange assessments, assessing for COD had an overall mean score of 3.5, followed by HCV ($M = 3.5$) and HIV ($M = 3.4$). Thus, just more than half of the inmates in the overall sample were tested for either the HCV or HIV. Table 1 shows statistically significant differences only for HCV screening, where the other specialized facility group mean score of 4.7 was greater than the scores for the psychosocial ($M = 3.4$) and non-special-needs facilities ($M = 3.3$).

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Proportion of inmates receiving services—As expected, physical health services were provided for almost all inmates (*M* = 4.6), followed by religious or spiritual sessions (*M* = 4.0). Services in the midrange in terms of the proportion of inmates receiving them include life skills management, anger or stress management, cognitive skills development, social skills development, and job placement, with mean scores ranging from 3.0 to 3.4. At the lower end of the spectrum, fewer than half of the inmates received mental health counseling (*M* = 2.9), COD counseling (*M* = 2.6), family therapy (*M* = 2.3), and domestic violence intervention (*M* = 2.2).

Overall, the psychosocial and other specialized facilities provided more services to at least half of the offender population compared to the generic prison—an average of 14 and 13 services, respectively, to an average of 9 for the nonspecialized prison. Significant differences were found among the three prison types on provision of HIV counseling, with psychosocial facilities offering these services to significantly more of their inmate population compared to other specialized facilities ($p < .05$). Furthermore, significant differences were found for the provision of HCV screening at these institutions, with other specialized facilities offering these services to more of their inmate population compared to psychosocial facilities ($p < .05$) and nonspecialized facilities ($p < .02$). Significant differences were found between the three groups for social skills training, anger or stress management, and cognitive skills development, with psychosocial facilities offering these services to more of their population than nonspecialized facilities ($p < .03$, $p = .01$, and $p < .01$, respectively).

Organizational Factors Related to Types of Prisons

Table 2 shows the distribution of organizational variables across the three types of facilities. Interesting, the size of the average daily population is not statistically significant (this appears because of the extremely large standard deviations), even though specialized facilities are smaller (less than half the size) than nonspecialized facilities. Differences in the number of full-time employees and supervisors, reflecting differences in facility inmate populations, are significant. As would be expected, psychosocial facilities had significantly fewer employees compared to non-specialized facilities ($p < .02$). Similarly, nonspecialized prisons had significantly more supervisory staff compared to both psychosocial ($p = .002$) and other specialized ($p < .05$) facilities. Not shown in Table 2, staff-to-inmate ratios vary considerably, with nonspecialized facilities having the highest ratio at 6.8 to 1, other specialized facilities at 5.1 to 1, and psychosocial at 4.6 to 1. Psychosocial facilities, which specialize in different types of care, tend to have the lowest staff-to-inmate ratios. The finding in Table 2 shows that nonspecialized and specialized facilities had similar numbers of programs and substance abuse services, which is counter to the reasonable expectation that more would be found in specialized facilities.

Table 2 also shows the results of organizational scales available in the NCJTPS. The Hierarchy (organizational structure), Staffing Needs, Training Needs, Program Funding, and Physical Facilities subscales all reflect Likert-type ratings ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The organizational support scales showed mostly midrange scores indicating general neutrality—neither agreement nor disagreement. Only Staffing Needs appears to approach signification, with $p < .10$. Staffing Needs, reflecting the ability to hire and retain staff, differs across facility categories, with the psychosocial facilities reporting significantly more difficulty in hiring and retaining staff than nonspecialized facilities ($p < .05$).

The remaining two systems integration scales illustrate the degree to which the prison collaborates with substance abuse treatment and community correctional agencies (for a total of 11 possible shared activities). Facilities differ in their interagency relationships in reference to the extent to which they share information and are integrated with community substance abuse treatment programs. As expected, the psychosocial facilities have the highest mean score

NIH-PA Author Manuscript

($M = 4.39$) and differed significantly from both other specialized facilities ($p < .02$) and nonspecialized facility ($p < .03$). There was very little integration between any type of correctional facility. Finally, there was moderate sharing of information and integration between prisons and community corrections agencies, with the number of information-related activities ranging from 3 to 4, although these were not statistically significant differences.

