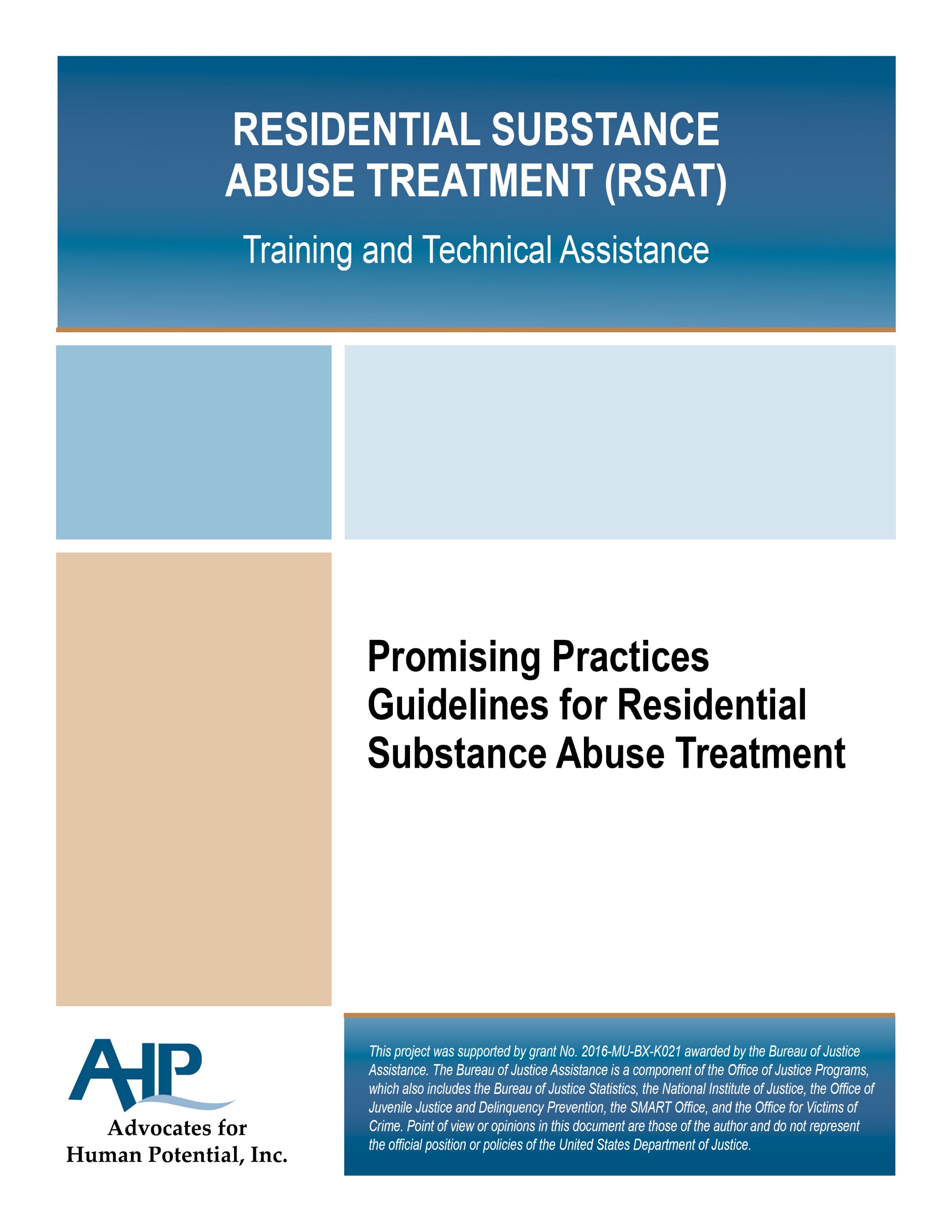
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Promising Practices Guidelines for   
Residential Substance Abuse Treatment

# 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 use disorder 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 incarcerated individuals.

Congress has set limited basic requirements for RSAT programs. Programs in state correctional facilities must be at least six months in length, and participants must be physically separated from the general population. Jail-based programs must be at least 90 days in length and physically separated from the general population if the facility permits. RSAT participants are required to be randomly tested for illicit drugs at admission into the program and during the program. The RSAT programs, if possible, are to be limited to participants 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 individuals; 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 individuals 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.

The Justice Department National Institute of Justice Crime Solutions registry lists only four studies of RSAT programs that have been found promising. None has received enough study for rating beyond “promising.” Programs rated as promising have some evidence to indicate they achieve their intended outcomes, but they have not been studied enough to be rated as “effective.” Programs rated as “effective,” the highest rating, by contrast have strong evidence to indicate they achieve their intended outcomes when implemented with fidelity. As stressed in the registry, however, the Registry is not intended **“to replace or supersede informed judgment and/or innovation.”** “We recognize that rigorous evaluation evidence is one of several factors to consider in justice programming, policy, and funding decisions. We also recognize the importance of encouraging and supporting innovative approaches that may not yet have extensive evidence of effectiveness.[[1]](#endnote-1)

The four Registry recognized RSAT programs include: 1) the Minnesota Department of Correction substance use disorder treatment program based on the therapeutic community (TC) model; 2) the Forever Free Program at the California Institute for Women that follows a cognitive-behavioral curriculum stressing relapse prevention designed by Gorski;[[2]](#endnote-2) 3) the Amity In-Prison Therapeutic Community located in a medium security prison in San Diego that uses workbooks, teacher’s guides, and videotapes as well as psychodrama groups and “lifer mentors,” highly committed, recovering substance users with criminal histories, and 4) the Delaware Department of Correction Key/Crest programs that begins with a prison TC component and continues with post-release community TC treatment.

The four programs vary considerably, reflecting the wide diversity of RSAT programs around the country and U.S. territories**.** The Minnesota RSAT provides 15-25 hours per week of programming with a staff to participant ratio of 1:15. Minnesota abandoned its 90-day program after it was found to be less effective than two longer term programs, one lasting 180 days and the other 365. The medium program of 180 days proved to be the most effective in reducing recidivism.

The California Forever Free program is six months and reserved for women at the end of their sentences. It provides 4 hours of programming a day, five days a week plus 8 hours of day work or education assignments, individual substance abuse counseling, special workshops, educational seminars, 12-step programs, parole planning and urine testing. The Gorski curriculum was designed to assist clients in identifying symptoms of post-acute withdrawal and relapse and teach clients skills and strategies to successfully deal with them.

The Amity In-Prison program is also a TC program. Research found it had its greatest effect, however, when its In-Prison graduates then completed up to a year of post-release residential TC treatment.

Finally, the Delaware RSAT program lasts 12 to 18 months and includes constant staff oversite and access, but only twice a week meeting group sessions. Aftercare includes six months in the residential Crest program, the last 3 months of which included daily work release. While the Key/Crest Programs were found to be effective, the Key Program alone findings were mixed, with some studies finding it effective and others not.

Again, what the few studies reported above suggest is that RSAT programs that have been studied and found to be promising vary in terms of gender served, geographical locations, treatment modalities adopted, length, structure, and aftercare. As a result of the limited study of RSAT programs, and the diversity of the few evidence-based RSAT programs documented, 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.

Reading the Guidelines

Each of the following nine sections begin with a general guideline issue/activity, indicated by a Roman Numeral, followed by specific practices that have been found to constitute promising practices in regard to that issue/activity. These are each contained in gray boxed texts and denoted alphabetically. The Guide describes the rationale for each promising practice and a brief description of the practice. It may also include the major relevant research (labeled **Research**) that suggests the evidence behind the practice and an example of a state department of corrections that currently incorporates that practice in its official protocols and procedures (labeled **State Department of Correction Protocol**).

