Promising Practices Guidelines for Residential Substance Abuse Treatment

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Promising Practices Guidelines for Residential Substance Abuse Treatment

Introduction

The Residential Substance Abuse Treatment (RSAT) for State Prisoners Program (42 U.S.C. § 3796ff et. seq.) assists states and local governments in the development and implementation of substance abuse treatment programs in state, local, and tribal correctional and detention facilities. Funds are also provided to create and maintain community-based aftercare services for individuals after they are released from incarceration. As of 2016, there were approximately 77 jail, 80 state prison or juvenile, and 28 aftercare RSAT programs in all but two states, serving more than 12,000 inmates.

Congress has set limited basic requirements for RSAT programs. Prison programs must be at least six months in length, and participants must be physically separated from the general population. Jail programs must be at least 90 days and physically separated from the general population if the facility permits. RSAT participants must be tested both periodically and randomly for drugs, including once before entering the program and during the program. The RSAT programs, if possible, are to be limited to inmates with 6 to 12 months remaining in their confinement so they can be released directly from the treatment facility instead of being returned to the general population after completing the program.

When funding RSAT programs, states are required to give preference to programs that provide aftercare services. This includes coordination between the correctional treatment program and other human service and rehabilitation programs, such as education and job training, parole supervision, halfway houses, and self-help and peer groups, that may help rehabilitate offenders. This includes more than providing phone numbers of referral agencies in the community.

The goal of the RSAT program is to break the cycle of drugs and violence by reducing the demand for, use, and trafficking of illegal drugs. RSAT enhances the capabilities of states and units of local and tribal governments to provide residential substance abuse treatment for incarcerated inmates; prepares individuals for reintegration into their communities by incorporating reentry planning activities into treatment programs; and assists individuals and their communities through the reentry process through the delivery of community-based treatment and other broad-based aftercare services.

RSAT Promising Practices Guidelines Goal

The goal of the following **RSAT Promising Practices Guidelines** is to assist correctional officials and practitioners at the state and county level to establish and maintain RSAT programs that adhere to the best practices suggested by existing research, related standards developed for substance abuse treatment and criminal justice programming, as well as what experts and experienced practitioners have found to work best for inmates with substance use disorders. Unlike drug courts and community-based substance abuse treatment, there is little direct research and few evaluations pertaining specifically to RSAT or correctional substance abuse treatment programming. For this reason, the following guidelines are considered “promising,” not evidence-based practices, and they are compiled as “guidelines,” not standards.

It is the expectation that, once adopted, these guidelines will encourage the requisite specific research as well as practitioner feedback so that, once confirmed, these practices will form the basis of evidence-based standards for measurable improvements within RSAT and other correctional substance abuse treatment programs.

Promising Practices Guidelines for Residential Substance Abuse Treatment

I. Intake, Screening, and Assessment

The first set of guidelines deals with targeting who should be admitted into RSAT programs. Frequently, this determination is not made by counselors or persons who staff RSAT programs within the correctional institution, but are instead made by the institution's personnel charged with classifying all new prisoners. For this reason, it is important that these personnel are fully apprised of RSAT eligibility criteria.

A) Inmates with substance use disorders should be eligible for RSAT, regardless of their risk for recidivism. To determine whether an inmate has a substance use disorder, they should be screened using a validated instrument.[1]

Inmates with substance use disorders are in need of treatment to prevent relapse, including increased risk of death from an opioid overdose after release, regardless of their risk for reoffending. Their imprisonment presents a unique opportunity to assist them in beginning to address their substance use disorder, set them up with continuing treatment after release, and put them on the path to long-term recovery. Although mixing low- and high-risk offenders has been found to have negative effects in community-based substance abuse treatment, there is no equivalent research within the context of prison and jail substance abuse treatment programming.

B) Although RSAT participation is voluntary, inmates should be eligible for RSAT regardless of the sincerity of their motivation or commitment to addressing their substance use disorder.

After admission, the RSAT program should provide the motivation for inmates to commitment to treatment through motivational enhancement therapies that incentivize clients to take interest in their substance use disorders. A system should be in place to use social support for participating in programs. Research suggests that, especially when it comes to substance use, mandated treatment can be as effective as voluntary treatment. Inmates should not be referred to RSAT based on rewards or consequences for institutional behavior or plea/sentencing agreements that are antithetical to eligibility for RSAT programming.

C) Inmates with co-occurring disorders should be eligible for participation in RSAT as long as they are able to function in the program and not disrupt the treatment of their peers. However, to ensure RSAT programming is responsive to inmates with co-occurring disorders, inmates' co-occurring disorders should be identified by validated assessment tools.[2]

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[1] Validated screening instruments can be found on various websites of evidence-based programming, including the U.S. Department of Justice's Crime Solutions, www.crimesolutions.gov/, and SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP), www.nrepp.samhsa.gov/01_landing.aspx.

[2] See Psychiatric Research Interview for Substance and Mental Disorders (PRISM), described with other instruments in Peters, R., et al., *Screening and assessment of co-occurring disorders in the justice system*. Delmar, NY: CMHS National GAINS Center.

The overlap between substance use disorders and mental illness, including trauma, is substantial. Studies have found that approximately 17% of jail inmates with **serious mental illness** have a co-occurring substance use disorder,[3] and 59% of state prisoners with mental illness have a co-occurring substance use disorder.[4] To bar inmates from RSAT because of mental disorders will preclude too many inmates with substance use disorders in need of treatment. RSAT programming should be flexible enough to reach inmates with diverse needs. Allowing inmates to continue taking prescribed antipsychotic medications after incarceration will allow many of these inmates to participate in RSAT programming.

D) Following screening, either before or after being admitted to RSAT, inmates should be fully assessed for behavioral, physical health, and criminogenic risks, needs, and responsivity. Assessments should also inform the formulation of individualized treatment plans and case management for RSAT inmates.

Inmates should be fully assessed for substance abuse, risk, need, responsivity, trauma, mental health, physical health, literacy, and any other factor that will affect their ability after release to remain abstinent from alcohol and/or prevent relapse. Assessment is the first step in treatment. (See NIDA Drug Abuse Treatment Principles for Criminal Justice Populations, "Program conducts screening and assessment with valid instrument.") Tailoring services to fit the needs of the individual is an important part of effective alcohol and substance use treatment for criminal justice populations. Individuals differ in terms of age, gender, ethnicity and culture, problem severity, recovery stage, and level of required supervision. Individuals also respond differently to treatment approaches and treatment providers. In general, alcohol and substance use treatment should address issues of motivation, problem solving, and skill building for resisting alcohol, substance use, and criminal behavior. Lessons aimed at supplanting alcohol and substance use and criminal activities with constructive activities and at understanding the consequences of one's behavior are also important to include. Tailored treatment interventions can facilitate the development of healthy interpersonal relationships and improve the participant's ability to interact with family, peers, and others in the community.

II. Treatment Programming

Required by Statute/BJA:

Treatment practices/services should be, to the extent possible, evidence based and should develop the inmate's cognitive, behavioral, social, vocational, and other skills to facilitate recovery for the substance use disorders and related problems.

