

# 8 Treatment Issues Specific to Jails

## In This Chapter...

Definitions  
Trends  
Treatment Services in Jails  
Description of the Population  
Key Issues Related to Treatment  
What Treatment Services Can Reasonably Be Provided in a Jail Setting?  
Coordination of Jail Treatment Services  
Examples of Jail Treatment Programs  
Research Related to Jail Treatment  
Recommendations for Treatment Providers

## Overview

This chapter addresses treatment options that can be provided for jail inmates with substance use disorders who are incarcerated for relatively short periods of time. This chapter discusses treatment issues specific to jails through an examination of what constitutes a jail, who is incarcerated in jail, how and when substance abuse treatment can be provided, and what types of treatment are effective in this setting.

Recommendations are made regarding the treatment services that can be provided within the physical, legal, and policy confines of a jail; and, finally, the treatment interventions that are best suited for brief, short-term, and long-term periods of jail treatment. This is followed by an overview of the larger systems that affect treatment in a jail setting.

Lastly, the chapter outlines the research, provides examples of existing programs, and makes recommendations for the treatment of substance abuse in jails and detention centers. It should be noted that this chapter addresses diversion only as it relates to the jail population. For more information on diversion, see chapter 7.

## Definitions

Jails (also called detention centers) house diverse groups of people detained for a wide variety of reasons. Jails confine people during the adjudication process (i.e., arraignment, criminal court, grand jury, hearings, trial, sentencing). These individuals are referred to as detainees and have not yet been sentenced. Jails also confine those sentenced to short-term incarceration (usually 1 year or less) and serve as a holding facility for

- Individuals who have allegedly violated probation, parole, or bail conditions
- Those who are absconding from court-ordered programs or other community placements
- Juveniles who are awaiting transfer to juvenile authorities or adult State prisons

## Defining a Jail

For the purposes of the Jail Manager Certification Program only, the American Jail Association defines a jail as

1. A county, municipal, or regional facility(ies) that houses pretrial and sentenced inmates and/or an institution that houses pretrial and sentenced inmates where the State is responsible for jail operation(s) (e.g., Alaska, Connecticut, Delaware, Hawaii, Rhode Island, Vermont); and/or a private facility that houses pretrial and sentenced inmates *and* exists to serve the local jail needs of the community in which it operates.

AND/OR

2. A facility that houses only pretrial detainees, regardless of what entity operates it. This includes, but is not limited to, facilities that house people for less than 72 hours (lockups); facilities that house Federal or military custody inmates awaiting trial (e.g., the Immigration and Naturalization Services, U.S. Marshals, Armed Forces); institutions where the State is responsible for the operations of jails, and private facilities.

AND/OR

3. A local government or private facility that houses convicted people who, without this facility's existence, would serve their sentence in the local jurisdiction's jail (e.g., Milwaukee County House of Correction).

A facility is not a jail if its purpose is to house sentenced inmates

1. Who are, or who would be under normal circumstances, incarcerated in a State institution
2. Who are, or who would be under normal circumstances, incarcerated in a Federal institution

These institutions include State prisons, Federal prisons, Texas State Jails, State work camps, and State boot camps.

- Inmates awaiting transfer to State, Federal, or other local authorities
- Inmates transferred from overcrowded Federal, State, or other prisons
- Individuals detained by the military
- Those held for protective custody
- People punished for contempt
- Witnesses detained by the court
- People with mental illness pending transfer to appropriate mental health facilities (Harlow 1998)

The approximately 3,365 jails in the United States (Stephan 2001) range in size from small jails located in rural areas to large jails typically located in or near large urban areas. The sociodynamics of jails vary according to size. For example, inmates housed in jails that serve rural communities often are familiar with other

inmates, while those incarcerated in large, complex systems have less chance of being housed with someone they know.

## Trends

Several recent trends have led to changes in the jail population. Enactment of harsher sentencing laws for drug offenses has led to increases in the number of minority and female inmates. At the same time, significantly reduced funding for the mental health care system has led to an increase in the number of multiproblem inmates (National GAINS Center 2002; Peters 1993; Peters et al. 1997).

As a result of these changes, jails house growing numbers of individuals who have been displaced from traditional societal "safety nets" such as State hospitals. By necessity, jails have enlarged the scope of their mission

to serve as community “gatekeepers” in identifying and addressing a range of psychosocial problems, such as HIV/AIDS, domestic violence, educational deficits, homelessness, mental illness, and, increasingly, substance use disorders (Peters and Matthews 2002).

Substance use disorders among the jail population have risen since the 1980s. In 1989, 67 percent of jail inmates had committed a drug offense or used drugs regularly. By May 1998, that number had increased to 70 percent—approximately 7 in 10 jail inmates. An estimated 16 percent committed their offense to obtain money for drugs (Wilson 2000). Increases in jail substance abuse treatment programs have not kept up with this trend (Belenko and Peugh 1998; Peters and Matthews 2002). In recent years, however, levels of substance use and abuse seem to have stabilized or even decreased slightly depending on the substance in question. In 2002, 66 percent of jail inmates reported regular alcohol use (down from 66.3 percent in 1996) and 68.7 percent reported regular illicit drug use (up from 64.2 percent in 1996), with *regular use* defined as use at least once a week for a month or more (James 2004).

Jails often serve as the first opportunity for offenders to have their substance use disorder and other problems (e.g., other mental disorders) identified, to have their acute needs stabilized (e.g., detoxification from alcohol or opioids), and to receive referrals to in-house or community services (Peters and Matthews 2002). In fact, many offenders’ initiation into treatment is in jail (Mumola 1999). Thus, the challenge to jail administrators is two-fold: to recognize the need for treatment and to understand that treatment must vary based on the population (e.g., by culture, average length of stay, type of crimes, psychosocial needs).

## Treatment Services in Jails

Findings from several studies indicate the effectiveness of in-jail substance abuse treatment programs in reducing criminal recidivism (Peters and Matthews 2002). Reductions in rearrests for treated inmates range from 5 percent to 25 percent in comparison to untreated inmates, over followup periods of 6 months to 5 years. Treated inmates also have a longer duration to rearrest following release from incarceration, relative to untreated inmates. Other positive outcomes associated with in-jail treatment include reduced rates of relapse among treatment participants (Tucker 1998), lower levels of depression (San Francisco County Sheriff’s Office Department 1996), and fewer disciplinary infractions (Tunis et al. 1997). Cost savings associated with jail treatment programs have been reported from \$156,000 to \$1.4 million per year (Center for Substance Abuse Research 1992; Hughey and Klemke 1996).

Despite the positive outcomes associated with in-jail treatment, two-thirds of jails do not offer treatment (excluding such ancillary services as assessment, self-help groups, and educational programming) (Substance Abuse and Mental Health Services Administration [SAMHSA] 2000). About two-thirds have self-help programs and about 30 percent have detoxification programs. Of jail inmates who reported ever having used drugs, only one in eight had participated in any treatment (even broadly defined) since their admission, and most of those reported were self-help programs (Wilson 2000).

## Description of the Population

At midyear 2003, local jails held or supervised 762,672 people, of whom approximately 10 percent (71,371) were outside the jail facility (e.g., under electronic monitoring, in outside treatment programs, on work release, etc.); this figure represented a 3.9 percent

increase over the number of inmates held in jail at midyear 2002. Between 1995 and 2003 the number of jail inmates per 100,000 residents increased from 193 to 238, an increase of over 23 percent. More than half of the adult jail inmates (60.6 percent) were not yet convicted of the crime for which they were being held (Harrison and Karberg 2004). According to a 1999 survey of jail inmates, 5 percent were known to be noncitizens (Stephan 2001).

## Crimes

Crimes committed, or allegedly committed, by jail inmates are fairly evenly divided between violent offenses (24.4 percent), property offenses (24.4 percent), drug offenses (24.7 percent) and public-order offenses (24.9 percent). The most common offenses are drug trafficking (12.1 percent), assault (11.7 percent) and drug possession (10.8 percent) (James 2004). Compared to other jail inmates, offenders driving while intoxicated are older, better educated, and more likely to be Caucasian and male (Maruschak 1999a).

## Income and Education

According to 2002 data, approximately 44 percent of jail inmates had not received a GED or graduated from high school. Twenty-nine percent of jail inmates were not working at all at the time of their arrest and only 57.4 percent were employed fulltime. Jail inmates also reported low incomes, with 59 percent reporting monthly incomes of less than \$1,000 (James 2004).

## Gender

Between midyear 1995 and midyear 2003, the percentage of male inmates dropped from 89.8 percent to 88.1 percent, while the percentage of female inmates rose from 10.2 to 11.9 percent. This means that as of 2003 men were per capita eight times more likely than women to be in a jail. During the year prior to June 30, 2003, the number of female

inmates in jail rose 6.3 percent while the number of male inmates increased by 3.7 percent (Harrison and Karberg 2004).