The Appendix includes additional guideline more specifically focusing on medication assisted treatment programming for incarcerated individuals. It is extracted from a larger publication that addresses promising practice guidelines for ensuring access to medication assisted treatment for justice-involved populations at all criminal justice intercept points from police diversion to parole.

# 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 potential participants. For this reason, it is important that these personnel are fully apprised of RSAT eligibility criteria.

### A. Individuals with substance use disorders should be eligible for RSAT. To determine whether a potential participant has a substance use disorder, they should be screened using a validated instrument.[[3]](#endnote-3) However, low risk individuals with substance use disorders may be better treated in less restrictive alterative facilities, including pre-release centers, half-way houses or diversion programs in the community.

Individuals 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. Further, in most jails, all individuals, low, medium or high risk are generally housed together anyway, although state correctional systems may maintain separate maximum, medium or minimum security facilities.

As admission generally occurs at the end of an individual’s sentences, risk levels can change since the day of incarceration. Most validated risk instruments are based on historical measures, not contemporary circumstances. Facing the challenge of reentry into the community, some may be at higher risk for reoffending than they were upon entry into the institution. Others may be much lower risk for reoffending, but high risk for relapse and recidivism.

Research: A study of 30,237 released by the Washington Department of Corrections found 443 died during an average follow up period of less than two years. The overall mortality rate was 77.7 deaths per 10,000 person-years. The adjusted death rates for those released from incarceration was 3.5 times than among other state residents. During the first two weeks after release, the risk of death was 12.7 times than among other state residents, with a much more markedly elevated relative risk of death from drug overdose (129 times). Following deaths by overdose were deaths as a result of cardiovascular disease, homicide and suicide.[[4]](#endnote-4) The revised December 2015 overdose death rates posted by the

National Institute of Drug Abuse reports drug overdose deaths rising across the country from the two years before for prescription drugs, prescription opioid pain relievers, Benzodiazepines, Cocaine, and Heroin.

State Department of Correction Protocol: The State of Washington Department of Corrections policy for substance use disorder treatment services includes in its “Triage for Priority Placement” non-criminogenic factors including “pregnant or postpartum offenders,” and “HIV/AIDS or Hepatitis C positive offenders.”[[5]](#endnote-5)

### B. Although RSAT participation is voluntary, incarcerated individuals 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 individuals 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. Individuals 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.

RSAT staff should assess potential participants’ readiness to change and adapt programming to match their stage of readiness.

### C. Individuals 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. For this reason, co-occurring disorders should be identified by utilization of a validated screening tool.[[6]](#endnote-6)

The overlap between substance use disorders and mental illness, including trauma, is substantial. Studies have found that up to 59% of state prisoners with mental illness have a co-occurring substance use disorder.[[7]](#endnote-7) To deny individuals admission to RSAT because of mental disorders has the potential to preclude too many individuals with substance use disorders in need of treatment. RSAT programming should be designed and implemented to meet the diverse needs of incarcerated populations. Allowing individuals with mental health disorders to continue to take prescribed antipsychotic medications and incorporating mental health treatment will allow many to be able to participate in RSAT programming.

### D. Following screening, either before or after being admitted to RSAT, individuals 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 participants.

Once screened for admission into RSAT, individuals 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 and not reoffend. Assessment is the first step in treatment.[[8]](#endnote-8)

Individuals differ in terms of age, gender, ethnicity and culture, substance use disorder severity, readiness to change, recovery stage, and level of required supervision. Individuals also respond differently to different 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.

Although the more limited duration of many jail RSAT programs may also limit the ability of the programs to provide intensive individualized treatment programming, completing individualized assessments may allow programs to at least define subgroups of participants with similar needs so that programming can better meet their specific sets of need.

The American Society of Addiction Medicine (ASAM) calls for the following to constitute comprehensive assessment:[[9]](#endnote-9)

* A physical exam
* A mental status exam
* Medical and psychiatric history
* A detailed past and present substance use history, including assessment of withdrawal potential
* A history of the pathological pursuit of reward or relief through engagement in addictive behaviors such as gambling or exercise
* Substance use disorder and addictive disorder treatment history and response to previous treatment, including history of use of pharmacotherapies and response to such interventions
* Family medical, psychiatric, substance use, addictive behavior and addiction treatment history
* Allergies
* Current medications
* Social history
* Consultation with appropriate collateral sources of information
* A summary of the patient’s readiness to engage in treatment, potential to continue unhealthy use or return to unhealthy engagement in substance use or addictive behaviors, and the recovery environment that can support or impede recovery
* Diagnostic formulation(s)
* Identification of facilitators and barriers to treatment engagement including patient motivational level and recovery environment

State Department of Correction Protocol: The Hawaii Department of Corrections Procedures include the following: “All patients with a drug or alcohol history shall be referred to a provider for a physical examination including:

1. an assessment of their current medical condition;
2. documentation on the medical record regarding health care findings;
3. prescription of condition specific medications, as needed;
4. referral to mental health services for documented assessments and follow-up; and
5. the ordering of appropriate diagnostic tests to evaluate for the occurrence of associated disorders such as liver disease.”[[10]](#endnote-10)

## II. Treatment Programming

REQUIRED BY STATUTE:

Treatment practices/services should be, to the extent possible, evidence- based and should develop participants’ 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 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 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 (including age, gender, ethnicity and race, special needs, culture, and so on); 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. As concluded in the Crime Solution Registry of evidence-based correctional programs, however, innovation requires experimentation, trying new approaches, and building on evidence-based programming to both meet the evolving needs of RSAT participants as well as the evolving dictates of research. Treatment and correctional staff need the knowledge and skills to use any program. There needs to be a feedback loop to see that the program fits, is implemented with fidelity, and works as implemented.[[11]](#endnote-11)

Clinical supervision of RSAT treatment staff may both help ensure fidelity to the treatment model as well as offer support to RSAT counselors and staff.

### C. Offenders with co-occurring drug and/or alcohol abuse and mental health issues require an integrated treatment approach.[[12]](#endnote-12)

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.[[13]](#endnote-13)

### D. Medications should be considered part of the contemporary standard of care for the treatment of individuals with alcohol and opioid use disorders and also for individuals with co-occurring mental illness.

Medicines used in medication-assisted treatment (MAT), such as Methadone, Buprenorphine, and Naltrexone, for opioid use disorders and Naltrexone, Acamprosate Calcium and Disulfiram for alcohol use disorders should be made available to individuals who could benefit from them.[[14]](#endnote-14),[[15]](#endnote-15) 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 potential RSAT participants 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.[[16]](#endnote-16)

If RSAT participants are on prescribed FDA-approved agonist (Methadone) or partial agonist (buprenorphine) 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. Programs should also assist RSAT graduates obtain access to appropriate medication upon release if they, their physicians and treatment providers deem it appropriate.

Medication assisted treatment begun or continued in prison or jail results in much higher rates of aftercare treatment entry post-release than inmates who receive in-jail or prison treatment without medication.

The National Governors Association has called upon state corrections to: 1) increase access to MAT in prisons and correctional settings; 2) ensure continued access to MAT upon reentry into the community; and 3) provide overdose education and naloxone for offenders during the re-entry process, when they are most vulnerable to overdose.[[17]](#endnote-17) The National Commission on Correctional Health Care adopted the following position in 2015 that also includes that correctional staff “undergo training that includes education regarding opioid overdose and its signs; correct technique for administration of naloxone, either by intramuscular injection (medical staff) or by nasal inhalation (medical and nonmedical staff); positioning of the individual; and essential related procedures, including performance of cardiopulmonary resuscitation and emergency transfer of the individual to a facility equipped to treat overdose.”[[18]](#endnote-18)

Research: A trio of studies typify the effectiveness of these medications specifically for prison and jail populations. A randomized clinical trial of prison-initiated Buprenorphine provided to male and female individuals who were previously heroin dependent prior to incarceration found that those 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.[[19]](#endnote-19) A study at Riker’s Island jail in New York City found the use of injectable Naltrexone decreased illicit opioid use by more than 50% following release.[[20]](#endnote-20) And a Methadone maintenance treatment with counseling in a Baltimore prison that continued upon release reported half the rate of illicit opioid use compared to those who received counseling only.[[21]](#endnote-21)

*Note:*Additional, more detailed and specific guidelines on MAT are included in the Appendix.