A) Treatment should target factors associated with criminal behavior in addition to substance and alcohol use disorders.

"Criminal thinking" is a combination of attitudes and beliefs that support a criminal lifestyle and criminal behavior, such as feeling entitled to have things one's own way, feeling that one's criminal behavior is justified, failing to accept responsibility for one's

[3] Abram, K. M., & Teplin, L. A. (1991). Co-occurring disorders among mentally ill jail detainees, *American Psychologist, 46*(10), 1036–1045.
[4] Ditton, P. (1999). *Mental health and treatment of inmates and probationers.* Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

actions, and consistently failing to anticipate or appreciate the consequences of one's behavior. This pattern of thinking often contributes to alcohol and substance use and criminal behavior. Treatment that provides specific cognitive skills training to help individuals recognize errors in judgment that lead to alcohol and substance use and criminal behavior may improve outcomes.

B) RSAT programs should only offer treatment that is evidence based, unless none exists for the specific treatment need being addressed.

As described earlier, almost all of the evidence-based substance use disorder treatment programs are community based, not located in prisons and jail environments. However, in the absence of specific prison and jail evidence-based substance use disorder treatment programs, RSAT programs should adopt treatment programs that are at least evidence based for justice populations. RSAT staff must then determine that the program is transferable to an institutional correctional setting; that the researched program served an equivalent population in as equivalent a setting as possible; that the evidence-based program can be implemented with reasonable fidelity in the specific RSAT jail or prison; that RSAT has the resources and capacity to implement the program; and that the staff, treatment and correctional as well as administration, perceive its utility. In implementing the evidence-based program, it should be aligned with existing process and procedures that will require adaption of the program or modification of existing RSAT or prison/jail practices. Treatment and correctional staff need the knowledge and skills to use the program. There needs to be a feedback loop to see that the program fits, is implemented with fidelity, and works as implemented.[5]

C) Offenders with co-occurring drug and/or alcohol abuse and mental health issues require an integrated treatment approach.[6]

Personality, cognitive, and other serious mental disorders can be difficult to treat and may disrupt substance use disorder treatment. The presence of co-occurring disorders may require an integrated approach that combines alcohol and substance use disorder treatment with psychiatric treatment, including the use of medication. Individuals with either an alcohol and substance use or mental health problem should be assessed for the presence of the other. Although mental illness is not a general risk factor for recidivism, it is a factor for program responsivity.[7]

D) Medications are an important part of treatment for many drug abusing offenders and also for offenders suffering from co-occurring mental illness.

Medicines used in medication-assisted treatment (MAT), such as methadone, buprenorphine, and naltrexone, have been shown to reduce opioid and alcohol use and

[5] National Institute of Corrections. *Implementing EBP in community corrections: The principles of effective intervention*; Crime and Justice Institute*. Implementing evidence-based practices, revised.* Center for Effective Public Policy, 2010; Taxman & Belenko, 2012.

[6] Table 3.3, NIDA Drug Abuse Treatment Principles for Criminal Justice Populations.

[7] "(A)s of yet, (there is) no direct support for the applicability of the three core RNR principles to treat (persons with mental illness involved in the criminal justice system)." Skeem, J. L., Steadman, H. J., Manchak, S. M. (2015). Applicability of the risk-need-responsivity model to persons with mental illness involved in the criminal justice system. *Psychiatric Service, 66*(9), 916–922. doi: 10.1176/appi.ps.201400448.

should be made available to individuals who could benefit from them.[8,9] Effective use of medications can also be instrumental in enabling people with co-occurring mental health problems to function successfully in both prison/jail and the community. If inmates are on licit antipsychotic medication, they should be allowed to continue receiving the medication pending medical and psychiatric assessments. Antipsychotic medication discontinuity has the potential to affect both recidivism and health care costs after release as well as disorder, overuse of solitary confinement, and suicide within prisons/jails.[10] If inmates are on prescribed FDA-approved agonist (methadone) or partial agonist (Suboxone) medications for opioid disorders, they should be allowed into RSAT programs and either allowed to continue the medication or be given the option of safely tapering off the medication while in the program.

A randomized clinical trial of prison-initiated buprenorphine provided to male and female inmates who were previously heroin dependent prior to incarceration found that inmates receiving the medication were significantly more likely to enter community treatment upon release (47.5% vs. 33.7%). However, the researchers noted that, although Buprenorphine can facilitate community treatment entry, concerns remain with in-prison treatment due to attempted diversion of medication.[11]

E) BJA RSAT length requirements should be considered minimum, not maximum limits and, optimally, RSAT durations should depend on each participant's needs and circumstances.

The treatment provided by RSAT programs should be considered the first phase of ongoing treatment that begins in prison or jail but continues after release. Institutional administrators, paroling authorities, and judges should be advised to allow inmates to remain in RSAT programs at least for these minimum lengths. Research has found that inmates who do not complete their RSAT program, including those who do not complete because they were granted early parole, have significantly higher recidivism rates post release than those inmates who complete the program.[12]

F) RSAT treatment programs should be provided in flexible phases.

Inmates should advance based on their performance and behavior. Graduation from one phase to the next should be based on behavior, not time. As recommended by the Adult Drug Court Best Practice Standards Committee, RSAT programming should be designed so that inmates receive services in phases. The first addresses responsivity needs such as orientation to the rules of the RSAT pod and program, mental health symptoms, substance-related cravings, withdrawal, anhedonia, or readiness to change and motivation. In the next phase, services address resolution of criminogenic needs that co-occur with substance abuse, including criminal thinking and the like. In the last

[8] Rich, J. D., McKenzie, M., Larney, S., Wong, J. B., Tran, L., Clarke, J… Zaller, N. (2015). Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: A randomized, open-label trial. *The Lancet*. doi: 10.1016/S0140-6736(14)62338-2

[9] Gordon, M. et al. (2014). A randomized controlled trial of prison-initiated buprenorphine: Prison outcomes and community treatment entry. *Drug Alcohol Depend, 142*, 33–40. doi: 10.1016/j.drugalcdep.2014.05.011

[10] Reingle Gonzalez, J., & Connell, N. (2014). Mental health of prisoners: Identifying barriers to mental health treatment and medication continuity. *American Journal of Public Health, 104*(12), 2328–2333.

[11] RSAT funding may be used to pay for medication.

[12] Klein, A., & Wilson, D. (2002). *Outcome Evaluation of a residential substance abuse program: Barnstable House of Corrections*. U.S. Department of Justice, Office of Justice Programs, National Institute of Justice; Wilson, D., & Klein, A. (2003). A study on the habilitation of chronic offenders in a Massachusetts House of Correction. Waltham, MA: BOTEC Analysis Corporation.

phase, services are provided that are designed to maintain treatment gains by enhancing inmates' long-term adaptive functioning.[13]

G) Positive programming should account for the majority of the inmates' day.