Over 55 percent of jailed women report physical or sexual abuse prior to admission, with 44.9 percent reporting physical abuse and 35.9 percent reporting sexual abuse (James 2004). Women are also more likely to be identified as having mental illness. Approximately 22.7 percent of female inmates and 15.6 percent of male inmates were identified as having mental illness (Ditton 1999). A survey of inmates in State prisons and jails indicated that men with mental illness were twice as likely as other men to report a history of abuse (Ditton 1999).

Offenses vary by gender. For example, women were more likely to be held for drug possession than trafficking, whereas the reverse was true for men; women were also more likely to be held for property offenses than violent offenses, and again the reverse was true for men. However, a greater percentage of women in jail are there for drug offenses. The common offenses for which women in jails were being held in 2002 were drug possession (14.5 percent), fraud (14 percent), drug trafficking (10.9 percent), and larceny/theft (10.3 percent). For men, the most common offenses were drug trafficking (12.3 percent), assault (12.2 percent), drug possession (10.3 percent), and burglary (7.2 percent) (James 2004).

## Race and Ethnicity

As of midyear 2003, the largest proportion of jail inmates were Caucasian (43.6 percent) or African American (39.2 percent). African Americans were 5 times more likely than Caucasians and 3 times more likely than Hispanics/Latinos to be in jail (Harrison and Karberg 2004). Caucasian jail inmates reported higher rates of mental illness (21.7 percent) than either African Americans (13.7 percent) or Hispanics/Latinos (11.1 percent) (Ditton 1999). Among convicted jail inmates, Caucasians were more likely to be using alco-

hol (38.5 percent) and/or illicit drugs (33.2 percent) at the time of their offense than African Americans (29.3 percent and 27.3 percent respectively) or Hispanics/Latinos (30.1 percent and 23.8 percent respectively) (James 2004).

## Substance Abuse

A history of drug use is a common characteristic of the jail population, although patterns of use have changed somewhat in recent years. Compared to jail inmates in 1996, inmates in 2002 reported more use of marijuana, depressants, stimulants (other than cocaine), and hallucinogens in the month prior to the offense and less use of cocaine and heroin/opioids. As noted earlier, in 2002, 66 percent of jail inmates reported regular alcohol use and 68.7 percent reported regular illicit drug use. Approximately 35 percent of all convicted males and 31 percent of females reported that they had been drinking alcohol when they committed their offenses (James 2004). Of convicted jail inmates who were actively involved with drugs, 72 percent were on criminal justice status at the time of their arrest (i.e., were on probation or parole, had pretrial status, were out on bail, or had escaped) (Wilson 2000).

The percentage of those who participate in substance abuse treatment programs in jails varies widely. The average population is young, male, and, like the general jail population, fairly evenly distributed between African Americans (42 percent) and Caucasians (39 percent). The majority of participants (58 percent) are ordered to treatment programs as a condition of their sentence, and most have prior felony convictions (Peters and Matthews 2002). The percentage of jail inmates who used alcohol or other drugs regularly participating in some type of substance abuse treatment (including self-help group participation) after arrest has increased from 12.3 percent in 1996 to 15.1 percent in 2002 (James 2004). Among inmates jailed for driving while intoxicated (DWI) offenses, only 17 percent are involved in pro-

grams such as self-help and educational groups for alcohol abuse, compared with 62 percent of probationers who receive these services. Only 4 percent of those jailed for DWI receive any type of alcohol abuse treatment including detoxification or counseling (Maruschak 1999a).

## HIV Status

At midyear 2002, 1.3 percent of jail inmates who reported their test results were known to be HIV positive (Maruschak 2004), rates far in excess of those within the general population (Centers for Disease Control and Prevention 2004a). Between 1998 and 1999, AIDS-related deaths accounted for 8.5 percent of all deaths in jails making it the third leading cause of death in jails (death by natural causes was the leading cause of death, followed by suicide) (Maruschak 2001). However, the number of AIDS-related deaths in jails decreased from 9 per 100,000 inmates in 2000 to 6 per 100,000 in 2002 (Maruschak 2004).

In 2002, 3 percent of African-American women, 2.9 percent of Hispanic/Latino inmates (both male and female), 1.6 percent of Caucasian women, 1 percent of African-American men, and .6 percent of Caucasian men reported testing positive for HIV. African-American men, however, made up the largest number (163,219) of HIV-positive jail inmates (Maruschak 2004).

The percentage of those who participate in substance abuse treatment programs in jails varies widely.



## Co-Occurring Mental Disorders

In 1998, an estimated 16 percent of jail inmates reported either a mental disorder or an overnight stay in a mental hospital. Mental illness was most commonly reported by offenders between the ages of 45 and 54, with 23 percent identified as mentally ill (Ditton

1999). Many people with mental illness cycle through jails repeatedly.

Individuals with mental illness are admitted to jails at approximately eight times the rate at which they are admitted to public psychiatric hospitals. As a result, there are more people with severe mental illness in U.S. jails than in State hospitals (Torrey et al. 1992). A review of administrative data for jail detainees and inmates in New

Jails can serve a pivotal role in engaging family members, peers, and community organizations in supporting the recovery efforts of inmates.

York City found that approximately 15,000 people with mental health problems cycle through that correctional system and back into the community each year, of which a significant portion have co-occurring disorders (Lamon et al. 2002). The Urban Justice Center, a New York City advocacy group, reported that detainees and inmates with mental illness spend significantly more time incarcerated—an average of 215 days versus 42 days—when compared to those not identified as mentally ill (Winerip 1999). One study found that homelessness is strongly associated with mental illness among jail inmates: half of the ever-homeless sample of inmates in the New York City correctional system responded positively to at least one mental illness screening question (Michaels et al. 1992). Of those, many, if not most, are repeat offenders.

According to the research collected and reported by the National GAINS Center (2002), 6.4 percent of male and 12.2 percent of female jail detainees have severe mental illness. Among male detainees at intake, 2.7 percent meet the criteria for schizophrenia/schizophreniform disorder, 1.4 percent for mania, and 3.9 percent for major depressions. Among female detainees, 2.0 percent meet the criteria for schizophrenia/schizophreniform disorder, 1.4 percent for mania, and 10.5 percent for major depression. Twenty-nine percent of male and 53 percent of female jail detainees have a substance use disorder, and both male and female detainees have a 72 percent rate of both mental illness and substance use disorders (National GAINS Center 2002). Inmates with both disorders are significantly more likely to have multiple problems in terms of employment, family relations, and health, and are at greater risk for not complying with treatment, rearrest, homelessness, violence, and suicidal behavior when compared to those without this combination of disorders (Borum et al. 1997; Peters et al. 1992; RachBeisel et al. 1999; Steadman et al. 1998; Swartz and Lurigio 1999). In a study of 204 pretrial jail detainees in substance abuse treatment in a Chicago jail, more than half met the lifetime criteria for at least one mental disorder, and the lifetime rates of serious mental illness were higher than those reported in the general jail population. Individuals with co-occurring disorders were also more likely to have been arrested for property offenses; to be dependent on alcohol, marijuana, or PCP; and to have more than one psychiatric disorder. Moreover, the study revealed a correlation between severe mental illness, antisocial personality disorder, and drug abuse (Swartz and Lurigio 1999).

## Key Issues Related to Treatment

Several factors affect the availability and effectiveness of treatment in jails. It has been the experience of consensus panel members that treatment, if available at all, may not be offered to those in need because the methods for screening and selecting treatment participants may not be comprehensive. For some inmates, the length of jail stay may be too short for substance abuse interventions. Others, especially those in pretrial status, may decline to participate. Even when services are available, they are not always responsive to the inmates' psychological, social, medical, and mental health needs, and some inmates have special needs that are too complex to be addressed fully in brief or short-term treatment.

This section addresses factors unique to jails that the consensus panel believes can impact the availability and/or effectiveness of treatment. See chapter 5 for more general issues affecting treatment.

### Public Perceptions About Jails

Although jails are designed to improve public safety and to provide punishment through the short-term detention of defendants and convicted inmates, they are sometimes perceived negatively by the public. A negative perception can affect the morale and attitudes of jail staff, particularly relating to treatment services. The community may not realize that jails hold a significant number of individuals who are arrested for low-level, nonviolent charges; that many offenses committed by jail inmates are related to their substance abuse and/or mental health problems; and that most will return to their community within a short amount of time.

Through their work with local community agencies, treatment staff can assist in dispelling misperceptions and increase the sense of inclusion of the jail as part of the community's network of services. Because of their

involvement with individuals who often cycle through a variety of community services and agencies, jails are ideally situated to develop partnerships to improve community services. Many jails have worked to establish "beachheads" to develop healthcare services, prevention and education programs, and vocational services, particularly for "high-risk" groups such as the homeless, those with HIV/AIDS, and inmates with co-occurring mental disorders. Jails can serve a pivotal role in engaging family members, peers, and community organizations in supporting substance abuse treatment and the recovery efforts of inmates who are enrolled in treatment services. Jails can also help facilitate partnerships between community groups and local corrections for the purpose of identifying, treating, and referring (through diversion or aftercare) inmates with substance use disorders, and reinforce the concept that "treatment works."