### 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 participants to remain in RSAT programs at least for these minimum lengths. Potential RSAT participants should be advised in advance, however, if RSAT program completion will impact on their eligibility to be considered for early release, one way or the other.

Research: Two studies of a jail RSAT program found that those who did not complete their RSAT program, including those who did not complete because they were granted early parole, had significantly higher recidivism rates post release than those who complete the program.[[22]](#endnote-22) Graduation from one phase to the next should be based on behavior, not time.

### F. RSAT treatment programs should be provided in flexible phases, based on participants reaching specified behavioral and recovery milestones.

As recommended by the Adult Drug Court Best Practice Standards Committee, RSAT programming should be designed so that participants 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 phase, services are provided that are designed to maintain treatment gains by enhancing RSAT participants’ long-term adaptive functioning.[[23]](#endnote-23)

### G. RSAT programs should be culturally competent.

The development of culturally responsive clinical skills is vital to the effectiveness of behavioral health services. According to the U.S. Department of Health and Human Services (HHS), cultural competence “refers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time.” Culturally responsive skills can improve client engagement in services, therapeutic relation-ships between clients and providers, and treatment retention and outcomes. Cultural competence is an essential ingredient in decreasing disparities in behavioral health.[[24]](#endnote-24)

Knowledge of a culture’s attitudes toward mental illness, substance use, healing, and help-seeking patterns, practices, and beliefs is essential in understanding iindividuals’ presenting problems, developing culturally competent counseling skills, and formulating culturally relevant agency policies and procedures. RSAT staff need to learn and understand how identification with one or more cultural groups influences each client’s worldview, beliefs, and traditions surrounding initiation of use, healing, and treatment.[[25]](#endnote-25)

SAMHSA has developed a checklist to evaluate cultural competence in treatment programs and organizations, some of which is applicable for RSAT programs. The checklist as well includes acculturation and ethnic identity measures.[[26]](#endnote-26)

State Department of Correction Protocol: The Virginia Department of Corrections provides that its therapeutic community programs with substance use disorders must include, at a minimum, “culturally sensitive treatment objectives, as appropriate.”[[27]](#endnote-27)

### H. Positive programming should account for the majority of the participants’ day.

Although many RSAT participants will be segregated from the general prison or jail population, negative influences can be further minimized if individuals are involved in positive programming most of the day. For this reason, it is imperative that correctional officers who spend more direct facetime with participants 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 RSAT participants positively engaged is one of the reasons why many RSAT programs employ modified therapeutic communities to address participants’ substance use disorders. Some programs use activity logs to track participants’ structured activities. Others provide participants with electronic tablets that can be monitored to measure time spent on specific educational or treatment programming available on the tablet.

### I. Recovery support is a critical component of ongoing recovery success during RSAT treatment and after release.

Connections to safe and supportive peers, other people in addiction recovery, and pro-social networks of support are important components of successful RSAT programs. Often re-entering individuals with long histories of substance use have very few contacts on the outside that are not connected with drug and alcohol use. Some have no contact with supportive family members; even a good friend who does not use drugs may be a thing of the past. Increasing RSAT participants’ connections to pro-social peer support begins in the treatment setting and is a key aspect of the therapeutic community approach. Recovering peers have role in treatment settings - distinct from staff. In RSAT programs, an outside peer recovery presence is desirable; however, peers who have completed treatment and are awaiting release can serve a similar purpose. Just as peers are not qualified to do certain things that counselors do, peers are uniquely qualified to do what professionals cannot. These unique contributions fall into four categories that complement professional services. Peers in addiction recovery can:

1. Promote hope through positive self-disclosure; assuring others that recovery is possible.
2. Model recovery thinking, re-entry success, positive parenting, and gainful employment.
3. Share knowledge, unwritten rules, resources, and pro-social "street smarts,” vital for navigating social services systems.
4. Engage others in informal networks of support that provide an alternative to anti-social companions and activities.

Recovery coaching, mentoring, attendance at recovery support groups, and connections to local recovery community resources are examples of peer-led elements of successful RSAT programs.

Research: Multiple studies have verified the effectiveness of peer support programs for adolescents in the juvenile justice system, women offenders, justice-involved veterans, and adult offenders in addition to treatment.[[28]](#endnote-28)

## III. Treatment Modalities and Structured Program Activities

### A. RSAT treatment programming should be responsive to a diverse population, include both group and individual counseling, delivered in a therapeutic milieu that supports and reinforces the acquisition of skills required to sustain recovery, and be periodically reviewed to ensure adopted modalities provide the best fit for participants.

Treatment programs should include both group and individual counseling to accommodate diverse needs of participants. Both cognitive behavioral therapy and modified therapeutic communities have been found to be effective treatment modalities for RSAT programs. NIDA has listed the following behavioral therapies as helpful to 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)
* Therapeutic Communities (TC)
* Contingency management (CM) interventions/motivational incentives
* Community reinforcement approach (CRA) plus vouchers
* Motivational enhancement therapy (MET)
* The Matrix Model
* Twelve-step facilitation therapy
* Family behavior therapy (FBT)
* Behavioral therapies, including Multisystemic Therapy (MST)[[29]](#endnote-29)

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.[[30]](#endnote-30)

The Substance Abuse and Mental Health Services Administration (SAMHSA) lists the following as 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](http://nrepp.samhsa.gov/ViewIntervention.aspx?id=324) 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.[[31]](#endnote-31)

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.

RSAT programs have also found evidence-based manualized treatment interventions 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.[[32]](#endnote-32) The quality of the interpersonal relationships between staff and the offenders, along with the skills of the staff, are as important to risk reduction as the specific programs in which offenders participate.[[33]](#endnote-33)

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

Incarceration-based Therapeutic Communities (TCs) for adults have been found to be effective for multiple crime/offense types. TCs use a comprehensive, residential drug treatment program model for treating substance-abusing and addicted populations to foster changes in attitudes, perceptions, and behaviors related to substance use. The practice is rated “Effective” in Crime Solutions, reducing recidivism rates after release for participants in the TCs. The defining feature of TCs is the emphasis on participation by all members of the program in the overall goal of reducing substance use and recidivism. The TC theory proposes that recovery involves rehabilitation to learn healthy behaviors and habilitation to integrate those healthy behaviors into a routine.[[34]](#endnote-34) TCs differ from other models of treatment by their focus on recovery, overall lifestyle changes, and the use of the “community” as the key instrument for that change.[[35]](#endnote-35) The community includes peers and facility staff. TCs use a stepping-stone model in which participants’ progress through several levels of treatment. As they progress through each treatment level, their level of responsibility also increases. TCs are implemented in a residential setting to help participant adjust to the idea of a community working together toward a common goal.[[36]](#endnote-36) Treatment includes aftercare and reentry services as a means of providing continued support and relapse prevention after leaving the community.[[37]](#endnote-37)

Modified therapeutic communities for offenders with mental illness and chemical abuse disorders have also been found to be “promising” in Crime Solutions.[[38]](#endnote-38)

For TCs to be most effective, the Therapeutic Communities of America, a membership organization of over 650 substance abuse and mental health treatment centers, recommends:

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.[[39]](#endnote-39)

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

1. having counselor-led groups,
2. having peer-led groups,
3. providing a process for a participant 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.

