

# CJ-5B ADDENDUM

OMB No.1121-0094: Approval Expires 11/30/2009

|                         |                                                                                                                          |        |                                                                                                              |                   |                                                                                                        |          |
|-------------------------|--------------------------------------------------------------------------------------------------------------------------|--------|--------------------------------------------------------------------------------------------------------------|-------------------|--------------------------------------------------------------------------------------------------------|----------|
| <b>RETURN TO</b>        | Cynthia Helba<br>Survey of Jails in Indian Country<br>RA1100<br>Westat<br>1650 Research Boulevard<br>Rockville, MD 20850 |        | FORM <b>CJ-5B ADDENDUM</b><br>(09-27-07)<br><br><b>2007 ANNUAL<br/>SURVEY OF JAILS<br/>IN INDIAN COUNTRY</b> |                   | U.S. DEPARTMENT OF JUSTICE<br>BUREAU OF JUSTICE STATISTICS<br>AND ACTING AS COLLECTION AGENT<br>WESTAT |          |
|                         |                                                                                                                          |        |                                                                                                              |                   |                                                                                                        |          |
| <b>DATA SUPPLIED BY</b> |                                                                                                                          |        |                                                                                                              |                   |                                                                                                        |          |
| <b>NAME</b>             |                                                                                                                          |        |                                                                                                              | <b>Title</b>      |                                                                                                        |          |
| <b>ADDRESS</b>          | Number and street or P.O. box/Route                                                                                      |        |                                                                                                              | City              | State                                                                                                  | Zip Code |
| <b>TELEPHONE</b>        | Area Code                                                                                                                | Number |                                                                                                              | <b>FAX NUMBER</b> | Area Code                                                                                              | Number   |
| <b>E-MAIL ADDRESS</b>   |                                                                                                                          |        |                                                                                                              |                   |                                                                                                        |          |

PLEASE CORRECT ANY ERROR IN NAME, MAILING ADDRESS, AND ZIP CODE.

## GENERAL INFORMATION

- If you have any questions about completing this form, please contact **Cynthia Helba** of Westat at **1-888-675-7330** or BJS Statistician, **Todd Minton** at **202-305-9630**.
- Please mail your completed questionnaire to **Westat** in the enclosed envelope before **November 15, 2007**, or FAX (all) pages to **301-315-5912**.
- Please retain a copy of the completed form for your records.

## Burden statement

Under the Paperwork Reduction Act, we cannot ask you to respond to a collection of information unless it displays a currently valid OMB control number. The burden of this collection is estimated to average 30 minutes per response, including reviewing instructions, searching existing data sources, gathering necessary data, and completing and reviewing this form. Send comments regarding this burden estimate or any aspect of this survey, including suggestions for reducing this burden, to the Director, Bureau of Justice Statistics, 810 Seventh Street, NW, Washington, DC 20531.

## INSTRUCTIONS

- If the answer to a question is "not available" or "unknown," write "DK" in the space provided.
- If the answer to a question is "not applicable," write "NA" in the space provided.
- If the answer to a question is "none" or "zero," write "0" in the space provided.
- When exact numeric answers are not available, provide estimates and mark (x) in the box beside each figure that is estimated. For example 1,234 (x)

**SECTION III — INMATE HEALTH****18. How does this facility provide health services to inmates? Mark (x) all that apply.**

- 1 ☐ On-site staff physicians or other medical employees of the jails
- 2 ☐ On-site physicians or other medical services provided by IHS
- 3 ☐ Off-site medical services provided by IHS
- 4 ☐ Off-site medical services provided by privately run facilities (e.g., private practice, hospital, etc.)
- 5 ☐ Other — *Specify* \_\_\_\_\_

**19. Does this facility detoxify CONFINED persons from drugs or alcohol?**

- Detox is the managed withdrawal from alcohol or drugs by medical or other trained professionals.

- 1 ☐ Yes — **On June 29, 2007, how many inmates were being detoxified?**

Inmates \_\_\_\_\_ ☐

- 2 ☐ No

**20. As a matter of policy, does this facility test inmates for TUBERCULOSIS infection?**

Mark (x) at least one box in each row.

- |                                                                                                                                             | Yes                      | No                       |
|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. At admission .....                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Annually or at regular interval .....                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Random sample .....                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Person with no history of vaccination .....                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Upon request .....                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Upon clinical indication of need .....                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. After possible exposure to active TB disease .....                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| <ul style="list-style-type: none"> <li>• Active TB disease, either confirmed by sputum culture or suspected with culture pending</li> </ul> |                          |                          |
| h. At release .....                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Other — <i>Specify</i> _____                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |

**21. As a matter of policy, does this facility test inmates for HEPATITIS B infection?**

Mark (x) at least one box in each row.

- |                                                                                                                  | Yes                      | No                       |
|------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. At admission .....                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Annually or at regular interval .....                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Random sample .....                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Person with no history of vaccination .....                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Upon request .....                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Upon clinical indication of need .....                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| g. After possible exposure to active Hepatitis B .....                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <ul style="list-style-type: none"> <li>• Active Hepatitis B confirmed by positive testing of serology</li> </ul> |                          |                          |
| h. At release .....                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Other — <i>Specify</i> _____                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |

**22. As a matter of policy, does this facility test inmates for HEPATITIS C infection?**

Mark (x) at least one box in each row.