### Time Constraints

One of the most serious challenges for substance abuse treatment in jails is the small amount of time available, both in terms of scheduling treatment and in terms of the duration of jail incarceration (Leukefeld and Tims 1992). Many pretrial inmates are housed in jail for only short periods of time. Time constraints are a particularly significant factor given that research shows a correlation between treatment effectiveness and length of time spent in treatment (Swartz et al. 1996).

A jail must operate on a schedule that includes periods of time during which inmates are locked-in for inmate count for meals or other structured activities (e.g., work). Thus, despite the importance of time spent in treatment, programs must compete for the inmate's time. Some jails offer evening programming, but this is sometimes difficult to arrange and substantially increases staffing costs. Due to scheduling constraints within jails, an inmate may have to decide between enrolling in a treatment or an educational program.

Also, offenders are confined to the jail for limited, and often uncertain, lengths of time. This is particularly true for unsentenced, pretrial inmates who may be released from jail unpredictably following a court hearing. Ideally, treatment programming can be developed according to a modular structure that accommodates differing time lengths and goals—from initial engagement and education to developing skills and completing steps.

## Environmental Issues

A large number of people enter jails both as visitors and as service providers. While reach-in from the community and visits from family should not be discouraged, coordinating and overseeing such activities is time consuming for staff who may need to spend time processing and escorting visitors that could otherwise be spent with clients. Treatment providers who visit clients from outside the institution may also find a significant portion of their time on the premises taken up with waiting and processing.

Jails also maintain a classification-based system that is typically based on security needs and bed/space availability, and which may or may not coincide with an inmate's treatment needs. Many small, rural, or older jails in particular have environments and structures that are not conducive to treatment: They were built to detain, house, and process inmates, and not to provide screening, assessment, or treatment services. There may not

be individual interview or treatment space available, and group treatment space may also be scarce. If activity space is available, educational, work, religious, and treatment programs often compete for this space, and the amount of treatment programming is often compromised. Architecturally, jail activity rooms and housing units are not soundproof. Noise can provide distraction from treatment activities and can be a source of stress for both clients and treatment providers.

Finding space that is private and that provides security for both staff and inmates is a challenge. While corrections and treatment staff may find joint solutions, informing clients of these limitations is important. The counselor should also be aware of the limitations this may create for discussing certain issues or engaging particular populations (e.g., detainees with certain charges, certain trauma events, severe mental illness), or even for conducting a thorough assessment. Privacy is also hampered by the fact that an inmate is never alone; there is electronic surveillance in jails as well as security personnel and other inmates.

## Gang Affiliation

The counselor should be aware of the jail's policies and programs regarding gang affiliation, including rules regarding who should participate in certain groups and activities or which actions may lead to an administrative

## ***Suggestions for Dedicated Program Space***

The effectiveness of substance abuse treatment services would be significantly enhanced by dedicated program space in jails that is isolated from general housing units. Dedicated staff office space would optimally be provided in an area within or adjacent to the isolated treatment unit. The benefits of providing dedicated treatment space include the following:

- Privacy in conducting treatment and staff meetings
- Reduced competition for treatment program space
- More readily available staff
- Reduction of issues related to inmate movement and coordination



or new criminal charge during detention. Knowledge of the gangs in the jail may allow the counselor to foresee which activities could be used to inflame rival gangs, to set clear group rules for activities, and to clearly define the counselor's role of balancing security and facility rules with good treatment practices, thereby avoiding sending mixed messages to the inmate or placing him- or herself at odds with corrections.

## **Stress Related to Incarceration**

A number of issues beyond the individual's readiness for treatment can affect his engagement in the treatment process within a jail setting. Many of the stressors identified in chapter 5 are present in jails, including trauma related to the recent arrest, uncertainty of the legal situation, and possible loss of a job or custody of children. Counselors are in a position to assist the client in developing coping mechanisms to address substance abuse issues within the context of multiple internal and external stressors, to clarify which issues can be addressed while incarcerated within the bounds of certain timeframes, and to make referrals to other jail or community services to address non-substance-abuse-related issues and to facilitate continuity of treatment from jail into the community (e.g., legal and medical problems, education, vocational training or work programs, diversion or aftercare programs). See chapter 7 for a more detailed discussion of interpersonal issues facing recent arrestees.

## **Issues Related to Justice System Processing and Legal Representation**

The legal process can understandably confuse detainees, and either this disorientation can persist for a lengthy period (e.g., during adjournments, plea bargaining, competency

## **Advice to the Counselor: Jailed Clients**

- Counselors should be aware of gang affiliations as well as the jail's policy regarding who should participate in certain groups. This knowledge may allow the counselor to foresee which activities could be used to inflame gang rivalries, set clear group rules for activities, and balance security with good treatment practices.

processes, or diversion planning), or the status of the case can rapidly shift and the detainee may be suddenly released from jail. Often there is little communication between the court, jail staff, and treatment staff, which has direct impact on the therapeutic relationship, as the detainee's legal status is a major concern.

Defense attorneys do not always visit clients while they are in jail, with brief visits often occurring at court prior to the stressful and sometimes confusing court proceedings. Further, for those detainees who reach out to peers for support, information is often inaccurate and can increase their sense of urgency and hopelessness. Due to the wide variety of populations incarcerated in jails, detainees may learn about scenarios that are not relevant to their own case processes.

Attorneys do not always recognize the benefits of treatment and may not encourage the inmate's involvement in treatment. For example, due to heavy caseloads, many public defenders do not take the time to advise clients about how treatment could benefit them. In some jurisdictions, the appointed defense counsel may not be from the public defender's office and may not be aware of diversionary or other treatment options. Despite the presence of substance abuse problems, defense counsel may in some cases be reluctant to advise their client to voluntarily submit to treatment due to conditions of supervision that are likely to lead to sanctions and incarceration. The flow of information between legal and treatment professionals can also be problematic, related to the types of

information that counselors can provide to their clients' attorneys, whether counselors can testify in court, and the types of legal information that the treatment provider needs for purposes of counseling.

## **Confidentiality**

Substance abuse treatment programs should establish clear guidelines regarding the type of information that may be disclosed after an offender has signed a proper consent form. The Federal confidentiality laws and regulations protect any information about an offender if the offender has applied for or received any substance abuse-related services from a program covered by the law. Programs included are those that specialize, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for offenders with alcohol or other drug problems. A different confidentiality issue can arise in small, rural jails, where inmates and officers often know each other. Residents with substance use disorders are well known, and it is difficult to keep confidential the fact that someone is receiving treatment. For more information about the confidentiality laws and regulations and their implications for substance abuse treatment in jails, see CSAT 2004.

## **Counselor–Client Issues**

Given the complexity of the environment and issues needing to be addressed, it is useful for the counselor to clearly describe his role and limitations related to that role, the structure of the proposed treatment, and the various options available. For instance, the counselor should explain whether he or she will become involved in legal, family, medical, disciplinary, or other issues. The counselor should describe the potential treatment options, how these options may or may not impact the client's problems, and what other types of treatment or interventions may be needed to address the client's problems that are not

offered within a jail setting. While the client's reactions to this information may initially vary from rage to indifference to relief, offering ways to cope with limitations and stressors is more useful than initially placating the client. The counselor should be aware of the protections and limits to protections that informed consent may have. (For more information on confidentiality, see CSAT 2004.)

## **Supervision and training**

Supervision and ongoing participation in training are essential for jail treatment counselors, given the complexity of issues, presenting symptoms, and behaviors related to the inmate population, and the limitations to the physical structure and environment of the jail. Supervision can support the counselor and help clarify the different systems' demands, potential personal reactions to these demands, and personal reactions to the clients themselves. These clarifications help determine when these issues should be part of or separate from the treatment and which issues should be addressed systemically. Support and continued professional development can reduce therapist burnout and increase treatment efficacy.

## **What Treatment Services Can Reasonably Be Provided in a Jail Setting?**

There have been several efforts to develop guidelines for jail-based treatment programs that describe model treatment approaches and minimum standards of care. For example, the Office for Treatment Improvement (now the Center for Substance Abuse Treatment [CSAT]) convened a "Criminal Justice Treatment Evaluation Meeting" in 1992 to identify critical elements of jail-based

substance abuse treatment programs and jail treatment guidelines (SAMHSA 1996). There is still a need, however, for more specific guidelines that can be operationalized by local jails. The American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCCHC) have standards related to jails, but they are extremely limited in the area of substance use, and far less specific and detailed than those developed for mental health services in jail. No specific guidelines have been adopted for substance abuse treatment in jail, nor do existing standards account for the elaborate contextual and environmental factors affecting treatment in jail settings.

