**Addressing the Substance Use Treatment and Aftercare Needs**

**of Incarcerated Individuals:**

**Challenges and Solutions Identified in the 2017 RSAT Evaluation**

In April 2017, Advocates for Human Potential, Inc. (AHP), published an evaluation of the treatment and aftercare services provided through the Bureau of Justice Assistance’s (BJA) Residential Substance Abuse Treatment (RSAT) for State Prisoners Program. Especially considering the growing opioid epidemic in the Unites States, this study of the effects of an innovative federal program addressing addiction issues among correctional populations is timely, offering insights into the barriers to program implementation program and notes some unique ways that grantees have responded to the challenges.

**RSAT Background**

The RSAT program was authorized in 1994 by federal legislation, in recognition of the fact that most inmates in state prisons and jails had histories of substance use, but few received treatment while incarcerated. Each state and territory is eligible to apply for and receive a base grant amount, supplemented by a proportionate share of additional funding based on each state’s prison population. Grantees must adhere to certain requirements, such as coordinating with state-level alcohol and substance use disorder agencies in the design and implementation of programs, using evidence-based practices, and additional programmatic conditions.

RSAT funding was first distributed in 1996, and, since then, it has supported the establishment or expansion of residential substance abuse treatment programs in the nation’s state prisons and jails. In 2007, recognizing that, without effective aftercare, the positive effects of substance abuse treatment could be lost in the reentry process, the Second Chance Act (SCA) amended the program’s requirements to mandate that individuals participating in RSAT-funded residential treatment programs receive aftercare services, although the amount of RSAT funds that could be used for aftercare was capped at 10%. In 2013, this restriction on the use of RSAT funds for post-release services was lifted. However, at the same time the cap was removed, federal RSAT funding was reduced leaving no additional monies for these purposes.

**RSAT Aftercare Study Ordered**

The SCA of 2007 also required the National Institute of Justice (NIJ), in consultation with the National Institute on Drug Abuse (NIDA), to conduct a study on the use and effectiveness of RSAT funds used for aftercare services under the amended legislation. NIJ awarded a grant to AHP, which designed a research study to gather in-depth information on treatment and aftercare programs funded through RSAT. The April 2017 report, **The Characteristics and Components of RSAT Funded Treatment and Aftercare Services** [<https://www.ncjrs.gov/pdffiles1/nij/grants/250715.pdf>], presents the findings of this study.

The primary aims of the evaluation were to:

1. Understand how states use RSAT funds for treatment and aftercare services
2. Describe the specific treatment and other services supported by RSAT grants
3. Describe aftercare services funded by RSAT grants and other sources, and factors that facilitated or posed challenges to implementing aftercare.

To address these research objectives, the study used two data collection activities: the RSAT State Coordinator Program Inventory and the RSAT Subgrantee Program Inventory. The State Coordinator Inventory was a web-based survey administered to BJA State Points of Contact (PoCs). It focused on the process for distributing state funds within each state/territory, the use of additional federal or state funding sources to support RSAT programs, dedicated funding to aftercare services, and the overall role and responsibility of the state PoC in administering RSAT program funds. Among the 56 states and territories that receive RSAT funding, 47 BJA state PoCs completed the survey (84% response rate).

The RSAT Subgrantee Program Inventory was a semi-structured interview administered via telephone to active RSAT-funded programs that served 10 or more individuals in a specific quarter. The interview asked about services provided in RSAT-funded correctional programs and in aftercare programs. The Subgrantee Inventory included questions on funding, staffing and enrollment criteria, screening and assessment procedures, program enrollment and completion rates, and types of treatment and other services provided. There were also open-ended questions asking about program strengths and facilitating factors to implementing aftercare services, as well as aftercare gaps and challenges. Seventy-seven programs met the criteria and 60 completed the interview (78% response rate).

**Identifying and Meeting the Challenges: Highlighted Findings**

**RSAT Programs Would Benefit if State Coordinators’ Leadership Role Was Strengthened**

Each RSAT grantees is required to have State Coordinator (referred to as a Point of Contact or PoC). These roles are typically filled by administrators in the state’s Department of Corrections or similarly titled agency. However, the titles of these coordinators varied considerably, suggesting that these officials have a range of qualifications and experience. For example, only 10 PoCs had the word “justice” or “corrections” in their title, the rest were more general administrative titles. While almost all PoCs reviewed quarterly Performance Management Tool Data (a Justice Department contract requirement) and most monitored contracts, only about half said they frequently monitored program implementation, and less than half frequently conducted monitoring site visits.