Although many RSAT inmates will be segregated from the general prison or jail population, negative influences can be minimized if inmates are involved in positive programming most of the day. For this reason, it is imperative that correctional officers who spend more direct facetime with inmates than treatment staff reinforce program behavioral standards and activities promoted by RSAT treatment staff. It is suggested that cross-training officers and RSAT treatment staff will encourage consistent, positive reinforcement for treatment. Keeping inmates positively engaged is one of the reasons why many RSAT programs employ modified therapeutic communities to address inmates' substance use disorders.

III. Treatment Modalities and Services

A) RSAT treatment programming should be responsive to a diverse inmate population, include both group and individual counseling, and be periodically reviewed to ensure adopted modalities provide the best fit for the inmate population.

Treatment programs should include both group and individual counseling to accommodate diverse needs of inmates. Both cognitive behavioral therapy and modified therapeutic communities have been found to be effective treatment modalities for RSAT programs.

NIDA[14] has found that the following behavioral therapies help engage people in alcohol and substance use disorder treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to abuse, and increase their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for alcohol and other drugs and prompt another cycle of compulsive abuse:

- **Cognitive behavioral therapy (CBT)** for alcohol, marijuana, cocaine, methamphetamine and nicotine;
- **Contingency management (CM) interventions/motivational incentives** for alcohol, stimulants, opioids, marijuana, and nicotine;
- **Community reinforcement approach (CRA) plus vouchers** for alcohol, cocaine, and opioids;
- **Motivational enhancement therapy (MET)** for alcohol, marijuana, and nicotine;
- **The Matric Model** for methamphetamine and cocaine;
- **Twelve-step facilitation therapy** for alcohol, stimulants, and opiates;
- **Family behavior therapy (FBT)** for substance abuse and other co-occurring problems;

[13] Adult Drug Court Best Practice Standards, Vol. II, 2015, National Association of Drug Court Professionals, p. 5.
[14] Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition).

- **Behavioral therapies** primarily for adolescents, including **Multisystemic therapy (MST)** for serious antisocial behavior in children who abuse alcohol and other drugs [15]

All of these evidence-based behavioral therapies found effective in addressing alcohol and substance abuse are for particular drugs of abuse and have been studied primarily in community settings. Their use in correctional settings requires adjustments and modifications. As a result, once implemented, it is imperative that RSAT programs evaluate whether they have maintained fidelity to the essential elements of the treatment that have been found effective and that the program, as modified and implemented, achieves commensurate results as that found in the research.

In addition to these behavioral therapies, NIDA also includes pharmacotherapies. For opioid addiction, it lists Methadone, Buprenorphine, and Naltrexone. For alcohol addiction it lists Naltrexone, Acamprosate, Disulfiram, and Topiramate.[16]

The Substance Abuse and Mental Health Services Administration (SAMHSA) lists some evidence-based alcohol and substance use disorder treatment programs specifically for youth (ages 18–25) and adults (ages 26–55) in correctional facilities:

- **Correctional Therapeutic Community** for Alcohol and Substance Abusers (CTC) six months from prison release,
- **Creating Lasting Family Connections Fatherhood Program (CLFCFP)** for family reintegration for men,
- **Forever Free** for women,
- **Helping Women Recover and Beyond Trauma** for women (manual driven treatment),
- **Interactive Journaling,**
- **Living in Balance (LIB)** (manual based),
- **Moral Reconation Therapy (MRT)** (cognitive behavioral approach), and
- **Texas Christian University (TCU) Mapping-Enhanced Counseling (MEC),** a communication and decision-making technique designed to support delivery of treatment services.[17]

RSAT programs have found evidence-based manualized treatment programs to be effective, offering structure and consistency. They are also easy to use and can help focus sessions, although they can be restrictive and counselors need to incorporate personal style and creativity in their use.[18] The quality of the interpersonal relationship between staff and the offender, along with the skills of the staff, are as important to risk reduction as the specific programs in which offenders participate.[19]

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[15] These programs are described in the Appendix.

[16] These medications are described in the Appendix.

[17] These programs are described in the Appendix.

[18] Godley, S. et al. (2001). Therapist reactions to manual-guided therapies for the treatment of adolescent marijuana users. *Clinical Psychology Scientific Practice, 8*, 405–417.

[19] Dowden, C., & Andrews, D. A. (2004). The importance of staff practices in delivering effective correctional treatment: A meta-analysis of core correctional practices. *International Journal of Offender Therapy and Comparative Criminology*, *48*, 203–214.

B) Therapeutic communities must be adapted to function within a prison or jail without sacrificing the essential components of a therapeutic community.

The overarching approach to a therapeutic community treatment should be "community-as-method," where activities take place in interactive group settings. To be most effective, the following are recommended:

1. It is most desirable to have at least some staff who can serve as ex-addict/offender role models or at least some ex-addict/offender role models involved in the program in some capacity, even as outside guest speakers, especially peers.
2. There must be a prevailing culture of positive peer pressure that counteracts the "inmate code" of the general population.
3. There must be a strong sense of community, with a common language, rituals and rites of passage, that prevents a "we-they dichotomy."
4. There must be a shared locus of control, with residents involved in running the program, but with staff maintaining ultimate control and applying it with rational authority and acting as pro-social role models.
5. Cooperation and continuous communication with security and administration personnel (e.g., warden) is essential to the autonomous functioning of the therapeutic community.
6. There must be a pro-social code of morality—"right living"—that promotes empathic relations between staff and clients along with open communication, honesty, trust, positive work ethic, community responsibility, etc.
7. Members should be organized by job functions in a hierarchical structure with corresponding rewards.
8. The community must adhere to strict behavioral expectations with certain consequences and sanctions applied in a mutual effort by other members and staff.
9. To ensure there is no corruption or programmatic drifting, it is essential to have regular therapeutic community-specific monitoring and training from outside the community.[20]

Therapeutic communities have a long history of treating clients involved in the criminal justice system, and the therapeutic community focus on treating the whole person (as opposed to drug problems exclusively) is particularly appropriate for this population. A considerable body of research supports the effectiveness of therapeutic community treatment for offenders, particularly in a continuum of care that involves prison treatment followed by community treatment.[21]

Therapeutic communities using CBT is the most supported model. Key components include the following:

1. having counselor-led groups,

[20] Therapeutic Communities of America.
[21] Knight, K., Simpson, D. D., & Hiller, M. L. (1999). Three-year reincarceration outcomes for in-prison therapeutic community treatment in Texas. *Prison Journal, 79*(3), 337–351.

2. having peer-led groups,
3. providing a process for an inmate to increase his/her role,
4. using the group to establish norms to socialize the group,
5. having individuals reward others,
6. creating an environment that supports change,
7. having separate housing units,
8. instilling a sense of unity and pride, and
9. including family treatment to develop social support network.

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C) Cognitive behavioral therapy (CBT) should not be limited to specific CBT sessions, but instead should be reinforced across the program and staff, including both treatment and correctional officers.