There is currently no single prototype for jail substance abuse treatment programs, but rather a range of available programs that vary in content and intensity according to the inmates' length of stay (Leukefeld and Tims 1992; Peters and Matthews 2002). Some detainees are in jail less than a week, during which they may receive only assessment and referral, whereas others are serving a sentence in a jail setting. Several different durations of treatment are discussed in this section to examine the range of treatment options that might be provided in jail. In this section the panel recommends a framework by which to identify priority treatment services, given a defined period of time available to provide treatment services for inmates. For purposes of this section, "brief" treatment is defined as up to 30 days, "short-term" treatment is defined as from 1 to 3 months, and "long-term" treatment is defined as 3 months and longer. Regardless of the duration of treatment, however, the goal should always be to engage clients so that treatment and recovery can continue when they leave jail. Issues of screening and assessment, regardless of the setting, are discussed in chapter 2.

Treatment intensity and duration are increased with length of stay, as is the scope of topics that can be addressed. More intensive treatment services are often necessary, given that the substance abusing lifestyle has taken years to

develop and cannot be altered in just a few weeks. Figure 8-1 (p. 168) outlines optimal treatment components that might be deployed at each level, followed by a more detailed explanation of each. Each successive level of treatment in this layered approach includes service components from previous levels.

Regardless of the duration of treatment, complicating factors for those in jail include co-occurring medical problems and histories of physical and sexual abuse, unstable relationships and social support structures, poverty, homelessness, gender, and cultural differences, among others.

Combinations of factors can interact differently with any of these subpopulations, have implications for treatment strategies, and have an impact on treatment outcomes. Consequently, when designing or adapting treatment programs, it is important to factor in these variables along with the substance choice patterns of use and types of previous treatment and services.

Support and continued professional development can reduce therapist burnout and increase treatment efficacy.

## Level I: Brief Treatment

Some offenders may be identified within a short period of jail detention for involvement in community diversion programs that include participation in treatment. For many other inmates who are incarcerated 30 days or less, case management, referral, and brief interventions can be provided. Brief treatment usually focuses on supplying information and making referrals.

**Figure 8-1**  
**Treatment Components**

Brief	Short Term		Long Term
Level I (1 to 4 weeks)	Level II (4 to 12 weeks)		Level III (3 months or more)
Motivational interviewing	Relapse prevention	Communication skills	Employment counseling
Orientation to treatment/treatment planning, and substance abuse education	12-Step programs	Dealing with domestic violence	Therapeutic community
Information on available community resources	Basic cognitive skills	Anger management	Family mapping and social networks
			Following through on 12 steps
Facilitating access to community services	Identity and culture	Problem solving	Continued stabilization
Community linkage and transition services	Strengths building	Social skills training	Cultural factors
Psychotropic medications: education and compliance			Criminal thinking

### ***Motivational enhancement therapy and motivational interviewing***

Motivational enhancement approaches help clients to address their ambivalence about involvement in substance abuse treatment, and to identify methods of dealing with this ambivalence. (For more information about motivational interviewing, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999b].) The goal of this process is to engage inmates in a discussion of the treatment process and their potential reasons for changing substance abuse behavior and to help inmates develop their own rationale for changing this behavior. This approach is designed to help counselors work with clients who are ambivalent

about treatment, in denial about their circumstances, and resistant to change.

In Project MATCH, the largest clinical trial ever conducted to compare different alcohol treatment approaches, a four-session motivational enhancement therapy yielded long-term overall outcomes that were similar to those of other, more intensive outpatient methods. Further, the results of this study strongly suggested that motivational interviewing could be applied across cultural and economic groups.

Enhancing detainees' motivation for change and increasing their receptivity to substance abuse treatment can be effective in this setting as well. For example, materials developed at Texas Christian University (TCU) include a board game called Downward Spiral, which helps clients examine the conse-

quences of substance abuse. Other useful exercises include the Decision Matrix, which looks at advantages and disadvantages of continued substance use from the client's perspective and at the benefits of choosing to discontinue use. This helps identify functional aspects of their substance use (e.g., socialization, reduction of negative emotions) that sustain patterns of use, and that may serve as barriers to continued abstinence and involvement in treatment.

### ***Substance abuse education***

Because inmates may not have examined the negative health consequences related to substance abuse, an educational component can inform and possibly change risky behaviors. Films, presentations, and literature can be used to present this education. The ultimate goal of treatment is abstinence, but people who have abused substances long-term have had difficulty successfully addressing issues such as boredom, anxiety, social discomfort, and being ostracized by family and peers.

### ***Information on available community resources***

Community resource information ranges from how to obtain a restraining order to what community organizations offer substance abuse treatment. Counselors in the pretrial setting need to be aware of their community's resources in order to assist their clients after release. Many of these individuals will be

released back to the community with their numerous needs unchanged and/or unmet. Clients can be referred to Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups, and counselors can provide help with finding job training programs, general educational programs, clothing, food, and public assistance. Before this information is presented to inmates, however, counselors must check to see that an agency will accept referrals from the criminal justice system, and assess eligibility criteria. Some programs have developed resource directories with descriptions of community services programs and relevant contact information.

### ***Facilitating access to community services***

Incentives can be established for substance abuse treatment staff to enter jails to work with inmates enrolled in treatment. One step is to develop contract language that identifies jail inmates as a priority group to receive publicly funded substance abuse treatment services. Another is to establish funding for health benefits. In New York City, for example, an inmate's Medicaid eligibility in a community program can be reinstated while the inmate is still in jail so the paperwork is ready when that inmate is released; a similar system has also been developed for establishing temporary Medicaid coverage. Some community organizations may be less resistant to taking on former inmates as clients if these individuals are receiving Medicaid support. Once a health problem or mental illness is

## ***A Voice of Experience***

I believe that jail administrators have an obligation to provide the programs by which inmates can better themselves, and this includes alcohol and drug abuse programs. But in South Carolina—and only in South Carolina—anyone sentenced to more than 90 days, with the exception of family court, goes to State prison. The rest come here. Consequently, with this small average length of stay, it's very difficult to justify the significant commitment of resources that are needed with such a revolving door atmosphere.

—Mark F. Fitzgibbons, CJM  
Director, Buford County (SC) Detention Center



identified, Medicaid may be needed in order to cover treatment in the community for those affected.

## **Community linkage and transition services**

Offenders who abuse substances are perhaps at their most vulnerable when they are making the transition back to the community. The treatment system needs to plan for an inmate or detainee who is leaving the jail, and the community needs to be prepared to receive the individual. Case managers or other types of “boundary spanner” staff are particularly trained to manage these transitions. They are cross-trained in issues related to the mental health, substance abuse, and criminal justice systems, and will help to facilitate aftercare or diversion (Steadman et al. 1995; Taxman 1998) (see also TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* [CSAT 1998b]).

These staff members can handle multiple tasks—from being advocates to understanding the available community resources and linking exiting inmates to those resources. The most common types of linkage and transition services provided by jail substance abuse treatment programs are assessment of aftercare needs, discharge planning, placement planning, and coordination with community treatment agencies (Peters and Matthews 2002). Jail aftercare coordinators or treatment counselors, community resource coordi-

nators, or case managers often provide these services. Specialized reintegration programs are often helpful in developing postrelease plans related to housing, aftercare, relapse prevention, and employment.

While the goal of treatment is to help an inmate to abstain from substance use, the reality is that inmates are at high risk for relapse and in some cases overdose upon their release from jail. Overdose prevention efforts prior to release can prevent deaths, especially for inmates who have been off the streets for a period of time. Counselors should provide inmates with information about the decreased tolerance that results from abstinence.

## **Psychotropic and other medications: Education and adherence**

Many inmates will benefit from education regarding psychoactive medications, how they work, the reason for certain medication schedules, flexibility in dosage, side effects and how to manage these, and the relationship between mental and substance use disorders and noncompliance with medications and decreased efficacy of medications. Clients should understand the distinction between psychotropic medication and substances of abuse but also be informed about which medications can be addictive. This type of education also provides a venue for discussing the relationship of mental disorder symptoms and the potential sense of stigma associated with

## **A Voice of Experience**

Since 1993, the Clark County (NV) Drug Court’s 1,725 graduates have experienced only a 17 percent recidivism rate—as compared with the 80 percent recidivism rate of people addicted to drugs who are released from jails or prisons. According to our drug court judge, this is the best method so far to treat people addicted to drugs. I agree. To have an impact on substance abuse in the jail population, an approach of long-term, high-quality treatment with community follow-up is the answer.

—Captain Marilyn Rogan  
Clark County (NV) Detention Center

## ***A Voice of Experience***

I am a psychologist working in a jail. We learned that our policy of stopping methadone “cold turkey” resulted in a very high frequency of booking recidivist inmates on drug charges related to heroin. So, working with our County Executive, we stopped withdrawing and stopped the practice of “stopping” on Sundays. Now, if someone comes in, they continue, and we encourage agencies to send their case manager into the jail and make plans for the inmate’s release, so there is no gap ... What we’ve noticed is—we have very, very few bookings of individuals who were taking methadone. But we haven’t reached the point of initiating methadone treatment—that would be our next step. And I think that would be a great idea, because everybody is so happy with what we’ve been doing.

