Residential Substance Abuse Treatment (RSAT)

Training and Technical Assistance

RSAT Training Tool: After RSAT: Transitional Strategies to Reduce Recidivism and Sustain Recovery

This curriculum is a cross-disciplinary training designed to increase knowledge of pre-release planning, aftercare and transition to community-based behavioral health treatment for offenders completing long-term substance abuse programs in prisons and jails. This manual includes information specific to re-entry aimed at reducing recidivism among offenders with substance use disorders as well as information about benefits that may be available as they transition to community care.

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After RSAT: Transitional Strategies to Reduce Recidivism and Sustain Recovery

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Introduction

Audience:

This training tool is designed for:

- RSAT program administrators
- RSAT clinical managers
- RSAT grant administrators
- Program staff
- Case managers
- Correctional staff and administrators
- Community corrections
- Addiction and mental health providers
- Housing agencies, re-entry programs, mentors, faith community and volunteers

Purpose:

Pre-release planning, linkages to community-based treatment, and transitional recovery supports, pave the way for success. Re-entry programming, including work release centers, halfway houses, employment readiness programs, behavioral health services, family reunification, relapse prevention, and 12-step fellowships all play a role in an RSAT graduate's successful return to the community, as do appropriate levels of correctional supervision.

Effective re-entry planning begins at intake, when offenders enter prison or jail. As soon as they enter, institutional classification and needs assessments should be conducted to identify programming priorities and factors that must be addressed to prevent a return to criminal behavior. These priorities may include housing and educational needs, cognitive impairments as well as substance abuse and mental health treatment. For offenders assigned to Residential Substance Abuse Treatment programs (RSAT), **pre-release re-assessment should be conducted six months prior to re-entry** in order to provide the roadmap for effective reintegration into the community and determine the degree of structured programming required upon release.

Fulfilling RSAT's Legislative Mandate

To qualify for RSAT funding, Federal Law (42 U.S.C. 3796ff-1(c)) requires state agencies administering the RSAT Program to ***"…ensure that individuals who participate in the substance abuse treatment program… will be provided with aftercare services. Aftercare services must involve coordination between the correctional treatment program and other social service and rehabilitation programs, such as education and job training, parole supervision, halfway houses, self-help and peer group programs."***

This legislative mandate to provide aftercare to RSAT offenders is based on research that demonstrates the need for a post-release continuum of care for offenders with substance use disorders (SUD) or co-occurring mental health and substance use disorders (COD). Structured re-entry aftercare that offers pro-social supports and encourages a recovery-oriented lifestyle maximizes the offender's investment in treatment and the public's investment in rehabilitation and public safety. A step-down approach from intensive residential treatment within correctional facilities to less restrictive levels of clinical care and correctional supervision has been found to be effective.

This manual provides cross-disciplinary training designed to expand the knowledge and resources available to RSAT staff. It should also serve as a useful tool for anyone charged with supporting offenders transitioning from in-custody programs to community-based treatment, post-release aftercare, community supports, and sustained recovery management. This includes correctional program planners, community corrections, collaborating public and private social service agencies, and peers working with justice-involved individuals in recovery.

The goal of this training manual is to introduce the most current research, practices, and tools for effective release planning for RSAT programs. This manual also highlights relevant trends in public policy that will determine the availability of resources for re-entering offenders.

The curriculum is designed to examine ways to structure treatment activities that support transitional planning, collaboration, and re-entry success. The manual emphasizes resources and approaches that respond to the unique needs of different subgroups of offenders, including women and those with co-occurring mental health disorders, whether they re-enter communities with or without ongoing correctional supervision.

Learning Objectives:

The expected outcomes of the curriculum are that participants will be able to:

1. Explain the rationale and research that support the continuum of community-based treatment, aftercare, and recovery management
2. Identify basic recovery self-management principles and best practices for motivating RSAT offenders in treatment
3. List tools and strategies for integrating transitional planning into the RSAT treatment model
4. Explain procedures to help establish pre-release enrollment into public benefits that can provide access to behavioral health treatment and primary care
5. List steps correctional staff and administrators can take in anticipation of The Patient Protection and Affordable Care Act of 2014 ("healthcare reform") and expanded eligibility for ex-offenders, effective in 2014
6. Discuss the unique re-entry needs of specific RSAT populations, including women and those with co-occurring disorders

7. Locate practical tools and information for further learning and identifying available community resources

Each module contains participatory exercises, a review of the topics covered, and a resource list. While it is impossible to address all aspects of re-entry, the resources included offer deeper information on a number of content areas.