Staff should focus on changing behavior and thinking, provide skills training and opportunities for skill rehearsal, and teach inmates to become aware of his/her thinking verbalize his/her thoughts; stop reacting to automatic thoughts; and understand how thoughts and beliefs trigger criminal and addictive behaviors. All RSAT staff should understand the program's basic CBT approach and key terms and on-site behavior should be consistent with the CB principles; CBT sessions should be monitored periodically to assure that proper techniques are employed; Staff should reinforce CB principles or skills outside of CBT sessions; Other treatment tools and program rules should be consistent with CB principles; Inmates should be held accountable for CB homework and for applying CB skills or principles in their ongoing program activities.[23]

D) Treatment plans must be assessed and modified continually to meet changing needs of inmates and incorporate planning for transitioning into the community.

The adoption of an evidence-based treatment program does not guarantee the same results found in the research. The RSAT program must adopt evidence-based practice. This requires definable and measurable outcomes so program effectiveness can be determined. In addition, it requires documentation of case information, including formal, valid mechanism for measuring outcomes. RSATs must routinely assess offender change in cognitive and skill development, and evaluate recidivism of RSAT graduates. Also, there should be periodic staff performance evaluations to achieve greater fidelity to the evidence-based program design, service delivery principles and outcomes. Staff monitoring, measuring and reinforcing promotes staff cohesiveness and

[22] Knight, K., Simpson, D. D., & Hiller, M. L. (1999). Three-year reincarceration outcomes for in-prison therapeutic community treatment in Texas. *Prison Journal, 79*(3), 337–351.
[23] F. Zackon, Key Elements of Effective Cognitive Behavioral Therapies, 2011.

greater support to the program mission.[24] Both inmates and program staff need feedback.[25]

E) RSAT programs should include compatible inmate treatment and social services.

Although all RSAT inmates suffer alcohol and/or substance use disorders, other needs must be addressed while they are incarcerated to prepare them for reintegrating into the community. These may include the following, also identified by drug court researchers:[26]

- clinical case management,
- housing assistance,
- mental health treatment,
- trauma-informed services,
- criminal thinking interventions,
- family and interpersonal counseling,
- vocational and educational services,
- medical and dental treatment,
- prevention of health-risk behaviors, and
- overdose prevention and reversal, including provision of Narcan to released inmates or their family member/significant other.

F) RSAT programs should be trauma informed regardless of whether trauma-specific services are provided.

At least one third of males and two thirds of females in RSAT programs may be experiencing lasting effects of trauma exposure that play a role in their continued use of drugs and alcohol.[27] Part of responsivity is ensuring that RSAT programming is accessible to inmates suffering from trauma. For this reason, all programming should be trauma-informed as much as possible, given that prisons and jails present challenging settings for trauma-informed approaches. Prisons and jails are designed to house perpetrators, not victims. For an inmate with Post Traumatic Stress Disorder (PTSD), there are scores of unavoidable triggers—shackles, overcrowded housing units, lights that are on all night, loud speakers that blare without warning and severely limited privacy. Pat downs and strip searches, frequent discipline from authority figures and restricted movement may all mimic certain dynamics of past abuse. All of these factors are likely to aggravate trauma-related behaviors and symptoms that can be difficult for staff to manage.[28] Inmates suffering from Post-Traumatic Stress Disorder

[24] Henggeler, et al., 1997; Milhalic & Irwin, 2003; Miller, 1988; Meyers, et al., 1995; Azrin, 1982; Meyers, 2002; Hanson & Harris, 1998; Waltz, et al., 1993; Hogue, et al., 1998; Miller & Mount, 2001; Gendreau, et al., 1996; Dilulio, 1993.
[25] Miller, 1988; Project Match Research Group, 1997; Agostinelli, et al., 1995; Alvero, et al., 2001; Baer, et al., 1992; Decker, 1983; Luderman, 1991; Miller, 1995; Zemke, 2001; Elliott, 1980.
[26] Identified in Drug Court Volume II.
[27] Miller, N. (2001). RSAT Training Tool Trauma informed Approaches in Correctional Settings, p. 8. www.rsat-tta.com/Files/Trainings/Trauma_Informed_Manual
[28] Owens, B., Wells, J., Pollock., Muscat, B., & Torres, S. (2008). *Gendered violence and safety: A contextual approach to improving security in women's facilities*. Washington, D. C.: U. S. Department of Justice, Office

(PTSD) may have used alcohol and drugs to cope with trauma responses and triggers. With the removal of these from the inmate's life, trauma related symptoms may worsen.[29]

Integrating trauma stabilization and coping skills training in RSAT's alcohol and substance abuse programs will make the substance abuse treatment more accessible for inmates suffering from trauma. Trauma-informed programs and cognitive behavioral trauma-specific interventions can help offenders master the skills that will set the stage for engagement in effective recovery programming. Trauma-informed RSAT programs have staffs who understand trauma and its impact on the addiction and recovery process; services designed to enhance safety, minimize triggers, and prevent re-traumatization; encourages relationships between staff and inmates based on equity and healing, empowering trauma survivors with information, hope and appropriate referrals upon release. Although there cannot be complete equity in relationships between staff and inmates, inmate councils, for example, can be formed to give inmates some input into how the RSAT programs or pods operate that do not compromise the security and safety of the institution. Trauma specific services include specific groups and effective interventions aimed at coping with the aftermath of trauma, decreasing symptoms of trauma-related disorders and increasing knowledge about trauma. Inmates are empowered with skills and techniques to manage and lesson the effects of trauma in their ongoing recovery. Although trauma-specific interventions have been found to be more powerful in reducing symptoms of trauma-related disorders than trauma-informed services alone, they are most effective when delivered in a trauma-informed environment. The combination of the two is more effective than either one alone.[30]

IV. Drug-Free Environments

Required by Statute/BJA:

A state must also agree to implement or continue to require urinalysis or other proven reliable forms of testing, including both periodic and random testing—1) of an individual before the individual enters a residential substance abuse treatment program and during the period in which the individual participates in the treatment program; and 2) of an individual released from a residential substance abuse treatment program if the individual remains in the custody of the state.

A) Urine testing should be supervised, periodic, and random. In addition, it must be done to ensure abstinence for inmates who will be provided injected Naltrexone prior to their release.

Alcohol and substance use during treatment should be carefully monitored. Individuals trying to recover from alcohol and drug addiction may experience a relapse, or return to drug use. Triggers for relapse are varied; common ones include mental stress and associations with peers and social situations linked to drug use. An undetected relapse can progress to serious alcohol and substance abuse, but detected use can present opportunities for therapeutic intervention. Monitoring alcohol and substance use

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of Justice Programs, National Institute of Justice; Covington, S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs 385 SARC Supplement 5, 165*(1).

[29] Loper, A. B. (2002). Adjustment to prison of women convicted of possession, trafficking, and non-drug offenses. *Journal of Drug Issues, 32*, 1033-1050.