Therapeutic communities have a 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 RSAT populations. 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.[[40]](#endnote-40)

Research: Synthesized results from 30 studies that examined the effectiveness of incarceration-based therapeutic communities for adults on recidivism post-release indicated that treatment group offenders were significantly less likely to recidivate than comparison group offenders after release (odds ratio = 1.38 for the treatment group). This means that if the comparison group has an assumed recidivism rate of 35 percent, treatment group offenders have a 28 percent recidivism rate.[[41]](#endnote-41) Another analysis of 18 effect sizes on the effectiveness of incarceration-based therapeutic communities for adults on recidivism indicated that treatment group offenders were significantly less likely to recidivate than comparison group offenders (effect size = –0.12).[[42]](#endnote-42)

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

Cognitive behavioral therapy (CBT) is a problem-focused, therapeutic approach that attempts to help people identify and change dysfunctional beliefs, thoughts, and patterns of behavior that contribute to their problem behaviors. For adult offenders, CBT explains how cognitive deficits, distortion, and flawed thinking processes can lead to criminal behavior. CBT programs emphasize individual accountability and attempt to help adult offenders to understand their thinking processes and the choices they make before they commit a crime.[[43]](#endnote-43)

CBT is based on a theoretical foundation that focuses on how “criminal thinking” contributes to criminal behavior and offending. For instance, distorted cognition is a characteristic very often found in criminal offenders. This can include self-justificatory thinking, misinterpretation of social cues, feelings of dominance and entitlement, and a lack of moral reasoning. CBT is based on the idea that an offender’s cognitive deficits and criminal-thinking patterns are learned, and not inherited, behavior. Therefore, CBT interventions typically use a set of structured techniques that attempt to build cognitive skills in areas in which offenders show deficits. CBT can also restructure cognition in areas where offenders show biased or distorted thinking.

RSAT staff, officers and treatment staff, should focus on changing behavior and thinking, provide skills training and opportunities for skill rehearsal, and teach participants 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; Participants should be held accountable for CB homework and for applying CB skills or principles in their ongoing program activities.[[44]](#endnote-44)

The National Institute of Corrections (NIC) has developed a cognitive-behavioral curriculum called Thinking for a Change. The program is rated “promising” by Crime Solutions. The curriculum has made a statistically significant difference in the proportion of offenders who recidivated between the treatment group and the control group, with the latter being 57 percent more likely to be arrested during the follow-up period.[[45]](#endnote-45)

SAMHSA’s National Registry of Evidence-based Programs and Practices lists more than 20 CBT-based programs, <http://nrepp.samhsa.gov/AdvancedSearch.aspx>. Crime Solutions finds Cognitive Behavioral Therapy (CBT) for moderate and high risk adult offenders has been found to be “promising.”

Research: Aggregating the results from 32 studies to examine the impact of cognitive behavioral therapy (CBT) on crimes committed by moderate- and high-risk adult offenders, researchers found a significant effect size (-0.14) favoring the treatment group, meaning that moderate- and high-risk adult offenders who received CBT were significantly less likely to commit crime, compared with adult offenders who did not receive CBT. [[46]](#endnote-46)

### D. Motivational Interviewing (MI) for Substance Abuse strengthens participants’ motivations to stop using drugs and alcohol and constitutes an important component of RSAT programming for participants who have volunteered for treatment but with varying degrees of commitment to abstinence.

Motivational Interviewing (MI) has been found to be “effective.” MI is a brief client-centered, semi-directive psychological treatment approach that concentrates on improving and strengthening individuals’ motivations to change. MI aims to increase an individual’s perspective on the importance of change. When provided to those who abuse substances, the long-term goal is to help them reduce or stop using drugs and alcohol. MI targets individuals who are less motivated or ready to change, and who may show more anger or opposition. MI can target substance abusers who may be ambivalent about changing their behavior. MI is a brief intervention. The substance abuser and the MI counselor will typically meet from one to four times, for about 1 hour each session. The settings of delivery can vary and consist of aftercare/outpatient clinics, inpatient facilities, correctional facilities, halfway houses, and other community-based settings. MI incorporates four basic principles into treatment: 1) expressing empathy, 2) developing discrepancy, 3) rolling with resistance, and 4) developing self-efficacy.

Research: Twelve studies looking at the extent of substance use when comparing individuals who received motivational interviewing (MI) with individuals who received no treatment at follow-up periods between 6 and 12 months showed that individuals in the MI treatment groups significantly reduced their use of substances compared with individuals in the no-treatment control groups. However, the effect size was small (standardized mean difference=0.15).[[47]](#endnote-47)

### E. Treatment plans must be assessed and modified periodically to meet changing needs of participants 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. while RSAT program should 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 and relapse rates 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 greater support to the program mission.[[48]](#endnote-48) Just as RSAT participants need feedback, so to RSAT staff.[[49]](#endnote-49)

### F. RSAT programs should include compatible treatment and social services.

Although all RSAT participants are engaged in treatment for alcohol and/or substance use disorders, other needs must be addressed while they are incarcerated to prepare them for reintegrating into the community. Examples include the following, also identified by drug court researchers:[[50]](#endnote-50)

* clinical case management,
* housing assistance (sober/drug-free)
* mental health treatment,
* trauma-informed and specific services,
* criminal thinking interventions,
* family and social support and interpersonal counseling,
* recovery community support
* peer recovery support
* pro-social and recreational activities
* vocational and educational services,
* medical and dental treatment,
* prevention of health-risk behaviors, and
* overdose prevention and reversal, including provision of Naloxone (Narcan) to individuals after they are released or their family member/significant other.

### G. 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.[[51]](#endnote-51) Part of responsivity is ensuring that RSAT programming is accessible to participants who have experienced 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 individual 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.[[52]](#endnote-52) Individuals with Post-Traumatic Stress Disorder (PTSD) may have used alcohol and drugs to cope with trauma responses and triggers. With the removal of these from the individual’s life, trauma-related symptoms may worsen.[[53]](#endnote-53)

Integrating trauma stabilization and coping skills training in RSAT’s alcohol and substance abuse programs will make the substance abuse treatment more accessible for individuals who have experienced 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 participants based on equity and healing, empowering trauma survivors with information, hope and appropriate referrals upon release. Although there cannot be equity in relationships between staff and RSAT participants, participant councils, for example, can be formed to give participants 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. Individuals 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, even they are most effective when delivered in a trauma-informed environment. The combination of the two is more effective than either one alone.[[54]](#endnote-54)

State Department of Correction Protocol: New York Department of Corrections provides a Female Trauma Recovery Program utilizes the Trauma Recovery Empowerment Model (TREM).[[55]](#endnote-55) Other issues addressed include substance abuse, parenting, health issues, and building interpersonal and resource networks. The program is followed by development of an aftercare plan for participants with ongoing treatment needs.[[56]](#endnote-56)

### H. RSAT programs that serve individuals with co-occurring disorders should offer integrated treatment as appropriate.

For many RSAT participants, the justice system may be their first exposure to substance use disorder treatment. Others may have made multiple attempts at treatment and recovery, but untreated mental health issues have sabotaged each period of recovery, resulting in a revolving door of recidivism. Still others may have accessed mental health services while their substance use problems went unaddressed and eventually contributed to their criminal justice involvement. Co-occurring mental health conditions among individuals with substance use disorders should to be considered more the rule rather than the exception. Up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime.[[57]](#endnote-57) Therefore, within specialty mental health and substance use clinical settings, it is the norm rather than the exception to see consumers with co-occurring disorders. RSAT programs should establish procedures for collaboration with mental health treatment staff.