Approach:

Each of the modules in this RSAT training series is centered on six basic principles that foster professional development and promote safe, effective, and efficient programs:

- **Strength-based orientation**: Ex-offenders with SUD and COD are especially susceptible to being labeled. Some providers may write them off as resistant or hopeless. RSAT staff can help offenders learn to recognize their strengths in some areas that can help compensate for vulnerabilities in others and help treatment providers understand that RSAT graduates inmates can be successful in the community.
- **Recovery-oriented approaches**: The recovery community has shown us that healing from severe addiction and mental health problems is possible. Recovery-oriented approaches focus on the importance of ongoing post-release supports and building pro-social community connections.
- **Culturally-aligned content**: Staff understanding of the effects of stigma, discrimination, and racial and economic disparities on access to care is critical. Anticipating barriers during pre-release planning is part of the process of overcoming them. Service linkages are critical challenges for RSAT staff; a realistic appraisal of the marginalization some offenders withstand is required.
- **Integrated interventions**: “Integrated” treatment attends to all of an individual’s needs with an emphasis on values and personal responsibility; targeting trauma, substance use recovery issues, and mental health and wellness issues while developing pro-social attitudes and reducing associated risk factors for recidivism.
- **Evidence-based strategies**: Extensive research on treatment strategies in jails and prisons has identified effective practices for different populations. These “evidence-based” approaches are compatible with institutional security and offender rehabilitation.
- **Present day accountability**: While inmates’ life histories may be characterized by patterns of illegal or anti-social behavior, treatment can result in change, enhanced client motivation, and increased substance-free coping skills. RSAT programs can help offenders master their thoughts and control their behavior.

Why an RSAT manual on transitional strategies?

Research confirms that the investment into RSAT programs can yield positive returns. Although RSAT treatment completers reoffend at lower rates, significantly lower rates of recidivism are achieved when RSAT programs also help offenders transition to community-based treatment and aftercare programs. As we learn more from evaluating the effectiveness of programs, it is evident that treatment gains must be supported by more than a meeting list and a referral to an alcohol and drug counselor (Marlowe, 2002). But, at last count, only about half of RSAT programs included an aftercare component (Harrison and Martin, 2003).

This manual does not provide a magical aftercare formula or promise a quick fix. It does, however, offer guidance and information to help programsrefine their strategic thinking about how to incorporate re-entry planning into the structure of current RSAT programs. This manual also provides practical strategies for improving the continuum of services from institution to community care. In addition, the contents of this manual contain helpful information, resources, and links and allows RSAT programs to locate the federally funded and non-profit initiatives that support re-entering offenders in each state; however, the challenge remains for each and every RSAT program to make effective, evidence-based transitional planning and implementation a reality.

Module I: The Big Picture: Re-entry, Rehabilitation and Recovery

A. Context and Background: Trends in Rehabilitation Programming
B. A Recovery-Oriented Continuum of Care
C. Opportunities to Maximize Post-release Supports
D. Resources and Review

Learning Objectives

After completing this module, participants will be able to:

- Explain the impact of substance abuse on the criminal justice system
- Identify recent changes in substance abuse recovery and offender rehabilitation approaches that influence RSAT re-entry programming
- Discuss outcomes of prison and jail-based substance abuse treatment with and without community follow-up and aftercare
- Locate information about local and national initiatives designed to improve the continuum of care for re-entering offenders

Knowledge Assessment Test

True False Questions

1. Research shows that drug education is a crucial component of offender rehabilitation, since the more offenders learn about the effects of drugs the less likely they are to use them.
   False

2. One approach that helps to ensure a continuum of care for RSAT graduates is transitioning them into early release programs, which provide a period of supervised community-based treatment and aftercare.
   True

3. Random urine screenings increase abstinence rates in post-release substance treatment programs. Providing incentives for consecutive drug-free screenings multiplies that effect.
   True