Discussion

It is reasonable to view prisons as the “institution of last resort” because they must provide basic services of food, shelter, and medical care to meet the basic needs of offenders. These services are provided to fulfill constitutional mandates that prevent cruel and unjust punishment in a democratic society and to avoid legal sanctions when falling short of acceptable standards of care. Although the CJ-DATS NCJTPS cannot assess the quality of the services provided, the survey does provide an opportunity to examine the nature and type of services provided to offenders in correctional settings. In this article, we have presented the services provided in adult prisons based on three types of prison facilities. We also examined the type of services provided to determine whether there were differential services based on the characteristics of the target population for the prison. In this way, we have presented a current snapshot of the types of specialized prisons, the services that are available, and the proportions of offenders who access these services. In addition, the survey data allowed for analyses of differences that organizational factors have in the provision of services in the facilities.

About half of the surveyed prisons were considered specialized and this group was divided into service-oriented (psychosocial: substance abuse, mental health and medical) and more functional population specialization (other) related to structural and process aspects of incarceration (e.g., reception, parole violators, youth, females, and work release). Psychosocial institutions were of primary interest because they reflect correctional responsiveness to the offender specific problems and disabilities. It should be noted that nationally about 12% of prisons are considered specialized. Therefore, the average offender is more likely to be exposed to the patterns that we have characterized in the nonspecialized prisons (88% of the prisons fit this description; see Taxman, Young, Wiersema, et al., 2006).

As noted in the survey findings, most prisons report a surprising overall number and types of services (including assessment and treatment services) offered. The services provided ranged from requisite medical to faith-based or spiritual services. It is not surprising that all types of prisons report offering medical services because they are constitutionally mandated to provide such services. Most prisons provide faith or spiritual services, often with volunteers. In many ways, the number of services that are available is misleading because it refers to generic services without attention to the nature and dosage units available. In another paper examining the survey data on substance abuse treatment services, we determined that the nature of the services provided was inadequate compared to the needs of the offender—the tendency was to provide alcohol and drug education or low-intensive outpatient substance abuse counseling sessions (Friedmann, Taxman, & Henderson, 2006; Taxman, Perdoni, & Harrison, 2006). Here, we found some of the same types of inconsistencies—although a majority of prisons report that they conduct mental health assessments and COD assessments, about 40% do not use a standardized tool. Based on the analyses, the high prevalence of medical, psychosocial, and other services should be taken as an indicator that the prisons have started the process of providing services. However, there is probably a need for greater attention to be paid to the nature of the services provided to determine whether they would be considered adequate to be effective.

The study also found that the prisons report offering assessments (TB and mental health) and physical health services to more than half of the inmates. However, fewer than half of the

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

offenders received counseling (mental health, COD, family, and domestic violence) and job placement—all of these services are considered critical to reentering offenders to improve stabilization after release from prison. The survey found, as expected, that the specialized facilities tend to offer more services on average than the generic prisons as part of the quest of meeting the needs of the population that is assigned to the prison. Prisons that specialize in psychosocial needs tend to offer more HIV counseling, HCV screening, social skills training, anger management, and cognitive skills development than other prisons. It was surprising that these prisons did not offer more job placement or mental health counseling.