[30] Morrissey J., Jackson E., Ellis A., Amaro H, Brown V., & Najavits L. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services, 56*, 1213-1222.

through urinalysis or other objective methods, as part of treatment or criminal justice supervision, provides a basis for assessing and providing feedback on the participant's treatment progress. It also provides opportunities to intervene to change unconstructive behavior—determining rewards and sanctions to facilitate change, and modifying treatment plans according to progress. In jails that do not have the facilities to separate RSAT inmates from the general population, alcohol and other drug testing should be more prevalent.

If inmates are to be provided Naltrexone, oral or injected, they must be drug tested first for opioid as abstinence from opioids for at least seven days is required before they can take this medication. Although Naltrexone also blocks the effects of alcohol, individuals do not have to be alcohol free before taking Naltrexone.

V. Health Insurance

A) RSAT programs should ensure inmates obtain any health insurance plan for which they are eligible and provide health care literacy so that they use the health care system to meet their physical and behavioral health needs, including access to preferred medication for assisted treatment.

Any gains in substance abuse treatment obtained in RSAT may dissipate upon release, especially if the inmates return to the same environments and peers which contributed to their drug use. RSAT treatment should be considered preliminary or the first phase of treatment for long term recovery. Insurance or access to free care is essential for the necessary continued treatment in the community.

In addition to substance use disorders, many RSAT inmates are likely to have other significant physical and behavioral health care needs requiring regular access to care after release.[31,32] Without access to health services immediately upon release, recently incarcerated individuals' physical and mental health conditions may deteriorate. In fact, research shows that individuals face a markedly increased risk of death—more than 12 times that of other individuals—during the first two weeks after release.[33] Research suggests that providing access to Medicaid upon release can promote more timely access to care, which may reduce that risk, particularly for individuals with chronic physical or mental health conditions.[34] In addition, continuous access to health care immediately after release may reduce the risk of re-arrest and reincarceration.[35]

In Medicaid expansion states, eligible inmates should be enrolled in their state's Medicaid program. There is no federal statute, regulation, or policy that prevents individuals from being enrolled in Medicaid while incarcerated. Notably, in 2004, CMS issued guidance reminding states that "[i]ndividuals who meet the requirements for eligibility for Medicaid may be enrolled in the program before, during and after the time in which they are held involuntarily in secure custody of a public institution." Federal law requires states to allow individuals to apply for Medicaid at any time. In all states,

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[31] Cloud, D., Vera Institute of Justice. (2014). *On life support: Public health in the age of mass incarceration 10*. Citing Spaulding, A. C. (2009). *HIV/AIDS among inmates of and releases from US Correctional Facilities, 2006: Declining share of epidemic but persistent public health opportunity*, 4 PLOS One e7558.
[32] Id. at 9. Citing Prins, S. J. (2014). Prevalence of mental illnesses in US state prisons: A systematic review. *Psychiatric Services, 65*, 862.
[33] Binswanger, I. A., et al. (2007). Release from prison: A high risk of death for former inmates. *Eng. J. Med., 157*, 160.
[34] Id. at 165.
[35] Morrissey, J. P., et al. The role of Medicaid enrollment and outpatient service use in jail recidivism among persons with serious mental illness. *Psychiatric Services, 58*, 794.

inmates may be enrolled in available subsidized or non-subsidized insurance plans offered through their state's market exchanges.

B) If RSAT inmates require hospitalization, RSAT programs should recommend out-of-institution in-patient care as appropriate with security needs to reduce institutional health care costs.

Although Medicaid will not cover RSAT inmates while incarcerated generally, it will cover care received by them in an inpatient hospital or other medical institution outside the prison or jail. States may receive Medicaid reimbursement for care provided to eligible individuals admitted as inpatients to a medical institution, such as a hospital, nursing facility, psychiatric facility, or intermediate care facility. This is also another reason why states should suspend as oppose to terminate inmates' Medicaid enrollment while imprisoned. Temporary suspensions will facilitate reimbursement for these out of prison/jail hospitalizations.

C) RSAT programs should encourage state Medicaid managed care contract provisions that require plans to provide care coordination services to individuals upon release from jail or prison and recommend that eligible inmates enroll in them.

Medicaid managed care entities may be well-positioned to help Medicaid enrollees quickly access necessary community-based services during this time period. Colorado, for example, requires behavioral health plans to "collaborate with agencies responsible for the administration of jails, prisons and juvenile detention facilities to coordinate the discharge and transition" of enrollees. In addition to ensuring that enrollees leaving incarceration receive medically necessary behavioral health services, plans must propose innovative strategies to meet the needs of enrollees involved with the criminal justice system.

Florida, for example, requires Medicaid managed care plans to "make every effort…to provide medically necessary community-based services for Health Plan enrollees who have justice system involvement." Among other things, plans must: (1) provide psychiatric services to enrollees and likely enrollees within 24 hours after release from a correctional facility; (2) ensure that enrollees are linked to services and receive routine care within 7 days after release; (3) conduct outreach to populations of enrollees "at risk of justice system involvement, as well as those Health Plan enrollees currently involved in this system, to assure that services are accessible and provided when necessary." In addition, plans must work to develop agreements with correctional facilities that will enable the plans to anticipate the release of individuals who were enrolled prior to incarceration.[36]

VI. RSAT Sanctions and Rewards

A) There should be four rewards to every sanction to encourage pro-social behavior and treatment participation.

When providing correctional supervision of individuals participating in alcohol and drug abuse treatment, it is important to reinforce positive behavior. Nonmonetary "social reinforcers," such as recognition for progress or sincere effort, can be effective, as can

[36]McKee, C., & Somers, S. The Kaiser Commission on Medicaid and the Uninsured State Medicaid Eligibility Policies for Individuals Moving into and Out of Incarceration, National Health Law program, Kaiser Family Foundation, April 2015, Issue Brief.

graduated sanctions that are consistent, predictable, and clear responses to noncompliant behavior. Generally, less punitive responses are used for early and less serious noncompliance, with increasingly severe sanctions issuing from continued problem behavior. Rewards and sanctions are most likely to have the desired effect when they are perceived as fair and when they swiftly follow the targeted behavior.

Confrontation should focus on negative behavior and attitudes and not on the individual.

As summarized by NIDA,[37] research has demonstrated the effectiveness of treatment approaches using contingency management (CM) principles, which involve giving patients tangible rewards to reinforce positive behaviors such as abstinence. Studies conducted in both methadone programs and psychosocial counseling treatment programs demonstrate that incentive-based interventions are highly effective in increasing treatment retention and promoting abstinence from drugs.

Consequences for participants' behavior are predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior modification.

VII. RSAT Staffing

A) In group activities, the ratio of inmates to staff should be no more than 20 to 1.

Regardless of treatment modalities employed, the ratio of treatment staff to inmates and correctional officers to inmates should be sufficient to provide an environment conducive to achieving RSAT program goals and objectives. The RSAT pod should provide for a safe environment where inmates are not distracted by extraneous commotion, noise and confusion and where they can think, reflect, and engage in constructive conversation with staff and their peers.

B) Both treatment and security staffs should receive training about substance and alcohol use disorders, trauma, and mental illness, as well as specific training about the RSAT program itself, including its mission, operations, policies, and practices. Training should also promote cultural competence.