4. The more prison or jail time parole violators face, the more they will be deterred from violating their parole.
   False

5. Recidivism rates are greatly reduced when low-risk offenders receive the most intensive level of substance abuse treatment available.
   False

6. Costs are irrelevant when public safety is involved.
   False

7. The longer someone remains in treatment and connected to aftercare, the better chance they have at sustaining recovery.
   True

8. RSAT programs are mandated to coordinate with their state's office of drug and alcohol treatment services.
   True

9. Health coverage and adequate healthcare for offenders in the community have no effect on recidivism.
   False

10. Release planning and aftercare coordination should begin in the final weeks preceding release.
    False

A. Context and Background: Trends in Rehabilitation Programming

Criminal justice, like any other public service, has been sensitive to the changing winds of public opinion. When it comes to public safety and security, people have understandably strong emotional reactions; however, many people have equally strong reactions in regard to public spending. Corrections has had to respond to both of these political concerns. Often the same stakeholders that called for "get tough" on crime last year are pushing for drastic spending cuts in corrections this year. The mandate for criminal justice professionals is clear: public safety is first, but public funds are limited. We must, therefore, invest in approaches that are cost effective and are based on the best available research on what works. And the research confirms what follows.

Data Driven Approaches to Reducing Recidivism

The RSAT model works because it is based on the evidence of the effectiveness of prison and jail-based, long-term residential treatment in intensive programs where inmates are removed from the general prison population. The research is clear, RSAT's reduce recidivism. While the extent of documented recidivism reductions vary from study to study (examples of studies are located on the RSAT website at http://www.rsat-tta.com/Library), researchers all agree that reductions in recidivism are even greater when RSAT graduates ***also*** complete a period of community-based treatment and aftercare (Taxman, Perdoni and Harrison, 2006).

RSAT programs are most effective when they fulfill the following conditions:

- Other data driven approaches to reducing recidivism and changing behavior, such as motivational approaches, cognitive behavior therapy, and opiate replacement therapy, are integrated.
- There is a system of incentives and rewards, as well as swift and certain sanctions and a deliberate focus on criminal risk factors, which prevent re-offending.
- Offenders have an opportunity to practice pro-social behavior; observe role modeling among staff, officers, and other residents and take on responsibilities and valued roles within the therapeutic setting.
- Re-entry preparation is built into the fabric of the program at each phase, in addition to offering a distinct pre-release phase of treatment.

Overview of the RSAT Model

The overarching goal of RSAT is to break the cycle of drugs and crime by reducing the demand for, use and trafficking of illegal drugs. To best accomplish this, RSAT should provide residential substance abuse treatment for inmates that prepares them for reintegration into communities by incorporating re-entry planning activities into treatment and assists offenders with the re-entry process through collaborative arrangements with community-based treatment and other broad-based recovery support. RSAT must foster positive social relationships among offenders living in the

same treatment community, but also incorporate a transitional planning phase for their re-entry into the community.

RSAT Program Goals

- Enhance the capability of states and units of local government to provide residential substance abuse treatment for inmates
- Prepare offenders for reintegration into communities by incorporating re-entry planning activities into treatment programs
- Assist both re-entering offenders and their community-based treatment providers in coordinating aftercare services and other recovery supports
- Reduce recidivism by promoting a recovery lifestyle and other pro-social supports

RSAT Program Components

RSAT programs give priority admission to inmates who are 6-12 months pre-release. This means offenders can be released into the community as soon after completing the program as possible, instead of returning to the general prison population. Minimally, RSAT programs are mandated to incorporate the following:

- Prison-based programs at least six and no more than 12 month's duration; jail based programs at least three months
- Prison residential treatment facilities set apart from the general correctional population—in separate facilities or dedicated housing units
- Development of the inmate's cognitive, behavioral, social, vocational, and other skills to solve the substance abuse and related problems
- Periodic and random urinalysis and/or other proven reliable forms of drug and alcohol testing for program participants and graduates while they remain in the custody of the state or local government

Aftercare

On April 9, 2008, the federal Second Chance Act (P.L. 110-199) was signed into law. The Act is designed to improve outcomes for people returning to communities from prisons and jails. It authorizes federal grants to government agencies and nonprofit organizations to provide employment assistance, substance abuse treatment, housing, family programming and mentoring, and other services that can help reduce recidivism. Notably, it also authorizes the use of medication assisted treatment for inmates in federally-funded treatment programs.