As part of the survey, we were interested in networking and integration of services because this has been a major theme regarding the provision of treatment services for offenders for the past 20 years (Taxman & Bouffard, 2000). A portion of the survey addressed these issues to increase the services both within the prison and after the offender is released. The integration scale was designed to examine different operational practices that prisons could engage in to collaborate services with other organizations or their own community correctional partners (e.g., parole, probation, etc.). The average number of integration was 4.94 items (out of 11) for prisons that focus on psychosocial, whereas the average number for other prisons was 1.18 and for generic was 3.84. It appears that prisons and community substance abuse programs moderately share information. The significantly higher level of integration found between psychosocial facilities and community substance abuse programs indicates greater efforts at coordinating services between prison and community treatment services. The same does not occur with community correctional programs.

Differences among the specialized and nonspecialized facilities appear in the percentages of the prisoner population that receives services. This is reasonable given that specialized prisons serve offenders with a wide variety of disabilities and special needs. Information from the BJS surveys suggests that nonspecialized facilities also serve offenders who exhibit needs in a variety of areas, as previously discussed. Although not specialized, these prisons attempt to meet the high needs of inmates but can offer the services to a smaller percentage of the population.

As noted above, this study begins to explore an area that has not been well researched—special prison facilities. The data used for this study are from a national survey. The study findings reflect the perspectives of the wardens and administrators who tend to report offering an array of services, but it is impossible to determine from this study the quality of the services or the number of inmates who actually utilize these services. Our study suggests that these services may exist but may not be of sufficient quality to be effective. Finally, the survey can also not test any casual assumptions.

The question that is raised by this analysis is the relative benefits of having specialized prison facilities. Many states do not sponsor such prisons because it complicates prison management —the number of offenders with such needs is often unpredictable. And the offenders, who have may have certain needs, may require different security levels. This article has shown that specialized prisons, when focused on psychosocial needs, can serve those needs better than a generic prison. The smaller size of the prison, coupled with more specialized staff, provide the formula for advancing the use of better practices. However, each special population is unique, and it is not adequate to provide services or programs that are responsive to the needs of some offenders while ignoring the needs of others. That being said, it is likely that the prisons have not yet considered what services or programs might be more suitable for their special populations, and therefore the survey responses do not reflect these unique needs. For example, for female offenders who tend to have low employment skills, an emphasis on self-sufficiency through employment has been discussed as an unmet need (Taxman & Cropsey, in press). Technical violators are a heterogeneous group that reflects the various failures to meet the

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

conditions of release; different interventions can be designed to meet the needs of these offenders, including more interpersonal and social skills. The challenge that prisons face is trying to identify these needs and then having the resources to put in place programs and services that can assist the offender to be more productive when he or she returns to society. The real question is whether prisons have advanced in that direction, and these survey findings suggest that small implementation steps have been taken. The next challenge will be to take a leap to further develop programs and services that are suited to the multifaceted needs of offenders.

Acknowledgements

This study was funded under a cooperative agreement from the U.S. Department of Health and Human Services, National Institutes of Health (NIH), and the National Institute on Drug Abuse (NIDA). The authors gratefully acknowledge the collaborative contributions by federal staff from NIDA, members of the Coordinating Center (University of Maryland at College Park, Bureau of Governmental Research and Virginia Commonwealth University), and the nine research center grantees of the NIH/NIDA CJ-DATS Cooperative (Brown University, Lifespan Hospital; Connecticut Department of Mental Health and Addiction Services; National Development and Research Institutes, Inc., Center for Therapeutic Community Research; National Development and Research Institutes, Inc., Center for the Integration of Research and Practice; Texas Christian University, Institute of Behavioral Research; University of Delaware, Center for Drug and Alcohol Studies; University of Kentucky, Center on Drug and Alcohol Research; University of California, Los Angeles, Integrated Substance Abuse Programs; and University of Miami, Center for Treatment Research on Adolescent Drug Abuse). The contents are solely the responsibility of the authors and do not necessarily represent the official views of the Department of Health and Human Services, NIH or NIDA, or other participants in CJ-DATS.