- |                                                                                                                  | Yes                      | No                       |
|------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. At admission .....                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Annually or at regular interval .....                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Random sample .....                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Person with no history of vaccination .....                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Upon request .....                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Upon clinical indication of need .....                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| g. After possible exposure to active Hepatitis C .....                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <ul style="list-style-type: none"> <li>• Active Hepatitis C confirmed by positive testing of anti-HCV</li> </ul> |                          |                          |
| h. At release .....                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Other — <i>Specify</i> _____                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |

**23. As a matter of policy, does this facility screen inmates for the antibody to the Human Immunodeficiency Virus (HIV) that causes AIDS?**

Mark (x) in at least one box in each row.

- |                                           | Yes                      | No                       |
|-------------------------------------------|--------------------------|--------------------------|
| a. At admission .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Random sample .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Upon request .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Upon clinical indication of need ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Upon involvement in incident .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| f. At release .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Other — Specify _____                  | <input type="checkbox"/> | <input type="checkbox"/> |

**24. As a matter of policy, does this facility —**

Mark (x) all that apply.

- ☐ 1 Screen inmates at intake for mental disorders
  - EXCLUDE screening for suicide.
- ☐ 2 Conduct psychiatric or psychological evaluation and assessments (other than at time of intake) to determine inmate mental health or emotional status
- ☐ 3 Provide 24-hour mental health care to inmates either on or off facility grounds
- ☐ 4 Provide therapy/counseling by a trained mental health professional on a routine basis
- ☐ 5 Prescribe, distribute, or monitor the use of psychotropic medications to inmates
  - Drugs having a mind-altering effect (e.g., antidepressants, stimulants, sedatives, tranquilizers, and other anti-psychotic drugs)
- ☐ 6 Provide assistance to release inmates to obtain community mental health services
- ☐ 7 Other — Specify \_\_\_\_\_
- ☐ 8 Does not provide mental health services to inmates

**25. What specific procedures for suicide prevention does this facility follow?**

Mark (x) all that apply.

- ☐ 1 Assessment of risk at intake
- ☐ 2 Staff training in risk assessment/suicide prevention
- ☐ 3 Special inmate counseling or psychiatric services
- ☐ 4 Live or remote monitoring of high risk inmates
- ☐ 5 Suicide watch cell or special location
- ☐ 6 Inmate suicide prevention teams
- ☐ 7 Other — Specify \_\_\_\_\_
- ☐ 8 None

## SECTION IV — FACILITY PROGRAMS

**26. Between July 1, 2006 and June 30, 2007, what type of work assignments were available to persons CONFINED in this facility?**

Mark (x) all that apply.

- ☐ 1 Correctional industries (e.g., wood products, textiles, manufacturing, services, etc.)
- ☐ 2 Facility support services (e.g., office and administrative work, food service, building maintenance, etc.)
- ☐ 3 Farming/agriculture
- ☐ 4 Public works assignments — inmates work outside the facility and perform road, park, or other public maintenance work
- ☐ 5 Other — Specify \_\_\_\_\_
- ☐ 6 None

**27. Between July 1, 2006 and June 30, 2007, did this facility provide counseling or special programs to persons CONFINED in this facility?**

*Mark (x) at least one box in each row.*

|                                                                                                          | On<br>facility<br>grounds | Off<br>facility<br>grounds | No<br>program            |
|----------------------------------------------------------------------------------------------------------|---------------------------|----------------------------|--------------------------|
| a. Drug dependency/<br>counseling/awareness . . .                                                        | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |
| b. Alcohol dependency/<br>counseling/awareness . . .                                                     | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |
| c. Sex offender treatment . . .                                                                          | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |
| d. Vocational training . . . . .                                                                         | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |
| e. Employment . . . . .<br>(e.g., job seeking and<br>interviewing skills)                                | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |
| f. Life skills and community<br>adjustment (including<br>personal finance, conflict<br>resolution, etc.) | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |
| g. Domestic violence<br>counseling . . . . .                                                             | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |
| h. Parenting/child<br>rearing skills . . . . .                                                           | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |
| i. Religious/spiritual<br>counseling . . . . .                                                           | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |

**28. Between July 1, 2006 and June 30, 2007, what type of educational programs were offered to persons confined in this facility?**

*Mark (x) at least one box in each row.*

|                                                                                                     | On<br>facility<br>grounds | Off<br>facility<br>grounds | No<br>program            |
|-----------------------------------------------------------------------------------------------------|---------------------------|----------------------------|--------------------------|
| a. Accredited education . . . .<br>program (e.g., basic<br>and high school classes)                 | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |
| b. GED program . . . . .                                                                            | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |
| c. Special education needs<br>program (e.g., programs<br>for inmates with learning<br>disabilities) | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |
| d. College level classes . . . .                                                                    | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |
| e. Provide tutors . . . . .                                                                         | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> |

**NOTES**