—Lawrence W. Smith, Ph.D.

Psychiatric Services Administrator

King County (WA) Department of Adult and Juvenile Detention

mental health problems and ongoing medication regimens.

For a significant number of inmates with a history of opioid abuse, review of existing opioid substitution medications will also be quite useful, including methadone, levo-alpha-acetyl-methadol, buprenorphine, and other medications used in detoxification from or reduction of opioid use. There has not been widespread use of these medications in jails, primarily because they are seen as potential sources of contraband, prolonging physical dependence on opioids, and requiring specialized medical supervision.

### **Level II: Short-Term Treatment**

Level II, short-term treatment (approximately 4–12 weeks in duration) enables greater depth of involvement in the treatment process. Short-term treatment is built upon the previously described basic Level I services. Level II or short-term treatment interventions provide more focus on coping skills to prevent substance use and sustain recovery.

### ***Substance cravings, urges, and relapse prevention***

Inmates learn about actions that can trigger their substance cravings and how cravings

and urges are tied into relapse prevention. They can also complete exercises to identify personal “substance use triggers” and review strategies for avoiding and dealing with these triggers. For example, group discussion may focus on what inmates may expect when returning to their families, who may not fully support their involvement in recovery. While support from non-substance-using family members can be an enormous contribution to help the client stay clean and sober after release, reunification with family members is often accompanied by stress related to the family’s distrust and anger over the offender’s past substance use, unresolved conflicts with the partner or spouse, shifting parental roles, and added financial obligations (Peters 1993). Returning to live with family members who actively use substances or who condone substance use within the home creates additional high-risk situations for the offender. In some cases, return to the home environment can trigger a relapse. Counselors should assess the home situation and possibly examine alternative housing arrangements. Counselors may instruct clients that certain areas of town (e.g., drug neighborhoods) are “no-fly” zones and that they will be violating conditions of their treatment program and/or supervision if they frequent those parts of town.

## **Self-help programs**

Level II treatment is an opportunity for inmates to learn about self-help programs and their availability in the community. While not typically considered substance abuse treatment, such groups as NA and AA provide a valuable and accessible source of peer support for inmates returning to the community.

In the past several years, new case law has found that AA and NA are essentially religious-based treatment programs (*Griffin v. Coughlin* 1996; *Kerr v. Farrey* 1996; *Warner v. Orange County* 1999). While many States continue to sentence offenders to AA or NA, in at least one State (New York), the court has found that doing so is a violation of the first amendment. Authorities may be able to resolve this issue, however, by either removing these coercive requirements or by incorporating nonreligious alternatives (Cohen 2000).

Some jails offer alternative types of peer support groups, such as SMART Recovery, which is based on cognitive-behavioral principles of Rational Emotive Behavioral Therapy. While licensed professionals in the community sometimes organize such groups, it is individuals in recovery who lead them.

## **Basic cognitive skills**

Cognitive skills training helps inmates correct thoughts that can lead to criminal behavior and substance abuse. These interventions help inmates understand the relationship between thoughts, emotions, and behaviors, and strategies to address maladaptive thought processes that can lead to interpersonal conflict, emotional disturbance, and aggressive and violent behavior. Cognitive skills learned in jail treatment programs are often generalizable to other settings, including work, school, and relationships with significant others and family members.

## **Strengths building**

Strengths building identifies and uses the assets that clients bring to the treatment program to improve their chances for successful recovery. Counselors can examine interactive ways for participants to recognize their strengths, for example, by having inmates write something positive about each group member, then by identifying characteristics of themselves they think are good, and considering how they can build on those strengths in the future.

Researchers at TCU have developed a series of readiness and induction interventions that incorporate a strengths-building strategy (Dees et al. 2000). These interventions give participants unique opportunities to define their roles in treatment and to discover their positive personal strengths and hidden cognitive potentials. In Tower of Strengths intervention, for example, participants examine their strengths and those they most wish to have. These activities are suitable for use in custody or community settings, and can be used in groups of up to 35 participants or in individual counseling.

The TCU readiness and induction interventions were designed specifically to overcome problems often encountered in working with those mandated to treatment. They address the distorted and negative expectations about treatment common among clients in criminal justice programs, and their lack of self-confidence resulting from personal failures, educational and vocational deficiencies, and poor coping skills.

## **Communication skills**

This type of intervention can improve interpersonal skills and increase assertiveness with key family members, significant others, and individuals at work. Key activities often address effective means of expressing anger and other negative emotions, dealing with conflict situations, and dealing with problems

that arise in personal relationships, whether at work or in the home.

## ***Anger management***

These activities can help inmates recognize when they feel angry, identify some of the causes of their anger, and learn to use alternative problemsolving techniques to help manage their anger. These interventions are also helpful in understanding the connection between anger and substance abuse, given that poorly managed anger often precipitates substance abuse.

## ***Domestic violence***

In these cases, short-term strategies are developed to maintain personal safety for victims of domestic violence and protect children, and longer term solutions are considered that involve legal and law enforcement action. Having staff who are aware of available community shelter and domestic abuse counseling services is also helpful.

## ***Problemsolving***

These skills allow people to address and solve their own everyday problems in a rational manner by defining those problems and examining potential solutions. Inmates can begin by talking about problems they have encountered in the past, how they tried to solve them, and whether their efforts succeeded or failed. Then they can examine problems they have solved in a positive manner. Inmates learn how to select a solution rationally, instead of emotionally or acting out immediately. This requires that they learn how to take time to look at a problem, weigh the advantages of alternate solutions, and anticipate their effects.

Discussions involving real incidents of problemsolving can help inmates articulate methods of problemsolving that typically produce success. For example, a client might describe an argument with his employer, and how he or she intentionally arrived 15 minutes late to

work the next day. If that individual's response did not improve the situation, others in the group might indicate what they would do when faced with a similar situation: "I would avoid the situation," "I'd try to ignore him," "When he asked me something, I'd get defensive." The purpose of this exercise is to identify effective ways to proceed. An effective response that could result in desirable responses and outcomes might be, "I went in to ask my boss if I could speak with him for a minute, apologized, gave him the reason for the tardiness, and made a commitment not to have this happen again." This approach is most effective when counselors make use of real-life issues, role-playing, and group interaction.

## ***Social skills training***

Social skills training can be provided independently or as part of modules related to problem-solving and anger management. This training can help inmates deal appropriately with coworkers, family members, and friends. The process includes acquiring and rehearsing drug-free and prosocial skills to deal with interpersonal problems faced during recovery. Key components include communication skills, assertiveness, skills for developing and sustaining interpersonal relationships, and specific drug coping skills to handle high-risk interpersonal situations. Other areas include conflict management and learning interpersonal skills related to work, family, and community settings.

Strengths building identifies and uses the assets that clients bring to the treatment program to improve their chances for successful recovery.

## ***A Voice of Experience***

Long-term actions, started in jails, which include voluntary acceptance of behavior altering elements, can be effective. They must include abusive substance abstinence, the unburdening of the conscience, and the concept of continuity of care. Treatment must have a solid aftercare component that provides social, family, and community lifestyle changes that encompass jobs as well as education. It must also include daily reinforcement of positive behavior and a new look at life, itself, from a healthy attitude, to be successful. When those actions encompass such a program, success of the individual is possible and productive life skills can be achieved.

—Tim Ryan

Santa Clara County (CA) Department of Correction  
President-Elect, American Jail Association

### **Level III: Long-Term Treatment**

When inmates are incarcerated more than 90 days, more treatment time is available to build on the tools provided in short-term treatment and aid the inmate in the transition back to the community. Level III or long-term treatment approaches include components similar to those found in residential treatment in many community-based programs. These interventions are designed to delve more deeply into personal values, belief systems, and issues related to cultural and family background that have supported a substance abuse lifestyle.

### ***Employment counseling***

Employment counseling, which can examine an inmate's employment skills and include skills testing, can be incorporated into work release or furlough. Counselors should provide pre-employment training (e.g., communication skills with employers, responsibility, punctuality) and résumé writing. To elicit information to strengthen their résumés, clinicians can ask such questions as what have clients done as a volunteer, community member, or in jail that contributes to their employment opportunities rather than considering only traditional work experience. Counselors can help their clients develop action plans for obtaining employment after release.

### ***Building a therapeutic community***

Limited duration therapeutic communities have been established in some jail programs. For a more complete discussion of therapeutic communities, see chapter 9, *Issues Specific to Treatment in Prisons*.

### ***Family mapping and social networks***

Family mapping is a structured approach to examine the family network and background. The purpose is to look at the family and try to understand its criminal and/or substance use history and how the family adapted over the years in an effort to maintain stability. The inmate looks beyond his or her immediate family to grandparents, aunts, and uncles because many criminal and substance-using behaviors run in families and move across generations. This close examination helps people understand how and why substance abuse and other maladaptive behaviors exist in their family.