RSAT staff should receive training on the signs and symptoms of mental health disorders and information on how the presence of one disorder can impact treatment and recovery from the other. Although those participating in RSAT programs may have been screened for mental health disorders, symptoms can emerge or develop during the course of substance use disorder treatment. RSAT staffs need to know how to identify RSAT participants that may require further screening and assessment by a qualified mental health professional.

There are different strategies RSAT programs can employ in dealing with individuals with co-occurring disorders. Some RSAT programs may be geared specifically to the needs of individuals with both mental health and substance use disorders, offering integrated treatment. Other programs work with mental health staff providing parallel treatment to RSAT participants with mental health issues. In some cases, services may be delivered sequentially, with RSAT participants completing a required course of mental health treatment to stabilize and manage their symptoms prior to their admission into addiction treatment.

According to the [National Institutes of Health](http://www.nih.gov/) and the [Substance Abuse and Mental Health](http://www.samhsa.gov/) Services Administration, both substance use and mental health disorders are brain conditions that respond better to integrated approaches that combine elements helpful to both mental health and addiction recovery into a comprehensive treatment program. The challenge for RSAT staff is to understand how these conditions interact, to provide RSAT participants with tools to manage recovery from both, and to ensure pre-release planning facilitates connections to the full range of required services and supports. Fortunately, a number of evidence-based approaches are effective for both substance use and mental health disorders. Fortunately, there are a number of evidence-based approaches that have proven effective for both substance use and mental health disorders, including: 1) Pharmacotherapies; 2) Motivational Approaches such as motivational interviewing, motivational enhancement therapy and contingency management; and 3) Illness Management and Recovery. The latter refers to a set of practices that teach people with mental illness how to manage their disorder, how to work with treatment providers, and friends and family to sustain recovery. These strategies align with current substance use disorder treatment principles, which impart information, tools and resources that empower people to effectively manage ongoing recovery.

SAMHSA has developed practice principles for integrated treatment as follows:

* Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders;
* Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses;
* Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages;
* Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage;
* Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages;
* Multiple formats for services are available, including individual, group, self-help, and family;
* Medication services are integrated and coordinated with psychosocial services.

Research shows that consumers in Integrated Treatment programs are more successful than consumers in non-integrated programs in the following areas: Reduced substance use; Improvement in psychiatric symptoms and functioning; Decreased hospitalization; Increased housing stability; Fewer arrests; and Improved quality of life.[[58]](#endnote-58)  In short, individuals with co-occurring disorders have high rates of recovery when provided Integrated Treatment for Co-Occurring Disorders. Briefly stated, research shows that consumers in Integrated Treatment programs were more successful than consumers in non-integrated programs in the following areas: Reduced substance use; Improvement in psychiatric symptoms and functioning; Decreased hospitalization; Increased housing stability; Fewer arrests; and Improved quality of life. In short, consumers with co-occurring disorders have high rates of recovery when provided Integrated Treatment for Co-Occurring Disorders.[[59]](#endnote-59)

Seeking Safety, a manualized cognitive–behavioral intervention for incarcerated women with co-occurring posttraumatic stress disorder (PTSD) and substance use disorders is rated “Promising” by Crime Solutions. Evaluation results suggest that the program significantly reduced PTSD and depression scores in program participants

**State Department of Correction Protocol:** The Georgia Department of Corrections provides an example, having opened two integrated treatment facilities in 2012. The program is nine months, highly structured, actively combining interventions intended to address both mental health and substance use disorder issues in persons with co-occurring disorders with the intention of treating both disorders, related problems and the whole person more effectively in a residential therapeutic community including a balance of individual and group sessions. Elements include screening, assessment to include risk-need responsivity, individualized treatment, on-going monitoring of mental health symptoms, cognitive behavioral treatment, illness management, trauma-focused treatment, psychoeducational, therapy, cognitive restricting groups, motivational enhancement therapy, relapse prevention, medication assisted therapies, psycho-pharmacologic interventions and illness management, problem-solving skills, dual recovery mutual self-help recovery, and a reentry plan to include a Wellness Recovery Action Plan (WRAP).[[60]](#endnote-60) Similarly, the New York Department of Corrections provides for “Integrated Dual Disorder Treatment” where “substance abuse services are co-facilitated by trained substance use treatment staff and mental health professionals.”[[61]](#endnote-61)

## IV. Drug-Free Environments

REQUIRED BY BJA/STATUTE: A state must also agree to implement or continue to require urinalysis or other proven 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 should be done to ensure abstinence for participants 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, and 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 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 participants from the general population, alcohol and other drug testing should be more prevalent.

If RSAT participants are to be provided Naltrexone, oral or injected, they must be drug tested first for opioids as abstinence 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. In order for RSAT graduates to take full advantage of aftercare treatment and medication assisted treatment after release, it is essential that they have obtained access to Medicaid or any other health insurance for which they are eligible. In addition, they must have basic health care literacy so that they use the health care system appropriately 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 RSAT graduates 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 participants are likely to have other significant physical and behavioral health care needs requiring regular access to care after release.[[62]](#endnote-62),[[63]](#endnote-63) 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. For drug addiction, the death risk is 129 times more likely.[[64]](#endnote-64) 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.[[65]](#endnote-65) In addition, continuous access to health care immediately after release may reduce the risk of re-arrest and reincarceration.[[66]](#endnote-66)

In Medicaid expansion states, eligible RSAT participants (as all incarcerated populations) 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, incarcerated populations may be enrolled in available subsidized or non-subsidized insurance plans offered through their state’s market exchanges.

While all incarcerated populations should be enrolled in Medicaid or obtain available health insurance before release, RSAT programs should also assist participants and provide basic information for utilization of same. Enrollment is just the first step. The second is appropriate utilization of the treatment and services covered.

The Bureau of Justice Assistance (BJA) and the American Correctional Association (ACA) released July 18, 2016, Health Care Reform, The Patient Protection and Affordable Care Act, A Practical Guide for Corrections and Criminal Justice Professionals that outlines enrollment strategies, structure for delivery of Medicaid services within states, and specifically a section on reentry from jails/prisons to the community. The latter section describes important linkages to community health services including Federally Qualified Health Centers (FQHC) and Medicaid health home referrals, as well as the need to establish processes for transmitting prison/jail health records to community providers. Other innovative linkages for justice-involved populations are described in Coordinating Access to Services for Justice Involved Populations, released by the Milbank Memorial Fund in August 2016.[[67]](#endnote-67)

The National Governors Association has called for states to consider suspending, rather than terminating Medicaid coverage during incarceration to facilitate access to treatment upon release.[[68]](#endnote-68)

### B. If RSAT participants 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 generally cover RSAT participants while incarcerated, 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 the Medicaid enrollment for incarcerated populations. Temporary suspensions will facilitate reimbursement for these out of prison/jail hospitalizations.

### C. RSAT programs should work with their correctional systems to 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 participants enroll in them.

Medicaid managed care entities, including “health homes,” 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.[[69]](#endnote-69)

## VI. RSAT Sanctions and Rewards

### A. There should be more rewards than sanctions 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 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 for 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. Consequences for participants’ behavior should be predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior modification

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

Research: As summarized by NIDA,[[70]](#endnote-70) 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.

State Department of Correction Protocol: The Michigan Department of Corrections provides in its Policy Directive that “a prisoner’s refusal to actively participate in required programming may be considered in determining whether to grant special good time or special disciplinary credits as set for in ‘Good Time Credits’ or ‘Disciplinary Credits/Drug Law Credits,’ as appropriate.”[[71]](#endnote-71)

## VII. RSAT Staffing

### A. In group activities, the ratio of RSAT participants to staff should be no more than 20 to 1.

Regardless of treatment modalities employed, the ratio of treatment staff to participants and correctional officers to participants 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 participants 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 RSAT participants). Both should be involved in discipline, performance reviews, including whether participants 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 and work as a team.