Both treatment staff and correctional officers should understand RSAT standards, philosophy, benchmarks, and objectives. Both should be expected to attend and participate in relevant program activities, including daily or weekly meetings and community meetings (with inmates). Both should be involved in discipline, inmate performance reviews, including whether inmates advance to the next phase of treatment, assessments, and clinical supervision. Both should be involved in cross training, including implementation of assessment instruments, MI techniques, accountability training, and addiction related trainings.

Treatment staff should attend correctional officer training and security related training and correctional officers should be exposed to treatment training. In addition to initial training, all staff should be required to complete a regimen of in-service training to keep up with latest evidence-based treatment. Whether the primary modality of treatment is a modified therapeutic community or not, counselors and correctional officers should be trained as a team.

[37] *NIDA Principles of Drug Addiction: A Research-Based Guide* (Third Edition).

C) Correctional officers should not be assigned to RSAT pods that lack training and should have an interest in working in RSAT programs.

To be effective, substance and alcohol abuse treatment programming should take up 50 to 70% of an abuser's time. This requires a joint correctional officer and treatment staff collaborative effort so that inmates are involved in the program beyond the limited hours counselors are available in the institution. In turn, this means that correctional officers must understand RSAT programming and be as committed to treatment as RSAT counselors and administrators.

D) Treatment and correctional officers should be represented in program administration.

Treatment providers and correctional officers, whether the former is contracted out or in house, should be centrally involved in program administration, operation, and direction. The most promising RSAT programs represent a collaboration among treatment staff, correctional officers and prison/jail administrators where each recognizes the needs of the others.

VIII. Transition and Aftercare Planning

Required by Statute/BJA:

States must give preference to subgrant applicants who will provide aftercare services to program participants. Such services must involve coordination between the correctional treatment program and other human service and rehabilitation programs, such as education and job training, parole supervision, halfway houses, and self-help and peer groups, that may help in rehabilitating offenders.

There have been two national evaluations of RSAT programs.[38] Both reached the same conclusion that the major challenge facing RSAT programs was development of post-release continuing treatment and care in the community.

As summarized in the first 2003 study: "Although research shows that aftercare leads to a reduction in re-offense rates, less than half of RSAT programs were able to include an aftercare component, largely because RSAT funds can be used only for residential treatment for offenders in custody" (p. 6). The second, two years later, concern for aftercare programming was repeated, admonishing RSAT programs to "(f)ocus on providing coordinated treatment and reentry into the services for offender aftercare community" (p. 13).

For many years, RSAT funding for aftercare was limited to 10% of the grants provided. This was lifted two years ago, but at the same time RSAT funding was greatly reduced so that no additional monies were actually available for RSAT funded aftercare. Nonetheless, RSAT programs should help inmates connect to the community resources, mobilize family and pro-social peers, and help the inmate develop a pro-social peer network, by encouraging Peer-To-Peer Learning, Peer Reentry Liaison and engagement in Twelve Step/Mutual Help/Faith Networks. All of this, in addition to specific treatment and service referrals.

[38] Harrison, L., & Martin, S. (2003). Residential Substance Abuse Treatment for State Prisoners, Implementation Lessons Learned, NIJ Special Report, DOJ, OJP, NIJ; ___ (2005). Residential Substance Abuse Treatment for State Prisoners (RSAT) Program, Program Update, DOJ, OJP, BJA.

Aftercare requires transition planning/programming, pre-release planning, a warm handoff to community-based treatment provider where practical, health insurance, Medicaid enrollment pre-release, referrals for employment/education, treatment, physical and behavioral case management, coordination with parole/probation, and first dose of medication where appropriate.

A) Continuity of care is essential for drug abusers re-entering the community.

Offenders who complete prison-based treatment and continue with treatment in the community have the best outcomes.[39] Continuing drug abuse treatment also helps the recently released offender deal with problems that become relevant after release, such as learning to handle situations that could lead to relapse, learning how to live drug-free in the community, and developing a drug-free peer support network. Treatment in prison or jail can begin a process of therapeutic change, resulting in reduced drug use and criminal behavior post-incarceration. Continuing drug treatment in the community is essential to sustain these gains. Regardless of the choice of intervention, positive outcomes from prison-based drug treatment programs are most likely to persist when offenders participate in post-release community treatment. The success of a continuing care model, which involves prison treatment followed by community treatment, is contingent on the released inmate appearing for admission to the community treatment program and continuing to attend. Many released inmates do not do so, even in States where post-release treatment is a condition of release, parole or probation.

B) Pre- and post-release case management systems should be included in RSAT programming to help support a smooth transition to the community.

Preparing an inmate for release to the community involves linkages to various departments and staff both inside and outside the corrections facility. One of the major obstacles faced by many reentry programs is poor follow through and follow up after release. It is important to accomplish as much as possible regarding recommended services prior to release. This includes ongoing communication with treatment staff, providers, and community corrections personnel. Some of these tasks include:

- Making after care appointments prior to release.
- Have multidisciplinary staffings at regular intervals during treatment.
- Reassess criminogenic needs at regular intervals.
- Collaborate with Community Corrections staff to ensure continuity of treatment and other services, including the transfer of treatment records.

If inmates will not be under correctional supervision after release, RSAT programs must motivate graduates to continue treatment on their own and help them put together a plan to get the supports they will need to assist them to remain drug-free after release.

Drug addiction is a serious problem that can be treated and managed throughout its course. Effective drug abuse treatment engages participants in a therapeutic process, retains them in treatment for an appropriate length of time, and helps them learn to maintain abstinence. Multiple episodes of treatment may be required. Outcomes for drug abusing offenders in the community can be improved by monitoring drug use and by encouraging continued participation in treatment.

[39] Fletcher & Chandler, R. (2006). *Principles of drug abuse treatment for criminal populations*. National Institute of Drug Abuse, Office of Science Policy and Communications.

C) If inmates will be under correctional supervision upon release, the RSAT program should collaborate with probation/parole workers to incorporate aftercare treatment and services.

RSAT personnel should work with inmates' post release supervisors to plan for the inmates' transition to community-based treatment and links to appropriate post-release services to improve the success of drug treatment and reentry. Abstinence requirements may necessitate a rapid clinical response, such as more counseling, targeted intervention, or increased medication to prevent relapse. Ongoing coordination between corrections and treatment providers is important in addressing the complex needs of these re-entering individuals.

D) Treatment planning for drug abusing offenders who are re-entering the community should include strategies to prevent and treat serious chronic medical conditions such as HIV/AIDS, hepatitis B and C, and tuberculosis, as well as overdose prevention.