Female inmates, in particular, remain part of their community even while in jail and continue to establish social relationships and maintain social supports. However, while in jail they encounter significant problems in maintaining family contact and support, such as having their children searched for contra-



## ***A Voice of Experience***

Both short-term and long-term substance abuse treatment programs in jails are most effective when accompanied by aftercare within the community upon release. Inmates will readily volunteer to participate in treatment programs within the confines of the jail. However, few inmates will participate in voluntary post-release care. To be effective, the post-release aftercare should be mandatory with ongoing monitoring and testing by drug courts.

—Terry L. Bunn, CJM  
Chief Deputy, Custody Operations  
Santa Barbara County (CA) Sheriff's Department

band, limits on visitation, glass barriers between mother and child, and having staff members monitor the visits, which often have a negative impact on family relationships. For some issues related to the family, it is important to have the family present.

There are innovative jail programs that work with the inmate and child welfare agency to create specific visit times for father or mother, caseworker, and child in order to streamline visit procedures for agencies (City of New York 2001). Such models may be able to be used for other types of family meetings.

### ***Co-occurring disorders***

Longer term treatment provides the opportunity for learning about the interrelated nature of substance abuse and mental disorders, including events leading up to relapse of mental disorders, such as discontinuation of psychiatric medication. Other key interventions include psychiatric consultation to review medications, education regarding mental disorders, and development of transition plans for followup mental health and substance abuse services in the community. Treatment of individuals with co-occurring substance use disorders and mental illness is discussed in greater detail in chapter 5.

### ***Criminal thinking***

Many inmates have developed ingrained patterns of thinking that contribute to poor

interpersonal relationships and lead to conflict with others and involvement in criminal behavior. Inmates frequently do not see the connection between their criminal behavior and these patterns of thinking or belief systems. By identifying and challenging maladaptive criminal thinking patterns such as generalizations, absolutes, exaggerations, and lies, offenders can become more critical in their thinking and question the thoughts that lead to their criminal behaviors. A number of structured curricula have been developed for this purpose that blend cognitive and behavioral approaches that are consonant with other skills approaches used in jail-based substance abuse treatment programs. For more information on criminal thinking, see chapter 5.

## **Coordination of Jail Treatment Services**

The consensus panel believes that in order to operate a successful jail drug treatment program, cooperation is needed between funding sources, the community, substance abuse counselors, criminal justice personnel, outside agencies, and the offender, among others. This section is based on the experiences of consensus panel members and highlights some of the potential barriers involved in coordinating jail treatment services, then discusses a number of possible solutions to barriers that are frequently encountered while implementing these services.

## Barriers to Treatment

A number of factors at work in the jail setting have the potential to interfere with effective treatment:

- Lack of funding for services
- Absence of administrative support for developing comprehensive treatment programming
- Tensions between substance abuse and criminal justice systems, which have overlapping but distinctive concerns (e.g., rehabilitation and substance abuse treatment versus safety, control, and punishment)
- Physical space and environment that are not conducive to treatment
- Competing institutional program activities
- Difficulties in developing mechanisms for sharing information between treatment providers and criminal justice staff
- Confidentiality issues and the need to share information
- Lack of case management or continuing care
- Lack of detoxification services
- Detoxification symptoms mistaken for mental illness
- Lack of methadone tapered doses for inmates enrolled in methadone treatment programs prior to relapse
- Bringing in family members for family reunification or family therapy without careful security screening
- HIV/AIDS and sexually transmitted diseases among inmates

- Inability to provide HIV/AIDS educational materials
- Institutional restrictions related to video equipment, TVs, VCRs (for video playback of practice job interviews)
- Difficulties implementing community in-reach for supplemental as well as basic treatment services
- Treatment providers' reluctance to work in jails

The competing goals of the criminal justice and treatment systems can sometimes pose problems, though the systems share many of the same objectives. Figure 8-2 highlights the specific goals of correctional and treatment systems within jail settings and the shared goals of these systems.

## Limited resources

The limited amount of funding provided for treatment in many jails reflects underlying community attitudes and beliefs. These include the belief that providing services, including treatment, runs counter to a jail's "purpose" of punishment and may interfere with management. There is also a general lack of knowledge of the impact that treatment can have on crime. Few are aware of the multiple problems that exist in those served by jails, the fluidity of this population between the jail and the community, and the lack of systematic interventions that would stop the expensive jail-streets-jail cycle. Further, the struggle for

**Figure 8-2**  
**Goals of the Treatment and Corrections Systems in the Jail Setting**

Goals of Treatment System	Goals of Corrections System	Shared Goals
Behavior change	Safety of inmates	Reducing crime
Public health	Safety of jail personnel	Reducing substance abuse
Rehabilitation	Punishment	Reducing violence
Long-term good of individual and family	Safety of community	Changing behaviors

jail treatment resources may mirror the underfunding of treatment in the community. Jail treatment programs may even compete with, or be viewed as competing with, community resources.

If a community surveys the needs of its jail population, scarce treatment resources can be allocated in a way that is most effective. Jails with adequate resources can develop both specialized and generalized substance abuse treatment services. Jails with fewer resources may choose to divide resources between identification and referral to community programs for inmates who have various co-occurring disorders and problems (e.g., people with severe mental illness, the homeless), and providing traditional treatment services to inmates whose primary problem is their substance use disorder.

To more efficiently focus limited resources, the consensus panel suggests that jail-based substance abuse treatment programs have clear goals and objectives tied to reasonable outcomes, given the limitations imposed by the correctional setting. For example, if the goal of jail treatment is to reduce inmates' negative health consequences related to their substance abuse (e.g., HIV risk), the program would be constructed somewhat differently than if the goal were for maintenance of sustained abstinence following release from custody. Jail treatment programs have found it useful to enlist the help of multiple stakeholder groups that can offer additional resources both in the institution and during transition to the community.

## **Solutions for Coordinating Jail-Based Treatment Services**

There are a number of ways substance abuse treatment providers can work to improve services for people in jails and overcome the barriers described above. These are discussed in the sections that follow.

## ***Prioritizing substance abuse treatment for traditional versus special needs populations***

Because of scarce resources, many jails find that they must prioritize how to allocate treatment services for inmates with differing levels of treatment needs. One major issue is whether to target populations that require specialized care and that are at greater risk for relapse, criminal recidivism, and high utilization of community services (e.g., chronically mentally ill, mentally retarded, or homeless inmates) or to focus resources on inmates with more traditional substance abuse treatment needs. There are advantages and disadvantages related to targeting one group in favor of another. The consensus panel recommends that jails assess their own resources available for treatment and the scope of subpopulations with special treatment needs to devise a plan that ideally would address the needs of both groups. Figure 8-3 (p. 178) compares the advantages and disadvantages of prioritizing substance abuse treatment services for traditional and special needs populations.

## ***Promote understanding of institutional security rules and confidentiality requirements***

An incomplete understanding of the rules related to confidentiality of substance abuse treatment information and to the security guidelines within the institution may lead to conflict between correctional and treatment staff and may reduce the effectiveness and credibility of the treatment program. For example, counselors may unwittingly bring materials into the jail for treatment purposes that could be considered contraband by security staff or may make promises to inmates regarding scheduled activities, visitation, telephone calls, or other privileges that are not

**Figure 8-3**

***Targeted Treatment for Specific Populations Versus Mainstream Treatment for Larger Populations***

Treatment for Specific Populations		Mainstream Treatment	
Advantages	Disadvantages	Advantages	Disadvantages
Can increase outreach to detainees and inmates otherwise not identified or provided with treatment	Comprehensive multi-problem screenings and assessments are costly	Rapid identification of detainees through charge category or urine testing	Possibly less effective because intensity of treatment is not matched to inmates' needs
Can reduce correctional officer and inmate injuries by providing stabilization and observation of potentially volatile inmates	Committed space and specially trained professional staff are more expensive and could reduce resources to general substance abuse population	Interventions reach more inmates	Less effective without discrete program space and experienced, trained staff
Makes more beds available through reduced cycling of "high-risk" inmates	Requires more aftercare planning staff and coordination with community agency visits	Focuses more resources on substance abuse treatment	Not as effective with special needs populations who need more intensive services
Allows for creation of aftercare and community linkages for special populations		Allows for direct aftercare and diversion linkage to reduce negative outcomes and increase positive gains	Requires aftercare planning staff, coordination with community agencies, and coordination with courts, and may increase officer time for court transportation and staffing agency visits

allowed. A thorough awareness of the rules allows the treatment program staff to anticipate these difficulties and develop creative solutions. Treatment counselors should be invited, and be willing, to participate in training related to security guidelines and methods. Treatment supervisors could also offer support by advising counselors on techniques for handling safety concerns and conflict with security staff. Finally, treatment and jail supervisory staff can use cross-disciplinary meetings and cross-training activities to joint-

ly address and solve potential areas of conflict related to housing assignments, scheduling, reviewing responses to critical incidents (e.g., dealing with contraband), information sharing, and other aspects of program development.