Section 102 of the Act specifically addresses aftercare for offenders leaving correctional treatment (see text box).

To ensure the utmost fiscal and programmatic efficiency, RSAT programs partner with other agencies to succeed. Collaboration can begin with each state's government

agency that is considered the ***Single State Agency*** (SSA) for substance abuse treatment efforts. This agency usually receives federal block grant dollars earmarked for substance treatment services. Most states and counties also dedicate additional funds to publiclyfunded community treatment services, although the ratio of federal to state or local funds varies widely.

102. IMPROVEMENT OF THE RESIDENTIAL SUBSTANCE ABUSE TREATMENT FOR STATE OFFENDERS PROGRAM.

(a) REQUIREMENT FOR AFTERCARE COMPONENT.—Section1902(c) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796ff–1(c)), is amended—
‘‘(1) To be eligible for funding under this part, a State shall ensure that individuals who participate in the substance abuse treatment program established or implemented with assistance provided under this part will be provided with aftercare services, which may include case management services and a full continuum of support services that ensure providers furnishing services under that program are approved by the appropriate State or local agency, and licensed, if necessary, to provide medical treatment or other health services.’’
(b) DEFINITION.—Section 1904(d) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796ff–3(d)) is amended to read as follows:
‘‘(d) RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAM DEFINED.—In this part, the term ‘residential substance abuse treatment program’ means a course of comprehensive individual and group substance abuse treatment services, lasting a period of at least 6 months, in residential treatment facilities set apart from the general population of a prison or jail (which may include the use of pharmacological treatment, where appropriate, that may extend beyond such period).’’

The Single State Agency Directory link below provides a 50 state directory of SSAs for substance treatment services. Some states have separate mental health, substance abuse prevention, and substance abuse treatment designees; others combine them into one office. RSAT programs are required to work with SSAs to coordinate a continuum of care for RSAT participants in community substance abuse treatment facilities as they are released. RSAT programs also collaborate with other public and private social service agencies on rehabilitation programs such as education and job training, transitional housing, family services, mental health, faith-based, self-help, and peer support programs. The directory at the end of this module provides useful links to information relevant to each state.

Established RSAT programs most likely already have connections and regular contact with these programs. In the best case scenario, RSAT programs are involved with communities that have a local re-entry taskforce that meets to coordinate services for re-entering offenders. Such groups may have been formed as part of past grant-funded initiatives. There may be both a statewide forum for collaboration and one or more local gatherings of community-level stakeholders and providers. If there is no forum to bring key people together to coordinate a continuum of care for re-entering offenders who have received treatment in RSAT programs, it may be something RSAT program administrators or facility heads may want to consider.

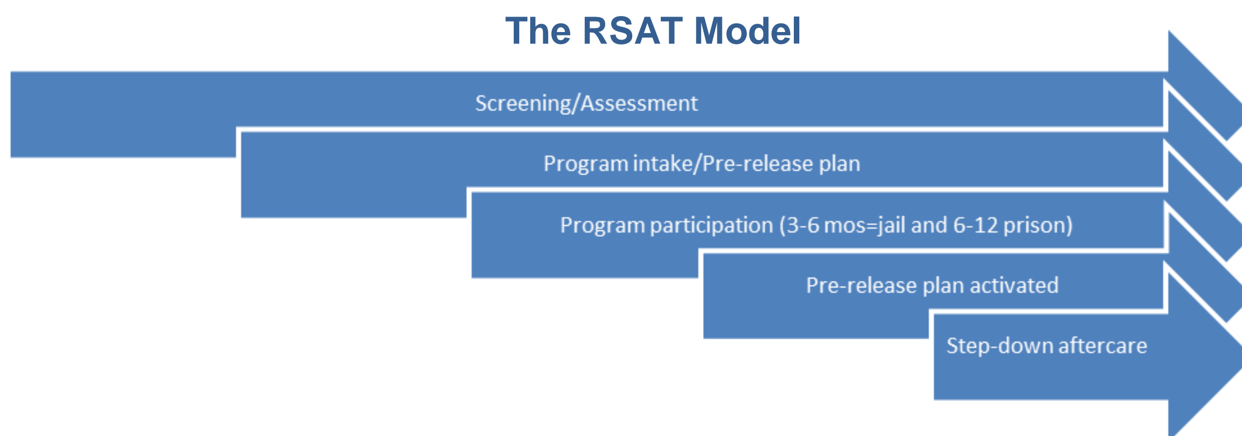
Single State Agency Directory:
http://www.samhsa.gov/grants/ssadirectory.pdf