The rates of infectious diseases, such as hepatitis, tuberculosis, and HIV/AIDS, are higher in drug abusers, incarcerated offenders, and offenders under community supervision than in the general population. Infectious diseases affect not just the offender, but also the criminal justice system and the wider community. Consistent with Federal and State laws, drug-involved offenders should be offered testing for infectious diseases and receive counseling on their health status and on ways to modify risk behaviors. Released RSAT graduates should be linked with appropriate health care services, encouraged to comply with medical treatment, and re-establish their eligibility for public health services (e.g., Medicaid, county health departments) before release from prison or jail. Inmates and their families should be informed on the availability of Naloxone and its use to prevent overdose deaths. Where available, they should be encouraged to have the medication on hand in case of emergency need.

IX. Measuring Results

The performance measures required by the Bureau of Justice Assistance are not sufficient in and of themselves to provide adequate measures of RSAT outcomes necessary for evidence-based practice and/or to determine if programming maintains fidelity to the evidence-based programs adopted. Although no program can be implemented with the exact same population of participants or under the same circumstances as the model, it is crucial that the key components of the model are implemented without compromising their integrity.

A) In-program outputs should include program participation, completion rates, urine test results, and the like. Program outcomes should include rearrests, reincarcerations, entrance and retention in treatment, relapses, drug overdose emergency room visits, and drug overdose deaths.

How an inmate performs in a RSAT program, called program outputs, does not reveal how well they will do once released. To determine program effectiveness, RSAT programs should follow how program graduates do after they are released, called program outcomes. The most easily obtained outcome measure is recidivism, new arrests and reincarcerations. Other important outcomes are measures of substance abuse relapse, generally associated with length of time in treatment. The most critical relapse outcomes that should be measured are death from overdoses and emergency room treatment for overdoses.

B) RSAT programs should encourage independent evaluations to determine how the outcome measures compare to other inmates involved in other correctional programs or no programming. Generally speaking, the comparison of inmates who complete the RSAT program with those who do not does not provide a sound measure of program effectiveness. The evaluation should also determine whether the program serves all subpopulations equally well.

It is difficult to evaluate a program's effectiveness without a random comparison group of like individuals. Generally, sophisticated evaluative research requires an independent research effort where there is no conflict of interest between the program and the researcher. It is important, however, that the researcher has a full understanding of the program and the population studied and the criminal justice context as well as allowing program officials to comment on the findings to ensure that the research has adequately interpreted the data found. For example, given the subjects involved, some RSAT grads may be reincarcerated subsequent to release but for charges that arose prior to their RSAT participation. Researchers must know how to read criminal records to decipher such circumstances.

To ensure that the RSAT program works as well for members of historically disadvantaged groups than non-disadvantaged groups, female as well as male inmates, the outputs and outcomes of the former should be compared against those of the latter. Differences may reveal a programmatic bias that is not obvious or may require more investigation to diagnose.

Evaluations should include all inmates initially referred to the RSAT program, including those that may drop or terminated before completing the program. Although an RSAT program might boast, for example, a perfect record among those that successfully complete the program, it may be that the vast majority of inmates that enter the program never complete it. Further, an analysis of the non-completers might reveal that the completers are only those inmates with the lowest risk/need scores of those admitted into the program or disproportionately one race or ethnicity suggesting the program lacks the cultural competence to deal with diverse populations. Intent-to-Treat analysis will inform the program whether it should limit its admission to those it is most effective for, or change its program to accommodate more diverse inmates.

The shorter the follow up, the more successful the program is likely to appear. Many criminal justice interventions appear to be successful in terms of recidivism at six months. However, if the time period is lengthened, the success rates decline dramatically. Generally speaking, to have much validity, follow up measures should be for at least a year or more.

C) Timely and reliable data entry is key for RSAT programs to make course adjustments to improve inmate outcomes.

Although in-depth independent evaluations are recommended, RSAT programs should review performance data periodically to measure progress and make incremental adjustments as indicated. There should be a system in place to capture data in a timely manner with as much accuracy as possible. If programs are to learn from their results, the results should be as current as possible because no program is stagnant. RSAT programs evolve and change over time as staff, correctional officers, prison/jail policies, and inmate populations change.

Postscript

This collection of promising practices guidelines is designed to be a living document. As more research is completed and as more feedback is received from RSAT programs across the nation and U.S. territories, these guidelines will be updated and revised. Lest it be forgotten, however, research has found that the quality of the interpersonal relationship between staff and the offender, along with the skills of the staff, is as important or more important to reducing risk than the specific programs in which offenders participate.[40]

[40] NIC, *Implementing EBP in community corrections: The principles of effective intervention*, retrieved from https://s3.amazonaws.com/static.nicic.gov/Library/019342.pdf; Crime and Justice Institute. (2010). Implementing evidence-based practices, revised. Center for Effective Public Policy.

Appendix

I. Participants in RSAT PPG Roundtable
II. Description of Evidence-Based Programs

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Description of Evidence-Based Programs

National Institute on Drug Abuse Cognitive Behavioral Therapy
CBT was originally developed to prevent relapse for problem drinking, and was later applied to cocaine addicted individuals. The program emphasizes the importance of learning processes in the development of maladaptive behaviors. Participants identify and correct these maladaptive behaviors by applying different skills to deal with drug abuse as well as other co-occurring problems. CBT in particular focuses on the enhancement of a participant's self-control through a variety of coping strategies. (https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral)

Contingency Management Interventions/Motivational Incentives
CM principles involve reinforcing positive behaviors (e.g., abstinence) in substance misusers with tangible rewards. Incentive-based treatments have proven to be highly effective in promoting abstinence from drugs. They typically are done using either voucher-based reinforcement, in which patients receive vouchers with monetary value that increase with every drug-negative urine sample, or through prize incentives in which patients are given the chance to win prizes for every drug-negative test they receive. (https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-0)

Community Reinforcement Approach Plus Vouchers
CRA is an "intensive 24-week outpatient therapy for treating people addicted to cocaine and alcohol." The two goals of CRA are: to maintain short term abstinence among its patients so that they can develop new life skills that serve to sustain abstinence in the long term; and to reduce alcohol consumption in patients whose cocaine use is associated with their drinking. To do this, CRA uses a range of social reinforcers and material incentives to make a drug-free lifestyle more rewarding than substance abuse. (https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-1)

Motivational Enhancement Therapy
MET promotes rapid and internally motivated change among patients through a counseling approach that helps individuals resolve their uncertainty about taking part in treatment and stopping their drug use. In general MET is most effective with adults who are addicted or dependent on alcohol and marijuana. It is seen as a more effective method for engaging drug abusers in treatment rather than as a way to produce changes in their drug use. (https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-2)

The Matrix Model
The Matrix Model provides a framework for patients to reach abstinence. In this treatment patients are instructed and supported by a therapist who acts as both a teacher and a coach. Patients learn about critical issues regarding their addictions and are familiarized with self-help programs. The Matrix Model uses a wide variety of treatment materials drawn from other tested treatment approaches (e.g., family and group therapy, 12-step programs). (https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-3)

Twelve-Step Facilitation Therapy
This therapy uses the principles of acceptance, surrender, and active involvement to increase the likelihood of a substance abuser becoming affiliated with a 12-step self-help group. Acceptance that drug addiction is a disease over which the patient has no control and that abstinence is the only alternative. Surrender to the fellowship and support of other recovering addicts and to the activities of the 12-step programs. Active involvement in 12-step meetings and associated activities. (https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-4)