### ***Improve coordination of information systems***

A lack of coordinated information can be a problem for detainees involved in multiple

systems. Several nonproprietary computerized management information systems have been developed for this purpose. This software allows efficient, timely, and continuous care through treatment matching and followup and may also include data on drug test results. One model, based on the University of Maryland's High Intensity Drug Trafficking Area Automated Treatment Tracking Software (HIDTA-HATTS), enables substance abuse treatment and criminal justice personnel to access the same information in making decisions about the client (Taxman and Sherman 1998). Other proprietary models based on drug courts have expanded their applications to include mental health screens and assessments. Still other jurisdictions have developed mechanisms to share mental health and substance abuse database information between the correctional institution and the community managed care provider (e.g., National GAINS Center 1999c). Each jurisdiction involved in developing these types of management information systems has worked out informed consent and differential confidentiality issues for information sharing. The models cited have also developed their work in the context of multisystem collaboration and at times through formal consensus-building processes between the key stakeholders relevant to ensure continuity of treatment (Broner et al. 2001b).

### **Educate staff regarding pharmacotherapies**

Some jail administrators resist using pharmacotherapy because they are philosophically opposed to administering medication (e.g., methadone, psychiatric medications) to people with substance abuse problems, but most jails administer a range of psychiatric medications for inmates with mental disorders. Most of these medications are not addictive and do not present a risk for distribution as contraband

within the institution. However, relatively few jails provide medication-assisted treatment for opioids and other drugs. Figure 8-4 (p. 180) describes some of the advantages and disadvantages of medication use, for inmates enrolled in jail substance abuse treatment programs.

There are legitimate concerns regarding the use of some medications in jails, particularly when there are not adequate healthcare staff available to monitor and supervise medication use. Pharmacological treatments used in jails should be monitored by a qualified physician or nurse practitioner. Project KEEP is an example of a program that integrates pharmacological treatments with a jail environment (see p. 181).

### **Provide for staff development**

Many front-line jails require that staff have only a GED or high school diploma and no criminal record. While correctional staff receive extensive security training, training is not always provided in working with specific populations and substance abuse treatment. Cross-training is an effective approach to have correctional and treatment staff learn from each other about key issues related to institutional security and rehabilitation. Correctional officers can benefit from learning about the length, course, and components of substance abuse treatment; effective com-

#### **Advice to the Counselor: Cross-Training**

- Treatment and corrections staff should learn from each other.
- Counselors in correctional settings can benefit from training in security guidelines, and learning about inmate behavior and attitudes.
- Correctional staff can benefit from training in working with specific populations, components of substance abuse treatment, and their role in shaping a therapeutic environment.



**Figure 8-4**  
**Varied Opinions Regarding Medication Use for Inmates  
in Jail Treatment Programs**

Advantages	Disadvantages
Provides continuous treatment from community to jail, and jail to community	Belief that “drugs” should not be tolerated in jails
Reduces cravings	Medications used to combat withdrawal may be used as contraband
Provides a humane response to treating symptoms of withdrawal and addiction	May lead to inmates’ selling or trading the medication within the population
Medications are constantly being developed and improved that can benefit inmates with substance abuse and mental health problems	Side effects are not always known
Benefits of treating medical problems (substance use disorders) medically	Benefits to learning to deal with problems without drugs
Resolves/improves symptoms of mental illness and allows the dually diagnosed individual to focus on substance abuse issues	Some medications (e.g., benzodiazepines) can be addictive

munication strategies with treatment staff regarding inmate behavior and attitudes; involvement in treatment team, group meetings, and other unit activities; and their role in shaping a therapeutic environment. Treatment staff can benefit from training related to security guidelines, effective communication with corrections staff regarding inmate behavior, contraband and other security infractions, and their role in maintaining the security of the housing unit and the jail. Both corrections and treatment staff can be productively involved in identifying critical incidents that may occur within the jail treatment unit, the type of information that needs to be shared between treatment and corrections staff, and methods of resolving these situations.

Instituting treatment programs within jails creates a unique opportunity for treatment staff to collaborate with jail staff in developing in-service training programs and to encourage certification and degree training at local universities. For instance, New York City offers incentives and tuition reimbursement for city employees for both undergradu-

ate and graduate training, along with a forensic certificate, through the New York University school of social work. Flexible job scheduling could help many employees improve their education, and providing course work for credit at the job site would allow jail personnel to work toward undergraduate or graduate degrees. Another option is to set aside time for career development on the job—with a few hours per week to take a class that will not only help their job performance, but will also aid their career progress.

### ***Developing community and correctional partnerships***

Creating partnerships between the jail and the community can allow for the development or enhancement of both in-jail treatment programs and coordination of offenders’ transition into community diversion and aftercare/reentry programs. Such a model of cooperation and collaboration exists in many jails in the areas of education and health care or in some jails for diversion and aftercare of those with substance use disorders or other mental

## **Project KEEP**

A significant increase in the number of drug-related arrests in the New York Metropolitan area in 1987 led to overcrowding and unrest at the Correctional Facility on Riker's Island. In response, researchers developed a program that serves as both a methadone program and an AIDS prevention initiative. Called KEEP (Key Extended Entry Program), the program enables opioid-dependent offenders who are charged with misdemeanors to be maintained on a stable dose of methadone during their stay at Riker's, and then receive a referral at release to a participating community methadone program. KEEP, intended to be a route into long-term community drug treatment, aims to break the cycle of illicit drug use and criminal recidivism. It was one of the first methadone treatment programs of its kind in the United States for incarcerated persons addicted to heroin (Tomasino et al. 2001). This program allows for a humane detoxification for offenders who desire it upon entry to jail, and it allows new patients to enroll in maintenance and to receive treatment in the community. Finally, and most importantly, it provides a continuity of care upon release from jail to people enrolled in methadone therapy prior to arrest.

Seventy-four to 80 percent of methadone treatment patients discharged to the community, mostly to outpatient KEEP programs, report to their designated program. Recidivism rates show that 79 percent of KEEP patients were re-incarcerated only once or twice during a recent 11-year period. KEEP data indicate the importance of administering sufficient blocking doses of methadone to patients in outpatient treatment centers in order to eliminate heroin craving and to maintain the patients in treatment. About 6 percent of KEEP patients are at a higher risk for recidivism (e.g., those with co-occurring disorders) and require specialized treatment (Tomasino et al. 2001).

disorders (Broner et al. 2002; Steadman et al. 1995). Such partnerships allow for the extension rather than duplication of an array of community resources to address many of this population's substance abuse, mental health, medical, vocational, educational, and social service needs.

On the other hand, coordinating the visits of large numbers of community volunteers can create both a security and staffing burden for the jail. Concerns include staffing patterns, security, contraband monitoring, coordinating schedules, staff time, escorting inmates to their group room and back, and escorting visitors. Therefore, arranging for services from the outside produces an additional workload for jail administrators that may in itself be a barrier. To overcome these problems, shared funding and community organizations' budgeting for jail officers' time could be employed. To find a compatible blend of needs and concerns on both sides, there must be a planning structure for community volunteers and jail administrators to facilitate communication and resolve problems.

### ***Creating linkages between jail treatment and diversion and reentry court programs***

Although typically operated by the criminal courts, drug treatment courts (DTCs) have formed productive partnerships with local jails in many jurisdictions (Tauber and Huddleston 1999). The first phase of treatment in some drug court programs is completed in jail, with intensive services provided that focus on a comprehensive psychosocial assessment, substance abuse education, and engagement in and orientation to treatment. In other drug court programs, an initial in-jail treatment component is optional, depending on the severity of drug treatment needs and the importance of a secure treatment setting. Jail treatment is also used with inmates who are awaiting placement in drug court treatment programs in the community. Another major function of jail treatment programs is to provide more intensive services on a short-term basis for drug court participants who relapse or commit other major infrac-

tions. In these cases, jail programs can serve as a therapeutic sanction to remove an individual from salient relapse cues (such as drug-using peers), to provide detoxification as needed, and to reengage individuals in their recovery programs. Many drug courts use progressive sanctions that provide an escalating number of days in jail (e.g., 2, 4, 7) for designated program infractions. In some cases, drug courts have provided longer jail

Jail programs can serve as a therapeutic sanction to remove an individual from salient relapse cues.

sentences, although the therapeutic effects of these sanctions are unclear.

Several drug courts have established a coordinated reentry approach with in-jail treatment programs (Huddleston 1998; Tauber and Huddleston 1999). Each of these partnerships is characterized by significant flexibility in addressing the individual needs of

drug court participants. Many of these drug courts also continue to monitor participants who are placed both in custodial and noncustodial settings. For instance, two drug court and jail treatment partnerships (Los Angeles County and San Bernardino County, California, and Uinta County, Wyoming), place offenders in the jail treatment program as the first phase of drug court. In the San Bernardino drug court, participants are given job assignments within the jail that allow for attendance in treatment groups and classes. In Los Angeles County, a separate housing unit is reserved for drug court treatment and receives referrals from several drug courts in the county. One Los Angeles drug court, designed for probation violators (one of 11 drug courts in the county), requires 3 months' in-jail treatment prior to completing subsequent phases of the program. In Uinta

County, Wyoming, drug court participants who have been unsuccessful in court-ordered treatment are placed in a 6-week jail treatment program as the first phase of drug court involvement. While they are in the jail treatment program, participants in Uinta County are required to appear in drug court once weekly for status hearings.