While the mean length of time in the job was 5.5 years, almost one-quarter of PoCs had been in their job for one year or less. Further, only a small percentage of State Coordinators are actively involved in treatment quality or client eligibility issues in the subgrantee programs which they oversee. These findings suggest that RSAT programs across the country lack a consistent official who is responsible for uniform oversight of the program’s essential treatment activities.

* 36% of PoCs say they are “never” involved with quality improvement issues, while 36 % report being “sometimes” involved and only 29% say they are “frequently” involved.
* 51% report that they are “never” involved with treatment quality issues, 31% say they are “sometimes” involved, and only 18% report they are “frequently” involved
* Similarly, 60% of PoCs say they are “never” Involved with client eligibility issues, 24 % report being “frequently involved, and 15% say they are “frequently” involved.

Most state PoCs do not report significant involvement with state policy issues related to substance use treatment in correctional settings. The majority of PoCs reported that they did not work with state legislators on these matters.

* While 83% are highly involved in decisions about distribution of RSAT funds, only 22% reported “quite a bit” of involvement in state policy issues related to substance use treatment and corrections. Almost half (47%) said they do not work at all on state policy issues at all.
* The majority of PoCs reported that they do not work with their state legislatures on issues relevant to RSAT (57%) and that they do not work with the Department of Corrections on health policy matters.

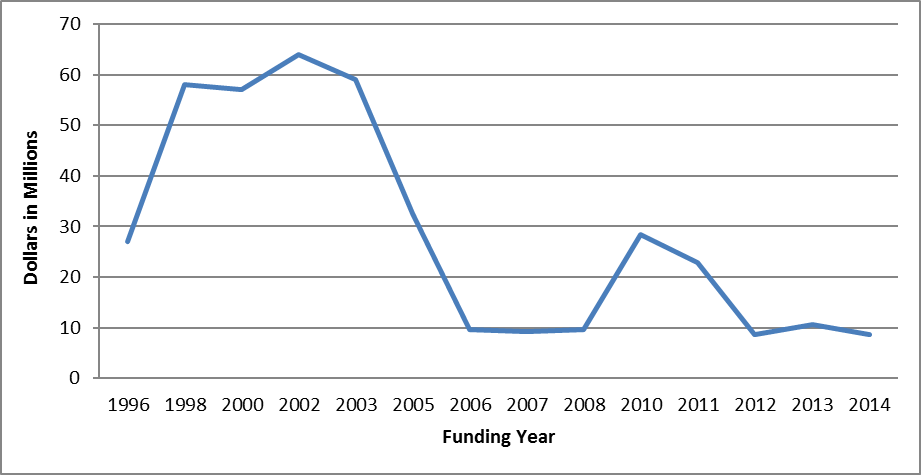
This suggests that PoCs play little or no role in shaping overall correctional department policies to ensure that they are consistent with or supportive of RSAT programs. Additionally, state PoCs may not have established relationships with key policy-makers in their states – such as legislators and leaders in Departments of Corrections, Health, or Substance Use Services, that could promote the RSAT program. In addition, they may not be knowledgeable about state issues relevant to RSAT programs, potentially missing opportunities to support and leverage state and local resources for programming.

**Long-term Declines in Funding Have Negatively Affected RSAT Implementation**

* In half of states and territories, RSAT funds are not sufficient to fully fund programming and must be supplemented by leveraging additional state, local and/or federal resources.
* Despite the federal requirement that RSAT-funded programs assure connections to aftercare services, only 55% of state Points of Contact (PoCs) said they required RSAT subgrantees to provide aftercare services, and less than 30% of PoCs reported that subgrantees - the programs that receive RSAT funding and implement the programs- used RSAT funds specifically for aftercare services. RSAT subgrantees themselves reported even less spending on aftercare; only 18% said they used these funds for aftercare services.