### 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 RSAT participants 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 BJA/STATUTE: 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.[[72]](#endnote-72) 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). In 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 participants connect to the community resources, mobilize family and pro-social peers, and help them 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.

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.

State Department of Correction Protocol: The Massachusetts Department of Correction mandates under “Continuity of Care” that “follow up shall be conducted in a manner consistent with the recommendations of the treatment plan. Substance abuse program providers shall update a participant’s personalized program plan prior to program completion to ensure continuity of care. Upon impending discharge, parole or transfer to pre-release, staff shall update the personalized program plan and develop aftercare plans. The aftercare plan is a separate plan that shall be incorporated into the personalized program plan. The plan shall be based upon the completed substance abuse specific assessment, input from program staff, the participant, community based treatment program staff and the institution parole officer, if applicable. All referrals and placements shall be entered in the designated (record) screen. When an actual placement is arranged (e.g. inpatient program), the Release Address screen shall also be completed.”[[73]](#endnote-73)

### 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.[[74]](#endnote-74) 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 individual appearing for admission to the community treatment program and continuing to attend. Many individuals upon release 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 individual 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.
* Having multidisciplinary staffings at regular intervals during treatment.
* Reassessing criminogenic needs at regular intervals.
* Collaborating with Community Corrections staff to ensure continuity of treatment and other services, including the transfer of treatment records.

If individuals 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.

### C. If individuals 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 participants’ post-release supervisors to plan for the participants’ 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. RSAT participants 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 like activities that can be measured. Program outcomes should include rearrests, reincarcerations, entrance and retention in treatment, relapses, drug overdose emergency room visits, and drug overdose deaths.

How an individual 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 measures are 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.

State Department of Correction Protocol: The Vermont Department of Corrections has reviewed its Intensive Substance Abuse Program since 1998. The most recent review demonstrated its statistically significant reduction in recidivism with completers recidivating within one year at a rate of 10% compared to 21% for non-completers. After three years, the rates were 30% compared to 21% for non-completers. For inmates with at least three prior convictions, the recidivism reduction was even greater for completers compared to non-completers, 22% versus 42%. According to the Department, the results “demonstrate a positive treatment outcome, affirming the hypothesis that the program achieves desired results with the population it serves.”[[75]](#endnote-75)

### B. RSAT programs should encourage independent evaluations to determine how the outcome measures compare to other participants involved in other correctional programs or no programming. Generally speaking, the comparison of participants who complete the RSAT program with those who do not does not provide the best measure of program effectiveness. Evaluations 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, females as well as males, 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 individuals initially referred to the RSAT program, including those who may drop out or be 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 individuals that enter the program never complete it. Further, an analysis of the non-completers might reveal that the completers are only those 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 participants.

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 participant 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 participant populations change.

# Postscript and Additional Resources

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.[[76]](#endnote-76) In short, there will never be a substitute for the work of dedicated counselors, correctional officers and other program staff who make up prison and jail RSAT programs.

To learn of the latest research establishing evidence-based substance abuse and correctional treatment programming, two cites will prove of particular value, the Justice Department National Institute of Justice **C**r**ime Solutions** that can be found at <http://www.crimesolutions.gov/> and the Substance Abuse and Mental Health Services Administration **Evidence-Based Practices Web Guide**, <http://www.samhsa.gov/ebp-web-guide>. In addition, the National Institute on Drug Abuse maintains **Principles of Drug Addiction Treatment: A Research-Related Guide,** now in its 3rd edition, that can be found at <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment>.

Various professional organizations also maintain related standards and promising practice guidelines that may be of interest, including the National Association of Drug Court Professionals **Adult Drug Court Best Practice Standards** that can be found at <http://www.nadcp.org/Standards>.

Some of the best research that specifically focuses on prison substance use disorder treatment and was relied upon in the development of these guidelines, in addition to the many studies cited in the footnotes, has been completed by Dr. Faye Taxman and her colleagues. The research includes the following:

Belenko, S. & Taxman, F. (2012). Implementing Evidence-based practices in community corrections and Addiction Treatment. Springer Series on Evidence-Based Crime Policy.

Taxman, F. & Belenko, S. (2012). Implementing evidence-based practices in community corrections and addiction treatment. Springer Series on Evidence-Based Crime Policy, New York.

Taxman, F. & Boufford, J. (2001). [Residential Substance Abuse Treatment (RSAT) in Jail: Comparison of Six Sites in Virginia](http://www.ncjrs.gov/pdffiles1/nij/grants/182858.pdf), U.S. Justice Department, Office of Justice Programs, National Institute of Justice

Taxman, F., Silverman, R., & Bouffard, J. (2001). [Residential Substance Abuse Treatment (RSAT) in Prison: Evaluation of the Maryland RSAT Program,](http://www.ncjrs.gov/pdffiles1/nij/grants/184953.pdf) U.S. Justice Department, Office of Justice Programs, National Institute of Justice.

To learn of Promising Practice Guidelines updates, trainings and technical assistance in their implementation, and to join the continuing discussion of them, the RSAT Training and Technical Assistance Project will keep you post on its website, [www.rsat-tta.com](http://www.rsat-tta.com).

# Appendix

## RSAT Promising Practices Guidelines Roundtable Attendees

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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>)

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>)