Biographies

Karen L. Cropsey, PsyD, is a clinical psychologist and assistant professor in the L. Douglas Wilder School of Government and Public Affairs at Virginia Commonwealth University. Her research investigates the use of combination therapies (pharmacotherapy and psychotherapy) for smoking and drug abuse among correctional populations. She has a K23 from NIDA to investigate the use of NicoDerm CQ plus a 10-week psychotherapy to help female prisoners quit smoking. She has another project investigating the use of acamprosate and psychotherapy to prevent alcohol relapse among inmates on community supervision. She is also part of a collaborative group that is investigating the use of Depot Naltrexone and psychotherapy for treatment of opioid dependence in those on probation or parolees.

Harry K. Wexler, PhD, is a clinical-research psychologist and a senior principal investigator (PI) in the Center for the Integration of Research and Practice at NDRI. He is best known for his landmark studies of the effectiveness of the therapeutic community in the community, prisons, and aftercare, which established prison treatment programs in 20 states. He was the co-chair of Treatment Improvement Protocol, Substance Abuse Treatment for Adults in the Criminal Justice System (TIP 44), and is PI on two current government-funded projects studying elements of prison treatment, community reentry (CJ-DATS), and the effectiveness of sealing records as a method of reducing recidivism by eliminating stigma. He has written numerous articles and has served as coeditor of several special issues of *The Prison Journal*. In 2005, he cofounded and serves as the codirector of the Center on Evidence-Based Interventions for Crime and Addictions (CEICA) at Treatment Research Institute in Philadelphia.

Gerald Melnick, PhD, is a senior principal investigator at CIRP (at NDRI). His current research activities include surveying the responsiveness of state criminal justice systems to the treatment of co-occurring substance use and mental disorder (COD), the development of screening instruments for COD in criminal justice settings, the effect of stigma on recidivism in first-time nonviolent felons, and the effect of organizational culture on clients' engagement in substance abuse treatment, substance abuse treatment outcomes, and staff attitudes toward

correctional institutions. His previous studies included the development of several instruments, including the Survey of Essential Elements Questionnaire (SEEQ), the Multimodality Quality Assurance Instrument (MQA), a Client Matching Protocol (CMP), and the Circumstance, Motivation and Readiness scales (CMR).

Faye S. Taxman, PhD, is a professor in the Wilder School of Government and Public Affairs and at the Institute for Drug and Alcohol Studies at Virginia Commonwealth University. She is the PI for the Coordinating Center for the NIDA-funded Criminal Justice National Drug Treatment Studies (CJ-DATS) (www.cjdats.org), where she directs a national survey of practices in correctional settings and is involved in several experimental studies. She is currently involved in four studies regarding translation of treatment to practice. She is the senior author of *Tools of the Trade: A Guide to Incorporating Science into Practice*, a publication of the National Institute on Corrections which provides a guidebook to implementation of science-based concepts into practice. She is on the editorial boards of *Journal of Experimental Criminology* and *Journal of Offender Rehabilitation*. She has published articles in *Journal of Quantitative Criminology*, *Journal of Research in Crime and Delinquency*, *Journal of Substance Abuse Treatment*, *Journal of Drug Issues*, and *Evaluation and Program Planning*. She received the University of Cincinnati award from the American Probation and Parole Association in 2002 for her contributions to the field.

Douglas W. Young, MS, is a senior faculty research associate with the Institute for Governmental Services and Research (IGSR) at the University of Maryland, College Park. At IGSR, he is involved in action research with state and local justice and public health agencies, conducting evaluations and providing systems development assistance in corrections and substance abuse treatment, offender reentry, and juvenile assessment and aftercare. He is co-PI of the Coordinating Center for NIDA's CJ-DATS network, and his current research includes a national, multilevel survey of offender treatment and a controlled study of technology transfer in juvenile case management and substance abuse treatment. Before joining the University of Maryland, he was at the Vera Institute in New York City, where he led studies on courts' use of new treatment alternatives, compulsory treatment, alternative-to-incarceration programs, drug courts, and prison treatment programs.