To provide a context for understanding why many states must supplement federal RSAT funding and most states are not fully in compliance with requirements to fund aftercare programs, it is instructive to consider the history of Congressional funding for the program. The program began with an initial allocation of $27 million in 1996. RSAT funding peaked during the early 2000s, with a high of more than $60 million dollars in 2002. But beginning in federal fiscal year (FFY) 2003, there was a precipitous decline in funding, with a low of about $10 million during FFY 2006. Although there was some increase in 2010 and 2011, RSAT funding has largely hovered around the $10 million mark for the last decade. While both costs and incarceration rates have increased over the years, RSAT funding has fallen, making it extremely difficult for states and territories to meet the minimum requirements of the program.

Table 1: BJA RSAT Funding Allocation Between 1996–2014\*



\*Data from some years were not available, and, in some years, RSAT Requests for Proposals (RFP) were not issued.

**Most RSAT Funds Support Basic Treatment Services in Correctional Facilities**

* Most programs (85%) use RSAT funds to support treatment services in correctional settings. The treatment modalities offered include group substance use disorder therapy (98%), substance use disorder education (91%), case management services (81%), social skills development (77%), and individual substance use disorder counseling (70%).
* Eighty-five percent of programs provided at least one evidence-based practice (EBP), usually Cognitive Behavioral Therapy (CBT) with another type of EBP (64%), typically a criminal thinking EBP or another type of targeted intervention (e.g., TREM, MATRIX, Seeking Safety).
* Only 13% of facility-based programs endorsed most or all of the 11 NIDA drug use treatment principles for criminal justice populations measured in the study. While most programs incorporated basic treatment principles, such as drug testing (100%), required by statute for RSAT funding, treatment planning and transitional planning (87%), and screening/assessment for substance use disorders (79%), fewer provided connections to medical services (36%) or linkages to post-release medication-assisted treatment (MAT) programs (23%).
* While most facility-based programs reported that participants have a written pre-release plan (98%) and case management staff to facilitate transition to the community (94%), the majority made these connections only through written referrals. Research indicates that formerly incarcerated individuals are more likely to follow through with appointments if in-person contact is made prior to release, but only 43% of programs provide this type of connection to community-based substance use disorder treatment.

**There are Programmatic Differences Exist between Prison-based and Jail-based Programs**

* Jail-based treatment programs reported using screening/assessment instruments for substance use problems at a lower rate (63%) than prison-based programs (95%).
* Almost all prison programs (91%) provide segregated housing and treatment in accordance with BJA RSAT guidelines, while only 54% of jail programs meet this which is not required by statute, unlike that required of prison RSAT programs.
* Twice as many jail programs use a personal appointment for connecting RSAT participants to community-based substance use treatment prior to release than do prison programs (54% vs. 29%). This can be explained by the fact that jails are local – typically county-based, while state prisons are often located in rural areas, far from the cities to which most inmates are released.
* Several jail programs reported challenges enrolling participants because the pool of eligible individuals was not as large as previous years, which respondents attributed to the implementation of the diversion and alternatives to incarceration programs in their communities that result in fewer drug offenders being incarcerated.

**Facility-Based RSAT Programs Face Unique Personnel Challenges**

Two key challenges were identified in implementing facility-based programs: the philosophical differences in approach between corrections and treatment staff, and the frequent rotation of correctional officers inside facilities. Successful RSAT programming requires close collaboration between correctional and clinical staffs, but this is difficult to achieve when officers do not remain assigned to the RSAT unit long enough to build relationships with clinical staff and with inmates, and do not have the opportunity for relevant training. While clinical staff are often onsite only during business hours, correctional officers are with participants 24/7, and their interactions can either advance treatment or undermine it. However, only 12% of programs reported having correctional officers dedicated to the RSAT unit, and only 9% reported using RSAT funds to train correctional officers about substance use treatment.

**RSAT-Funded Aftercare/Linkages to Community-based Aftercare: Barriers and Solutions**

While legislation in 2007 added a requirement that RSAT grantees fund aftercare services, federal funding for the RSAT has remained at essentially the same level for the past decade, making it difficult for states to implement this requirement. While aftercare funding was initially limited to 10% of a state’s grant, this requirement was lifted in 2013. However, without an increase in available funding, this change did not significantly affect the extent to which states were able to expand aftercare services.