In Broward County, Florida, the DTC refers participants to a 90-day jail treatment program if they have not successfully completed other less intensive approaches (e.g., outpatient treatment) (Tauber and Huddleston 1999). Individuals sentenced to jail prior to involvement in the Broward County drug court are also referred to the jail treatment program to engage them in treatment quickly. The drug court then monitors their progress in the jail treatment program and provides a reentry mechanism upon their transfer to the drug court program.

In New Castle County, Delaware, the DTC has combined both short-term (6 months) and long-term (11–18 months) custodial substance abuse treatment with continued care upon rearrest for probation violators who have committed new felony-level offenses. The court monitors the individual's progress through the prison- or jail-based treatment and develops a reentry treatment plan based on input from team members. This has had a positive effect on reducing recidivism (Statistical Analysis Center 1998).

Several other drug court and jail treatment partnerships offer unique elements. In Los Angeles County drug courts, participants who are transferring from the jail treatment unit to community settings can use transition housing. In San Bernardino County, a comprehensive assessment is provided after 10 weeks of treatment in the jail program and is provided to the drug court judge before status hearings. This assessment serves as the basis for the court's decision to order continued in-jail treatment, placement in a community residential treatment program, or placement in a community outpatient program. In

New Haven, Connecticut, the drug court judge orders jail sentences as a sanction and requests on an individual basis that drug court participants receive priority access to drug treatment and self-help groups during the ensuing period of jail incarceration (Huddleston 1998). For more information on drug courts and diversion programs, see chapter 7.

## **Examples of Jail Treatment Programs**

Several innovative components and unique features of metropolitan jail substance abuse treatment programs are described in this section.

### **Multnomah County Sheriff's Office In-Jail Intervention Program (Portland, Oregon)**

- Offers a specialized co-occurring mental disorders emphasis and features domestic violence services and a relapse prevention track.
- Provides acupuncture treatment to assist inmates in dealing with cravings and withdrawal symptoms during the initial stage of treatment.
- Offers an intensive short-term treatment program (22 days, 50 hours per week, 1:7 staffing ratio) with significant emphasis on aftercare linkage.
- Provides transition and linkage services, which includes driving inmates to community treatment providers (often residential services), as needed, and picking up medications and refilling prescriptions prior to the aftercare placement.
- Coordinates with community treatment providers to share information about aftercare treatment plans and other records.
- Plans aftercare programs that include case management and client needs assessment.

- Offers a treatment curriculum shaped in part by results of satisfaction surveys administered to inmates.

### **King County Jail System, North Rehabilitation Facility, Stages of Change Program (Seattle, Washington)**

- Provides an integrated system of “wraparound” treatment services.
- Partially funded through work contracts.
- County’s Department of Public Health manages the jail.
- Offers screening and triage for inmates placed in the jail for more than 1 week.
- Provides individual sessions with counselors.
- Offers acupuncture services.
- Assigns all inmates to jobs that have the potential of developing employment skills.

### **Philadelphia Prison System OPTIONS Program (Philadelphia, Pennsylvania)**

- Provides gender-specific programming for women.
- Provides relapse prevention services, combined with modules on the “psychology of achievement” and entrepreneurship training, using motivational and action-oriented strategies of Fortune 500 companies.
- Integrates family therapy sessions in which families come into the jail.
- Program staff make home visits.
- Program staff use videotaped material from jail and home-base settings for inmates and their families.
- Provides aftercare followup services.

## **Wayne County Jail Target Cities Jail-Based Substance Abuse Treatment Program (Detroit, Michigan)**

- Diverts nonviolent prison inmates to complete short-term jail treatment services, followed by involvement in community treatment.
- Reduces the need for prison space through cost-effective diversion approach.
- Addresses parenting skills and parental financial responsibility for family members.
- Uses feedback from an external evaluator to intensify services during the first 3–4 weeks of program involvement, the period in which many participants historically drop out.
- Offers an “Alumni Success” group for program participants.

## **Walden House and the San Francisco Sheriff’s Office SISTER Project (San Francisco, California)**

- Prepares incarcerated women for life after their release to prevent relapse.
- Encourages women to make productive use of their time in this 30- to 45-day program.
- Offers a 6-week academic course that provides women with information about college admission and financial aid.
- Provides five-stage testing for GED (high school equivalency) weekly, and holds cap and gown ceremony for graduates.
- Introduces women to a variety of potential job options and helps them to prepare their resumes in a computer class.
- Counsels women on how to keep a job after securing it.
- Prepares women for treatment and places them in community-based programs after their release (Chadwick 2001).

## **Research Related to Jail Treatment**

A survey of metropolitan jail treatment programs indicates that many jails have several treatment phases and endorse more than one therapeutic orientation (Peters and May 1992). More than half of the jail programs surveyed included 12-Step groups, cognitive-behavioral groups, and relapse prevention programs. Many jail treatment programs have developed specialized tracks for such groups as juveniles charged as adults, those with co-occurring disorders, groups for people arrested for driving under the influence, and blended groups for domestic violence and substance abuse (Peters and Mathews 2002).

## **Outcomes of Jail Treatment**

Jail treatment programs often are dependent on local resources or knowledge, rather than on consistent best practice models for this setting. While outcome studies are few and limited in scope, the therapeutic community model shows promise even for short-term stays. In particular, the Amity/Pima County Substance Abuse Treatment Jail Project, funded by the U.S. Bureau of Justice Assistance in the late 1980s, demonstrated the efficacy of drug treatment in a correctional setting (Pima County Sheriff’s Department 1988). Moreover, a number of studies demonstrate reduced rearrest and reconviction rates, longer time to rearrest, and fewer arrests during follow-up for those participating in in-jail drug treatment (Peters and Matthews 2002).

## **Effects of Treatment Duration**

Studies investigating the effects of duration of jail substance abuse treatment indicate that recidivism rates are related to the length of treatment, up to an optimal duration of 91–150 days (Swartz et al. 1996). Successful treatment outcomes have been reported for jail programs of 1.5–5 months duration. Involvement in aftercare treatment services



following release from jail has also been found to reduce criminal recidivism (San Francisco County Sheriff's Office Department 1996; Swartz et al. 1996). Offenders released from jail are more likely to participate in aftercare treatment if they have previously been involved in a jail treatment program (Taxman and Spinner 1997).

## Predictors of Treatment Outcomes

A number of studies have examined predictors of jail treatment outcomes—what elements help people finish treatment (“completers”) and what elements militate against completion (“noncompleters”). The most important predictor in one study examining rearrest during a 1-year follow-up period was the number of lifetime arrests, although other psychological indicators and living arrangements were also found to be predictors (Peters et al. 1993). A similar study (Peters et al. 1999) found that cocaine users were less likely to complete a treatment program than alcohol or marijuana users. Other factors predicting noncompletion were lack of a high school diploma, living outside a parent's home, lack of full-time employment, and having been arrested for charges other than drug possession. It is likely that similar factors may influence retention in jail treatment programs, although more research is needed in this area.

## Importance of Aftercare

Unfortunately, a majority of released detainees are not linked to aftercare services or treatment and the majority of jails do not use diversion resources such as drug courts. Treatment mandated by drug courts is associated with decreased recidivism, increased treatment retention, and better aftercare linkages (Leukefeld and Tims 1988). Tunis and colleagues (1997) found that drug treatment programs in jails provide a “behavioral management tool” that results in fewer behavioral problems, especially physical violence.

However, effects of the program on recidivism rates were modest in the year after release. Inmates participated in the treatment on a voluntary basis in the programs they studied, which consisted of counseling and self-help groups and aftercare opportunities in the community were extremely limited. Additional training for correctional staff could have increased their support for aftercare.

## Recommendations for Treatment Providers

The consensus panel believes that to maximize the benefits of substance abuse services, treatment staff working with clients in jails should consider the following recommendations:

- Recognize that many people in the community frequently move back and forth from community to jail and that triage and referral to services can be critical.
- For individuals in community treatment agencies, make staff available to provide services in jails and share expertise through training and consultation with jail treatment staff.
- Provide ongoing consultation to jail administrators and other jail staff about substance abuse issues, and work to establish a continuum of services in the jail and community for people with substance abuse problems.
- Develop treatment approaches that are targeted to recognized special populations, such as those described in this chapter.
- Assist in conducting periodic quality assessment reviews.
- Employ evidence-based practices such as motivational enhancement techniques, cognitive-behavioral interventions, relapse prevention, contingency management, and therapeutic communities.