## 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>

1. http://www.crimesolutions.gov/about.aspx. [↑](#endnote-ref-1)
2. The CENAPS® Model of Relapse Prevention Therapy (CMRPT®) is a comprehensive method for preventing chemically dependent clients from returning to alcohol and other drug use after initial treatment and for early intervention should chemical use occur. The CMRPT is a clinical procedure that integrates the disease model of chemical addiction and abstinence-based counseling methods with recent advances in cognitive, affective, behavioral, and social therapies. The method is designed to be delivered across levels of care with a primary focus on outpatient delivery systems. The CMRPT is an applied cognitive-behavioral therapy program. See, http://archives.drugabuse.gov/ADAC/ADAC4.html. [↑](#endnote-ref-2)
3. 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/](http://www.crimesolutions.gov/), and SAMHSA’s National Registry of Evidence-Based Programs and Practices (NREPP), [www.nrepp.samhsa.gov/01\_landing.aspx](http://www.nrepp.samhsa.gov/01_landing.aspx). [↑](#endnote-ref-3)
4. Binswanger, I. A., et al. (2007). Release from prison: A high risk of death for former inmates. N. Eng. J. Med., 157, 160. [↑](#endnote-ref-4)
5. State of Washington Substance Use Disorder Treatment Services, revised 10/12/15. [↑](#endnote-ref-5)
6. 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. [↑](#endnote-ref-6)
7. 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. [↑](#endnote-ref-7)
8. NIDA, Drug Abuse Treatment Principles for Criminal Justice Populations, Program conducts screening and assessment with valid instrument. [↑](#endnote-ref-8)
9. The ASAM Standards of Care for the Addiction Specialist Physician, American Society of Addiction Medicine, 2014. [↑](#endnote-ref-9)
10. Department of Public Safety, Corrections Administration Police and Procedures, Inmates with Alcohol and Other Drug Problems, October 20, 2015, Hawaii. [↑](#endnote-ref-10)
11. 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. [↑](#endnote-ref-11)
12. Table 3.3, NIDA Drug Abuse Treatment Principles for Criminal Justice Populations. [↑](#endnote-ref-12)
13. “(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](http://www.ncbi.nlm.nih.gov/pubmed/?term=Skeem%20JL%5BAuthor%5D&cauthor=true&cauthor_uid=25930045)., [Steadman, H. J](http://www.ncbi.nlm.nih.gov/pubmed/?term=Steadman%20HJ%5BAuthor%5D&cauthor=true&cauthor_uid=25930045)., [Manchak, S. M](http://www.ncbi.nlm.nih.gov/pubmed/?term=Manchak%20SM%5BAuthor%5D&cauthor=true&cauthor_uid=25930045). (2015). Applicability of the risk-need-responsivity model to persons with mental illness involved in the criminal justice system. [Psychiatric Service](http://www.ncbi.nlm.nih.gov/pubmed/25930045), 66(9), 916–922. doi: 10.1176/appi.ps.201400448. [↑](#endnote-ref-13)
14. 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 [↑](#endnote-ref-14)
15. Gordon, M. et al. (2014). A randomized controlled trial of prison-initiated Buprenorphine: Prison outcomes and community treatment entry.[*Drug Alcohol Depend*](http://www.ncbi.nlm.nih.gov/pubmed/24962326)*,* *142*, 33–40. doi: 10.1016/j.drugalcdep.2014.05.011 [↑](#endnote-ref-15)
16. 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. [↑](#endnote-ref-16)
17. K. Murphy, et al (2016). Finding solutions to the prescription and opioid and heroin crisis: A road map for states. National Governors Association. [↑](#endnote-ref-17)
18. National Commission on Correctional Health Care, Naloxone in Correctional Facilities for the prevention of Opioid Overdose Deaths, Position Statements, April 12, 2015. [↑](#endnote-ref-18)
19. RSAT funding may be used to pay for medication. [↑](#endnote-ref-19)
20. J. Lee, et. al., Opioid treatment at release from jail using extended release Naltrexone, Addiction (2015), <http://onlinelibrary.wiley.com/doi/10.1111/add.12894/epdf>. [↑](#endnote-ref-20)
21. T. Kinlock et. al., A study of Methadone maintenance for male prisoners:3-months post release outcomes, Criminal Justice Behavior (2008), <http://wwwncbi.nlm.nih.gov/pmc/articles/PMC2443939/>. [↑](#endnote-ref-21)
22. Klein, A. & Wilson, D. (2002). [*Outcome Evaluation of a residential substance abuse program: Barnstable House of Corrections*](http://www.ncjrs.gov/pdffiles1/nij/grants/196142.pdf). 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](http://www.rsat-tta.com/Files/Habilitation-of-Chronic-Offenders-in-a-Massachusetts-House-of-Correction). Waltham, MA: BOTEC Analysis Corporation. [↑](#endnote-ref-22)
23. Adult Drug Court Best Practice Standards, Vol. II, 2015, National Association of Drug Court Professionals, p. 5. [↑](#endnote-ref-23)
24. Improving Cultural Competence, Tip 59, SAMHSA, 2014, http://store.samhsa.gov/shin/content/SMA14-4849/SMA14-4849.pdf. [↑](#endnote-ref-24)
25. Ibid. [↑](#endnote-ref-25)
26. Ibid, p.258-272. [↑](#endnote-ref-26)
27. Virginia Department of Correction Offender Alcohol and Other Drug Testing and Treatment Services, effective July 1, 2015. [↑](#endnote-ref-27)
28. *Peers As Leaders* - NREPP: <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=205>; NIDA, *How do 12 step programs and peer support fit in?:* [https://www.drugabuse.gov/publications/seeking-drug-abuse-treatment/5-*How-do-12-step-or-similar-recovery-programs-fit-drug-addiction-treatment*](https://www.drugabuse.gov/publications/seeking-drug-abuse-treatment/5-how-do-12-step-or-similar-recovery-programs-fit-drug-addiction-treatment); SAMHSA, *Peer Recovery Support* Webpage: [http://www.samhsa.gov/recovery/*peer-support-social-inclusion*](http://www.samhsa.gov/recovery/peer-support-social-inclusion); NIDA, *Recovery Support Services, Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide:* https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/evidence-based-approaches-to-treating-adolescent-substance-use-disorders/recovery-support-services. [↑](#endnote-ref-28)
29. NIDA, *Principles of Drug Addiction Treatment: A Research-Based Guide* (3rd Edition).These programs are described in the Appendix. [↑](#endnote-ref-29)
30. These medications are described in the Appendix. Topiramate, primarily used for treating seizures and to prevent migraine headaches, is widely used for alcohol use disorders although it is not approved by the FDA for this purpose. [↑](#endnote-ref-30)
31. These programs are described in the Appendix. [↑](#endnote-ref-31)
32. 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. [↑](#endnote-ref-32)
33. 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. [↑](#endnote-ref-33)
34. NIDA, 2015, op. cit. [↑](#endnote-ref-34)
35. De Leon, G., & Wexler, H. (2009). The therapeutic community for addictions: An evolving

    knowledge base. Journal of Drug Issues, 39(1),167-177. Retrieved from EBSCOhost.; NIDA 2015 op cit; Welsh, W. (2007). Criminal Justice and Behavior: An International Journal 34 (11):1481 to 1498; Vanderplasschen, W. et al. (2012). Therapeutic Communities for Addictions: A Review of Their Effectiveness from a Recovery-Oriented Perspective. *The Scientific World Journal, 2013*. [↑](#endnote-ref-35)
36. Welch, 2007, op. cit. [↑](#endnote-ref-36)
37. NIDA, 2015, op. cit. [↑](#endnote-ref-37)
38. Sullivan, C., K. McKendrick, S. Sacks, & S. Banks. 2007. Modified Therapeutic Community Treatment for Offenders with MICA Disorders: Substance Use Outcomes. The American Journal of Drug and Alcohol Abuse 33:823–32. [↑](#endnote-ref-38)
39. Therapeutic Communities of America, <http://treatmentcommunitiesofamerica.org/>. [↑](#endnote-ref-39)
40. 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. [↑](#endnote-ref-40)
41. Mitchell, Ojmarrh, David B. Wilson, and Doris L. MacKenzie. 2012. "The Effectiveness of Incarceration-Based Drug Treatment on Criminal Behavior: A Systematic Review." Campbell Systematic Reviews 18.  
    <http://www.campbellcollaboration.org/lib/project/20/> [↑](#endnote-ref-41)
42. Drake, Elizabeth. 2012. *Chemical Dependency Treatment for Offenders: A Review of the Evidence and Benefit-Cost Findings.* Olympia, Wash.: Washington State Institute for Public Policy.  
    <http://www.wsipp.wa.gov/ReportFile/1112/Wsipp_Chemical-Dependency-Treatment-for-Offenders-A-Review-of-the-Evidence-and-Benefit-Cost-Findings_Full-Report.pdf> [↑](#endnote-ref-42)
43. Development Services Group, Inc. (2010). Cognitive-Behavioral Treatment, Literature Review. Washington, DC.: Office of Juvenile justice and Delinquency Prevention. <http://www.ojjdp.gov/mpg/litreviews/Cognitive_Behavioral_Treatment.pdf>; Lipsey, M., N. Landenberger, & S. Wilson (2007). Effects of Cognitive-Behavioral Programs for Criminal Offenders: A Systematic Review, Oslo, Norway: The Campbell Collaboration. [↑](#endnote-ref-43)
44. Zackon, F. (2011). *Key Elements of Effective Cognitive Behavioral Therapies, www.rsat-tta.com.* [↑](#endnote-ref-44)
45. Lowenkamp, C., D. Hubbard, M. Makarios, & E. Latessa. 2009. *“A Quasi-Experimental Evaluation of Thinking for a Change: A ‘Real World’ Application.” Criminal Justice and Behavior 36(2):137–46* [↑](#endnote-ref-45)
46. Aos, S., & E. Drake (2013).Prison, Police, and Programs: Evidence-Based Options that Reduce Crime and Save Money*. Olympia, Wash.: Washington State Institute for Public Policy.*[*http://www.wsipp.wa.gov/ReportFile/1396/Wsipp\_Prison-Police-and-Programs-Evidence-Based-Options-that-Reduce-Crime-and-Save-Money\_Full-Report.pdf*](http://www.wsipp.wa.gov/ReportFile/1396/Wsipp_Prison-Police-and-Programs-Evidence-Based-Options-that-Reduce-Crime-and-Save-Money_Full-Report.pdf)  [↑](#endnote-ref-46)
47. Smedslund, Geir, Rigmor C. Berg, Karianne T. Hammerstrøm, Asbjørn Steiro, Kari A. Leiknes, Helene M. Dahl, and Kjetil Karlsen. 2011. “Motivational Interviewing for Substance Abuse.” Campbell Systematic Reviews 6. <http://www.campbellcollaboration.org/lib/project/100/> [↑](#endnote-ref-47)
48. Henggeler, S. W., Pickrel, S. G., & Brondino, M. J. (1998). Multisystemic treatment of substance abusing and dependent delinquents: Outcomes, treatment fidelity, and transportability. Manuscript submitted for publication.; Mihalic, S., & K. Irwin, (2003). Blueprints for Violence Prevention: From research to real world settings: Factors influencing the successful replication of model programs. Youth Violence and Juvenile Justice, 1, 1-23: Miller, W., J. Sorensen, J. Slezer & G. Brigham (2006). Disseminating evidence-based practices in substance abuse treatment: A review with suggestions, Journal of Substance Abuse Treatment 31 (2006) 25– 39; Meyers, et al., 1995; Azrin, 1982; Meyers, 2002; Hanson & Harris, 1998; Waltz, et al., 1993; Hogue, et al., 1998; Miller, W. R., & Mount, K. A. (2005). A small study of training in motivational interviewing: Does one workshop change clinician