As noted earlier, differences between local jails and state prisons affect programming possibilities. These differences affect the extent to which- and the manner in which- grantees can support aftercare services or link inmates about to be released to community-based aftercare services. Since jails are generally county-based, RSAT program staff are likely familiar with the substance abuse treatment and aftercare providers in their community, and it is feasible for them to make in-person linkages between inmates being released and community-based services, or to provide aftercare services directly in the community to newly released inmates. Because state prisons are often located in rural areas that are far from the urban centers to which most individuals are likely to return, it is more difficult for RSAT staff to provide direct aftercare services to individuals who received in-prison RSAT services, except for residential facilities such as halfway houses.

The study found that only 18% (11) of RSAT programs funded aftercare services, primarily in outpatient settings, with a handful in residential settings. Fewer than half of these link directly to a facility-based RSAT-funded treatment program. Among the 49 correctional-based RSAT programs that do not link to RSAT-funded aftercare, only about half reported that RSAT participants are connected to other aftercare services.

The settings for RSAT-funded aftercare services are a mix of outpatient and residential treatment. Four programs use residential treatment for their aftercare program. The length of stay ranges from 30 days to 12 months. The other seven programs use community-based outpatient treatment, and all seven have a case manager position that assists in coordination of treatment services. The most common settings for post-release aftercare are community corrections centers and outpatient substance use disorder treatment providers.

However, some states reported that RSAT resources allowed them to fill community service gaps and offer innovative services. Some examples include:

* One program provides medication assisted treatment (MAT) to individuals transitioning from their jails, a service that would not be available in the community without RSAT funds.
* Another reported that RSAT helped fill a programmatic gap for a correctional-based residential program by providing step-down services and community-based support following treatment.
* RSAT funds helped fill a transitional service gap in correctional facilities by supporting a case management position that begins to work with individuals several months before release.

All states with RSAT-funded aftercare programs identified challenges to serving clients and many offered examples of programmatic strategies they used to address these challenges. The major challenges include:

* Widespread shortages of treatment and services to support individuals transitioning from correctional programming to the community
* Difficulty engaging individuals in aftercare services post-release
* Barriers to retaining clients in community-based aftercare programs

The strategies used by RSAT-funded aftercare programs to address these issues include:

* Developing a wide range of community provider partnerships and being actively involved in community reentry initiatives/workgroups. This helps leverage existing community resources and develop open communication with providers about the needs of RSAT program participants.
* RSAT grantees reported that relationships with community corrections can mean the difference between violating an individual on probation because of a positive drug screen or using it as an opportunity to intensify treatment.
* Pre-release engagement with staff who will work with RSAT program participants transitioning to the community is crucial. Individuals are more likely to show up for the first post-release appointment with someone they already know.
* Using individuals who have successfully completed the aftercare program to engage participants helps facilitate program buy-in for newly released inmates in after care.

**Conclusions**

The study found that the RSAT program overall has partially met its mandate to provide aftercare services to program participants. Just over half of RSAT correctional-based treatment programs reporting making connections to aftercare services for RSAT participants. However, only 18% of funded programs reported using RSAT funds directly for aftercare treatment and services. Reductions in RSAT funding in the past 10 years has made it difficult for grantees to meet the aftercare requirement.

Survey respondents reported that RSAT plays an important role in funding treatment services for incarcerated individuals, but stated that the resources are not sufficient to meet the growing need for treatment inside correctional facilities, much less to allow states to take on new aftercare programming activities. Most states need to leverage other resources from state and/or local funds, other federal programs, or private sources to support their RSAT programming.

Most treatment programs reported providing a wide range of counseling and support services to RSAT participants, including at least one EBP. Service components common to most correctional treatment programs are in line with NIDA drug treatment principles for criminal justice populations, including screening/assessment, treatment planning, sanctions/incentives, and drug testing. Additionally, almost all programs reported providing transitional planning and case management support to RSAT participants prior to release.

Given the limited federal funding available for RSAT institutional or aftercare services, the continued existence of RSAT programs in prisons, jails, and in communities represents a huge achievement. The study identified two major unmet needs that must be addressed if programs are to achieve their fullest potential, particularly as the nation continues to face a growing opioid addiction crisis. Addressing this issue in correctional setting will require additional financial resources. It will also require RSAT grantees to provide for consistent leadership and oversight on a statewide basis to ensure that correctional-based treatment and continuity of care in the community becomes both a correctional priority and a public health priority.