References

Albrecht LJ. Medical problems inside the walls of the Texas Prison System. Texas Medicine 1993;89:38–44. [PubMed: 8284771]

American Academy of Pediatrics Committee on Adolescence. Health care for children and adolescents in the juvenile correctional care system. Pediatrics 2001;107:799–803. [PubMed: 11335764]

American Psychiatric Association. Diagnostic criteria from DSM-IV. Washington, DC: Author; 1994.

Beck, AJ.; Maruschak, L. Mental health treatment in state prisons, 2000 (NCJ 188215). Washington, DC: U.S. Department of Justice Statistics; 2004.

Belenko S, Peugh J. Fighting crime by treating substance abuse. Issues in Science and Technology 1998;15(1):53–60.

Belenko S, Peugh J. Estimating drug treatment needs among state prison inmates. Drug and Alcohol Dependence 2005;77:269–281. [PubMed: 15734227]

Bradford J, Greenberg DM, Motayne GG. Substance abuse and criminal behavior. Clinical Psychiatry 1992;15(3):605–622.

Brooke D, Taylor C, Gunn J, Maden A. Substance misusers remanded to prison—A treatment opportunity? Addiction 1998;93:1851–1856. [PubMed: 9926573]

Bureau of Justice Statistics. Correctional populations in the United States, 1997 (NCJ 177614). Washington, DC: U.S. Department of Justice; 2000.

Bureau of Justice Statistics. Correctional populations in the United States, 1998 (NCJ 192929). Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; 2002.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

Bureau of Justice Statistics. Education and correctional populations (NCJ 195670). Washington, DC: U.S. Department of Justice; 2003.

Bureau of Justice Statistics. Hepatitis testing and treatment in state prisons (NCJ 199173C). Washington, DC: U.S. Department of Justice; 2004.

Cauffman E, Feldman S, Waterman J, Steiner H. Posttraumatic stress disorder among female juvenile offenders. Journal of the American Academy of Child and Adolescent Psychiatry 1998;37(11):1209–1216. [PubMed: 9808933]

Center for Substance Abuse Treatment. Substance abuse treatment for adults in the criminal justice system (TIP 44, (SMA) 05-4056). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2005.

Centers for Disease Control and Prevention. Hepatitis C infection in the United States. 2005. Retrieved September 25, 2006, from http://www.cdc.gov

Colsher PL, Wallace RB, Loeffelholz PL, Sales M. Health status of older male prisoners: A comprehensive survey. American Journal of Public Health 1992;82(6):881–884. [PubMed: 1533997]

Conklin TJ, Lincoln T, Tuthill RW. Self-reported health and prior health behaviors of newly admitted correctional inmates. American Journal of Public Health 2000;90:1939–1941. [PubMed: 11111273]

Cropsey K, Eldridge GD, Ladner T. Smoking among female prisoners: An ignored public health epidemic. Addictive Behaviors 2004;29(2):425–431. [PubMed: 14732432]

Cropsey KL, Kristeller JL. The effects of a prison smoking ban on smoking behavior and withdrawal symptoms. Addict Behaviors 2005;30(3):589–594.

Desai AA, Latta ET, Spaulding A, Rich JD, Flanigan TP. The importance of routine HIV testing in the incarcerated population: the Rhode Island experience. AIDS Education and Prevention 2002;14(5 Suppl B):45–52. [PubMed: 12413192]

Dillman, DA. Mail and Internet surveys: The tailored design method. New York: John Wiley; 2000.

Ditton, PM. Mental health and treatment of inmates and probationers: Special report (NCJ 174463). Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; 1999.

Estelle v. Gamble. 1976. Retrieved September 29, 2006, from http://www.findlaw.com

Fletcher BW, Wexler HK. National criminal justice drug abuse treatment studies (CJ-DATS): Update and progress. Justice Research and Statistics Association 2005;23:1–8.