Family Behavior Therapy
FBT focuses on addressing both substance abuse problems and co-occurring problems like conduct disorders, child mistreatment, depression, family conflict, and unemployment. It includes both the patient and at least one family member or significant other. Skills taught in this therapy are aimed at improving the home environment of patients. (https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-5)

Behavioral Therapies/Multisystemic Therapy
Behavioral therapies are uniquely adapted for drug-abusing adolescents to often include family involvement. One adaptation of behavioral therapy is multisystemic therapy (MST). MST examines the factors associated with antisocial behavior in drug-abusing children and adolescents. Treatment is often done in natural environments and addresses factors like: the child's characteristics, their family, their peers, their school, and their neighborhood to reduce drug use and incarcerations. (https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-6)

Pharmacotherapies
Methadone
Methadone is a long-acting synthetic opioid agonist medication that can prevent withdrawal symptoms and reduce craving in opioid-addicted individuals. It can also block the effects of illicit opioids. It has a long history of use in treatment of opioid dependence in adults and is taken orally. Methadone maintenance treatment is available in all but three States through specially licensed opioid treatment programs or methadone maintenance programs. It should be combined with behavioral treatment.

Buprenorphine
Buprenorphine is a synthetic opioid medication that acts as a partial agonist at opioid receptors—it does not produce the euphoria and sedation caused by heroin or other opioids but is able to reduce or eliminate withdrawal symptoms associated with opioid dependence and carries a low risk of overdose. Buprenorphine is currently available in two formulations that are taken sublingually: (1) a pure form of the drug and (2) a more commonly prescribed formulation called Suboxone, which combines buprenorphine with the drug naloxone, an antagonist (or blocker) at opioid receptors. Naloxone has no effect when Suboxone is taken as prescribed, but if an addicted individual attempts to inject Suboxone, the naloxone will produce severe withdrawal symptoms. Buprenorphine treatment can be provided in office-based settings by qualified physicians who have received a waiver from the Drug Enforcement Administration (DEA).

Naltrexone
Naltrexone is a synthetic opioid antagonist—it blocks opioids from binding to their receptors and thereby prevents their euphoric and other effects and reduces cravings for opioids. It can be taken orally, either daily or three times a week or injected for 28 days (Vivitrol®). Addicts must be opioid free 7 to 10 days

before an injection. Naltrexone also blocks receptors that are involved in the rewarding effects of drinking and the craving for alcohol.

Acamprosate

Acamprosate (Campral®) acts on the gamma-aminobutyric acid (GABA) and glutamate neurotransmitter systems and is thought to reduce symptoms of protracted withdrawal, such as insomnia, anxiety, restlessness, and dysphoria. Acamprosate has been shown to help dependent drinkers maintain abstinence for several weeks to months, and it may be more effective in patients with severe dependence

Disulfiram

Disulfiram (Antabuse®) interferes with degradation of alcohol, resulting in the accumulation of acetaldehyde, which, in turn, produces a very unpleasant reaction that includes flushing, nausea, and palpitations. if a person drinks alcohol. The utility and effectiveness of disulfiram are considered limited because compliance is generally poor. However, among patients who are highly motivated, disulfiram can be effective, and some patients use it episodically for high-risk situations, such as social occasions where alcohol is present. It can also be administered in a monitored fashion, such as in a clinic or by a spouse, improving its efficacy.

Topiramate

Topiramate is thought to work by increasing inhibitory (GABA) neurotransmission and reducing stimulatory (glutamate) neurotransmission, although its precise mechanism of action is not known. Although topiramate has not yet received FDA approval for treating alcohol addiction, it is sometimes used off-label for this purpose. Topiramate has been shown in studies to significantly improve multiple drinking outcomes, compared with a placebo.
https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapi-1

Substance Abuse and Mental Health Services Administration
Creating Lasting Family Connections Fatherhood Program

Provides services to reduce substance misuse, support recovery, and reduce repeat offenses among fathers and father-like figures who experience dissonance due to incarceration, substance misuse, or military service. (SAMHSA.gov)

Forever Free

Provides individualized substance abuse treatment with case planning for incarcerated women influenced by a 12-step model. The program teaches clients life skills to cope with life stress while helping them gain self-respect and a sense of empowerment. Serves the psychological needs of the women through in prison counseling, group services, educational workshops, 12-step programs, relapse prevention training, and community aftercare. (https://www.ncjrs.gov/pdffiles1/Digitization/152194NCJRS.pdf)

Helping Women Recover and Beyond Trauma

Two programs combined to serve women with substance use disorders who have co-occurring trauma histories. They aim to reduce substance use, encourage involvement in voluntary aftercare treatment upon parole, and reduce the likelihood of reincarceration. The programs use a series of trauma informed treatment sessions in group settings with female counselors. (http://mha.ohio.gov/Portals/0/assets/Initiatives/TIC/SAMHSAEvidenceBasedProgramsandPractices/Helping%20Women%20Recover%20and%20Beyond%20Trauma.pdf)

Interactive Journaling

"A structured and experimental writing process that motivates and guides participants toward positive life changes." The program provides resources that help people apply meaningful information to

their own lives to promote lasting change. (http://mha.ohio.gov/Portals/0/assets/Initiatives/TIC/SAMHSAEvidenceBasedProgramsandPractices/Helping%20Women%20Recover%20and%20Beyond%20Trauma.pdf)

Living in Balance
A program for adults in correctional facilities with issues relating to substance abuse, crime, treatment, and violence. It consists of a series of psychoeducational training sessions both on an individual basis and in groups. These sessions involve a large amount of role play to improve the client's level of functioning in a variety of life areas. (http://www.nrcpfc.org/ebp/downloads/AdditionalEBPs/Living_in_Balance_(LIB)_8.26.13.pdf)

Moral Reconation Therapy
MRT is a treatment strategy that aims to reduce reincarceration among juveniles and adult offenders by increasing moral reasoning. Through group and individual counseling MRT addresses ego, social, moral, and positive behavioral growth. It focuses on seven basic treatment issues: "confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of higher stages of moral reasoning." (http://www.nrcpfc.org/ebp/downloads/AdditionalEBPs/Moral_Reconation_Therapy_(MRT)_8.26.13.pdf)

TCU Mapping Enhanced Counseling
Provides evidence based guides for adaptive treatment services. They are developed from cognitive behavioral models designed for substance abuse treatment counselors. The manuals provide focused, time-limited strategies for engaging clients in important recovery discussions. (http://jpo.wrlc.org/bitstream/handle/11204/2151/3310.pdf?sequence=1)

Correctional Therapeutic Community
A program for clients with substance use disorders provides for an isolated community of participants to promote recovery and prevent relapse. The program separates participants from the general prison populace in order to enhance the effectiveness of the rehabilitative communities. (https://www.ncjrs.gov/ondcppubs/treat/consensus/lipton.pdf)