    and client behavior? Behavioural and Cognitive Psychotherapy, 29, 457–471; Gendreau, P., Goggin, C. & Smith, P. (1999). The forgotten issue in effective correctional treatment: Program implementation. International Journal of Offender Therapy and Comparative Criminology 43(2): 180-187.; Dilulio, J.J. (1993). Performance Measures for the Criminal Justice System. U.S. Bureau of Justice Statistics, Washington, DC. [↑](#endnote-ref-48)
49. Miller W. (1988). Project Match Research Group, 1997; Agostinelli, G., Brown, J.M. and Miller, W.R. (1995) Effects of normative feedback on Consumption among heavy drink ing college students. Journal of Drug Education 25: 31-40.; Alvero, A.M., Bucklin, B.R. & Austin, J. (2001) An objective review of the effectiveness and essential characteristics of performance feedback in organizational settings. Journal of Organizational Behavior Management 21(1): 3-29; Baer, J.S., Marlatt, A.G., Kivlanhan, D.R., Fromme, K., Larimer, M.E. & Williams, E. (1992) An experimental test of three methods of alcohol risk reduction with young adults. Journal of Consulting and Clinical Psychology 60(6): 974-979.; Decker, P.J. (1983) The effects of rehearsal group size and video feedback in behavior modeling training. Personnel Training

    36: 763-773.; Ludeman, K. (1991). Measuring skills and behavior. Training & Development, 61-66.; Miller, 1995; Zemke, R. (2001) Systems Thinking. Training February, 39-46; Elliott, D. (1980). A Repertoire of Impact Measures. Handbook of Criminal Justice Evaluation: 507-515. [↑](#endnote-ref-49)
50. Identified in Drug Court Volume II, op. cit. [↑](#endnote-ref-50)
51. Miller, N. (2001). RSAT Training Tool Trauma-informed Approaches in Correctional Settings, p. 8. [www.rsat-tta.com/Files/Trainings/Trauma\_Informed\_Manual](http://www.rsat-tta.com/Files/Trainings/Trauma_Informed_Manual) [↑](#endnote-ref-51)
52. 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 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). [↑](#endnote-ref-52)
53. Loper, A. B. (2002). Adjustment to prison of women convicted of possession, trafficking, and non-drug offenses. Journal of Drug Issues, 32, 1033-1050. [↑](#endnote-ref-53)
54. 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. [↑](#endnote-ref-54)
55. TREM is a manualized group-based intervention designed for women with histories of exposure to sexual and physical abuse. It is listed on the SAMHSA Registry of Evidence-based Programs and Practices as “Programs with Promising Outcomes.” [↑](#endnote-ref-55)
56. New York Department of Corrections, Program Services, Substance Abuse, undated. [↑](#endnote-ref-56)
57. Regier et al., 1990. Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study*, Journal of the American Medical Association, 264*(19):2511-8. [↑](#endnote-ref-57)
58. Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., et al. (2001). Implementing dual diagnosis services for clients with severe mental illness. Psychiatric Services, 52(4), 469-476. [↑](#endnote-ref-58)
59. Integrated Treatment for Co-Occurring Disorders, Building Your Program, U.S. Department of Health and Human Services, Substance Abuse and mental Health Administration, Center for Mental Health Services, 2009. [↑](#endnote-ref-59)
60. WRAP is listed as an evidence-based program on the SAMHSA National Registry of Evidence-based Programs and Practices. Wellness Recovery Action Plan (WRAP) is a manualized group intervention for adults with mental illness. WRAP guides participants through the process of identifying and understanding their personal wellness resources ("wellness tools") and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness. [↑](#endnote-ref-60)
61. New York Department of Corrections, Program Services, Substance Abuse, undated. [↑](#endnote-ref-61)
62. 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. [↑](#endnote-ref-62)
63. Id. at 9. Citing Prins, S. J. (2014). Prevalence of mental illnesses in US state prisons: A systematic review. *Psychiatric Services, 65*, 862. [↑](#endnote-ref-63)
64. Binswanger, I. A., et al. (2007). Release from prison: A high risk of death for former inmates. *N.* *Eng. J. Med., 157*, 160. [↑](#endnote-ref-64)
65. Id. at 165. [↑](#endnote-ref-65)
66. 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. [↑](#endnote-ref-66)
67. Heiss, C. et. al. (2016), Coordinating Access to Services for Justice Involved Populations, Milbank Memorial Fund. [↑](#endnote-ref-67)
68. K. Murphy, et al (2016). Finding solutions to the prescription and opioid and heroin crisis: A road map for states. National Governors Association. [↑](#endnote-ref-68)
69. 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. [↑](#endnote-ref-69)
70. *NIDA Principles of Drug Addiction: A Research-Based Guide* (Third Edition). [↑](#endnote-ref-70)
71. Michigan Department of Corrections Policy Directive, Substance Abuse Programming and Testing. Effective 01/01/2002. [↑](#endnote-ref-71)
72. Harrison, L., & Martin, S. (2003). [Residential Substance Abuse Treatment for State Prisoners, Implementation Lessons Learned, NIJ Special Report](http://www.ncjrs.gov/pdffiles1/nij/195738.pdf)**,** DOJ, OJP, NIJ; \_\_\_ (2005). [Residential Substance Abuse Treatment for State Prisoners (RSAT) Program, Program Update](http://www.ncjrs.gov/pdffiles1/bja/206269.pdf), DOJ, OJP, BJA. [↑](#endnote-ref-72)
73. Commonwealth of Massachusetts Department of Correction Substance Abuse Programs, #103 DOC 445, undated. [↑](#endnote-ref-73)
74. Fletcher & Chandler, R. (2006). *Principles of drug abuse treatment for criminal populations*. National Institute of Drug Abuse, Office of Science Policy and Communications. [↑](#endnote-ref-74)
75. Vermont Department of Corrections Intensive Substance Abuse Program Description, undated. [↑](#endnote-ref-75)
76. 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. [↑](#endnote-ref-76)