Friedmann, PD.; Taxman, FS.; Henderson, C. Quality of treatment offered to adult offenders in correctional settings. 2006. Manuscript submitted for publication

Glaze, LE.; Palla, S. Probation and parole in the United States, 2003 (NCJ 205336). Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; 2004.

Goldstein PJ. The drugs/violence nexus: A tripartite conceptual framework. Journal of Drug Issues 1985;15(4):493–506.

Greenfeld, LA.; Snell, TL. Women offenders. (NCJ 175688). Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; 1999.

Hammett, TM.; Harmon, P.; Maruschak, LM. 1996–1997 Update: HIV/AIDS, STDs, and TB in correctional facilities. Washington, DC: Bureau of Justice Statistics; 1999.

Hammett TM, Harmon P, Rhodes W. The burden of infectious diseases among inmates of and releasees from US correctional facilities, 1997. American Journal of Public Health 2002;92(11):1789–1794. [PubMed: 12406810]

Harrison, PM.; Beck, AJ. Prison and jail inmates at midyear 2005 (NCJ 213133). Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; 2006.

Lamb-Mechancik, D.; Nelson, J. Prison health care survey: An analysis of factors that influence per capita costs. Washington, DC: National Institute of Corrections; 2000.

Langan, PA.; Levin, DJ. Recidivism of prisoners released in 1994. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; 2002.

Langan, NP.; Pelissier, BMM. Gender differences among prisoners in drug treatment. Washington, DC: Bureau of Prisons, Office of National Drug Control Policy; 2001.

MacKenzie, DL. Sentencing and corrections in the 21st century: Setting the stage for the future. Washington, DC: U.S. Department of Justice, National Institute of Justice; 2000.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Marsteller, F.; Brogan, D.; Smith, I. The prevalence of substance use disorders among juveniles admitted to regional youth detention centers operated by the Georgia Department of Children and Youth Services. Rockville, MD: Center for Substance Abuse Treatment; 1997.

Martin SS, Buztin CA, Saum SA, Inciardi JA. Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware. The Prison Journal 1999;79:294–320.

Maruschak, LM. HIV in prisons and jails, 2002. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; 2004.

Marushack, LM.; Beck, AJ. Medical problems of inmates, 1997: Special report. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; 2001.

McLaughlin SI, Spradling P, Drociuk D, Ridzon R, Pozsik CJ, Onorato I. Extensive transmission of Mycobacterium tuberculosis among congregated, HIV-infected prison inmates in South Carolina, United States. International Journal of Tuberculosis and Lung Disease 2003;7(7):665–672. [PubMed: 12870688]

Melnick G, Sacks S, Banks S. Use of the COVR in violence risk assessment. Psychiatric Services 2006;57 (1):142. [PubMed: 16399985]

Monahan J, Bonnie R, Appelbaum PS. Mandated community treatment: Beyond outpatient commitment. Psychiatric Services 2001;52(9):1198–1205. [PubMed: 11533393]

Monahan J, Steadman H, Henry J, Robbins P. An actuarial model of violence risk assessment for persons with mental disorders. Psychiatric Services 2005;56(7):810–815. [PubMed: 16020812]

Mumola, CJ. Substance abuse and treatment, state and federal prisoners. Washington, DC: Office of Justice Programs; 1999.

Mumola, CJ. Incarcerated parents and their children. Washington, DC: U.S. Department of Justice; 2000.

National Commission on Correctional Health Care. The health status of soon-to-be-released inmates: A report to Congress. 2002. Retrieved September 26, 2006, from http://www.ncchc.org/

National Institute of Corrections. Rethinking the revolving door: A look at mental illness in the courts. 2001. Retrieved September 15, 2006, from http://nicic.org/

National Institute for Literacy. National Adult Literacy Survey. Washington, DC: Author; 2001.

General Assembly of the Commonwealth of Pennsylvania. Joint State Government Commission. Report of the Advisory Committee on Geriatric and Seriously Ill Inmates. 2005. Retrieved on January 31, 2007, from http://jsg.legis.state.pa.us/Inmates%20Report.html

Shelton, D. Maryland Juvenile Justice Advisory Council. 1998. Estimates of emotional disorder in detained and committed youth in the Maryland Juvenile Justice System.

Steadman, HJ.; Veysey, BM. Providing services for jail inmates with mental disorders: Research in brief (NCJ 162207). Washington, DC: U.S. Department of Justice, National Institute of Justice; 1998.

Steiner H, Garcia I, Matthews Z. Posttraumatic stress disorder in incarcerated juvenile delinquents. Journal of the American Academy of Child and Adolescent Psychiatry 1997;36(3):357–365. [PubMed: 9055516]

Substance Abuse and Mental Health Services Administration. Overview of findings from the 2003 National Survey on Drug Use and Health (04–3963). Rockville, MD: Author; 2004.

Taxman FS, Bouffard J. The importance of systems in improving offender outcomes: New frontiers in treatment integrity. Justice Policy Journal 2000;2(2):37–58.

Taxman FS, Cropsey KL. Women offenders in the criminal justice system: Next steps to reduce recidivism. Women & Criminal Justice. 2007in press

Taxman, FS.; Perdoni, M.; Harrison, L. Treatment for adult offenders: A review of the state of the state. 2006. Manuscript submitted for publication

Taxman, FS.; Young, D.; Wiersema, B.; Rhodes, A.; Mitchell, S. National Criminal justice treatment practices survey: Methods & procedures. 2006. Manuscript submitted for publication

Taxman, FS.; Young, D.; Cropsey, KL.; Wexler, HK. Assessment & referral practices in adult correctional settings: A national perspective. 2006. Manuscript submitted for publication

Thorburn KM. Health care in correctional facilities. The Western Journal of Medicine 1995;163:560–564. [PubMed: 8553640]

Tonry, MH.; Wilson, JQ. Drugs and crime. In: Tonry, M.; Morris, N., editors. Crime and justice: A review of the research. Chicago: University of Chicago Press; 1990. p. 521-546.

U.S. Department of Labor, Bureau of Labor Statistics. Labor force statistics from the current population survey. 2000. Retrieved January 3, 2007, from http://www.bls.gov/cps/prev_yrs.htm

Veysey, BM.; Bichler-Robertson, G. Prevalence estimates of psychiatric disorders in correctional settings. Chicago: National Commission on Correctional Health Care; 1999.

Wexler HK, Lipton DS, Johnson BD. The drug-crime connection: Rehabilitation shows promise. Corrections Today 1988;50(5):144–147.

White, HR.; Gorman, DM. Dynamics of the drug-crime relationship. In: LaFree, G., editor. The nature of crime: Continuity and change . Washington, DC: National Institute of Justice; 2000. p. 151-218.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Table 1

Types of Services Offered by Type of Facility

Services	Services Offered		Total		None[a]		Psychosocial[b]		Other[c]		*F* Test
	Number	%	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	
HIV testing	88	89.8	3.41	1.57	3.39	1.56	3.48	1.63	3.27	1.56	0.08
HIV counseling	83	84.7	3.05	1.60	2.91	1.54	3.58	1.63	2.27	1.4	3.40*
Tuberculosis screening	93	94.9	4.47	1.22	4.48	1.22	4.35	1.36	4.73	0.91	0.38
Hepatitis C screening	87	88.8	3.48	1.59	3.30	1.56	3.35	1.66	4.73	0.91	4.08*
Physical health services	92	93.9	4.55	1.60	4.50	1.22	4.55	1.21	4.82	0.60	0.34
Mental health assessment	94	95.9	4.26	1.31	4.13	1.35	4.42	1.29	4.45	1.21	0.64
Mental health counseling	88	89.8	2.91	1.43	2.73	1.30	3.10	1.62	3.27	1.49	1.05
Co-occurring disorders (COD) assessment	87	88.8	3.49	1.53	3.29	1.53	3.65	1.60	4.09	1.22	1.51
COD counseling	79	80.6	2.63	1.42	2.39	1.30	2.77	1.50	3.45	1.51	2.92†
Social skills training	88	89.8	3.19	1.46	2.91	1.38	3.74	1.48	3.09	1.51	3.42*
Family therapy	71	72.4	2.33	1.32	2.14	1.14	2.65	1.62	2.36	1.26	1.46
Domestic violence intervention	64	65.3	2.16	1.27	1.91	1.03	2.48	1.46	2.55	1.64	2.67†
Life skills management	93	94.9	3.36	1.38	3.13	1.28	3.84	1.42	3.18	1.54	2.88†
Anger or stress management	91	92.9	3.28	1.35	3.00	1.22	3.87	1.34	3.00	1.61	4.73*
Cognitive skills development	91	92.9	3.22	1.41	2.86	1.26	3.81	1.47	3.45	1.51	5.08**
Job placement	79	80.6	2.97	1.46	2.91	1.37	3.06	1.65	2.97	1.46	0.11
Religious or spiritual sessions	96	98.0	3.99	1.19	3.96	1.21	4.03	1.25	4.00	1.00	0.03

Note: $N = 98$. Services are scored on a Likert-type scale of percentage of offenders provided services (1 = *none*, 2 = *less than half*, 3 = *about half*, 4 = *more than half*, 5 = *all*).

[a] $n = 56$.

[b] $n = 31$.

[c] $n = 11$.

† $p = .10$.

* $p < .05$.

** $p < .01$.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Table 2

Characteristics of the Prisons (Organizational) by Type of Facility

Organizational Measures	Nonspecialized[a]		Psychosocial[b]		Other Populations[c]		*F* Test
	M	SD	*M*	*SD*	*M*	*SD*	
Average daily population	2522.27	5842.40	792.39	778.109	1101.64	1022.59	1.65
Number of new yearly intakes	1609.13	2014.78	901.15	862.75	1130.13	1881.35	1.48
Number of full-time employees	372.65	355.00	171.02	156.54	218.05	148.68	4.64*
Number of full-time supervisors	327.51	254.92	136.19	120.73	142.00	122.03	7.93**
Number of treatment staff full-time	31.03	41.88	29.82	24.52	23.25	20.10	0.20
Number of programs offered	2.29	1.07	2.45	1.09	2.45	1.04	0.29
Number of substance abuse services	5.32	2.77	5.65	2.99	6.00	2.83	0.32
Involvement	3.64	0.61	3.81	0.57	3.82	0.62	1.00
Consistency subscale[d]	3.95	0.68	3.87	0.59	3.82	0.52	0.27
Staffing Needs subscale[d]	3.05	0.73	2.62	0.81	2.86	0.67	3.20*
Training Needs subscale[d]	3.69	0.58	3.62	0.61	3.80	0.58	0.40
Program Funding subscale[d]	2.33	0.82	2.26	0.74	2.30	1.05	0.08
Physical Facilities subscale[d]	3.55	0.78	3.48	0.97	3.06	0.94	1.50
Sharing Information with Substance Abuse Program subscale[e]	3.68	3.55	4.94	4.39	1.18	1.72	5.60**
Sharing Information with Community Corrections subscale[e]	3.59	3.17	3.39	3.79	3.73	3.71	0.05

[a] $n = 56$.

[b] $n = 31$.

[c] $n = 11$.

[d] Subscales are on a Likert-type scale from 1 (*strongly disagree*) to 5 (*strongly agree*).

[e] Subscales represent the total number of common activities associated (from 0–11) with substance abuse treatment programs, with judiciary, or with community corrections programs.

* $p < .05$.

** $p < .01$.