It is important to keep in mind that RSAT programs have a lot to offer community-based substance abuse providers in return. The majority of people in long-term

residential treatment and about half of those in outpatient programs are involved with the justice system anyway (Marlowe, 2003). Treatment providers that serve RSAT graduates are working with that small segment of justice-involved offenders that have already successfully completed a treatment program and have a working knowledge of recovery principles. Not only may they be more amendable to successful treatment, but by their example they can help motivate other clients in treatment to succeed.

Building a Continuum of Care

When we speak of a ***continuum of care***, for RSAT offenders, we are referring to a sequential progression through the following stages of recovery services:



Pre-Treatment: Upon intake into the correctional facility, a ***screening*** is typically conducted to indicate if substance abuse is risk factor. There are multiple standardized tools, which can help identify the need for a more comprehensive substance abuse assessment.

A screening tool is used to detect likely substance use disorders and co-occurring mental disorder(s). Individuals who screen positive should receive an in-depth substance abuse assessment. The goal is to identify individuals who *might* have a substance use disorder and therefore require further assessment. Screening tools are designed so that correctional officers, classification staff, and other staff may administer them. This screening often includes:

- Having an individual respond to a specific set of questions
- Scoring those questions
- The "yes" or "no" process of identifying those that will go on to the next level of assessment
- Examples of screening tools include the MAST, the GAIN Q, and the AUDIT.
- For a comprehensive list of substance abuse screening and assessment tools with descriptions go to: http://www.ncsacw.samhsa.gov/files/SAFERR_AppendixD.pdf

Assessment: The assessment asks questions about past and present drug use. There are also questions that cover a number of domains such as, family background, living situation, work history, education, and health. The assessment is the starting place for looking at service needs and strengths and determining the appropriate level of care. This includes the amount and types of substances used, medical conditions, mental health conditions, and prescribed medications. Below are examples of assessment questions that cover several areas:

- Use history question: How much money would you say you spent on drugs in the last 30 days?
- Employment/means of support: How many days were you paid for working in the last 30 days?
- Family and social relationships: With whom do you spend most of your free time?
- Mental status: Have you ever been prescribed any medication for psychological or emotional problems?

The information should be considered along with criminogenic risks, protective factors, the role of substances in the crime, patterns of use, and motivation/readiness to participate. Specific strategies should be employed to strengthen motivation for treatment. Responsivity factors that could interfere with treatment engagement should also be evaluated. Is the offender illiterate? Are mental or physical health problems severe enough to distract from treatment? Are other interventions or programs needed prior to entering treatment?

Note: For more information on co-occurring disorders, visit the RSAT website at http://www.rsat-tta.com/Home and download the RSAT Co-Occurring Disorders and Integrated Treatment Manual or take the eLearning course.

Examples of assessment instruments include the Addiction Severity Index (ASI) and the Global Assessment of Individual Needs (GAIN). For a comprehensive list of substance abuse assessment tools with descriptions go to:
http://www.ncsacw.samhsa.gov/files/SAFERR_AppendixD.pdf

Primary Treatment: This component provides the level of treatment indicated by the assessment. Established client placement criteria (developed by the American Society of Addiction Medicine[1]) determine who qualifies for the long-term, intensive level of care offered by RSAT programs. In general, high risk offenders with substance abuse or dependency or those with long addiction profiles and high problem severity should be the target population for RSAT programs. During this stage, primary treatment needs are addressed, such as abstinence from drugs and alcohol; development of adaptive life/problem-solving skills; identifying needed lifestyle changes, ongoing recovery management, services and supports, family issues, health recovery, and vocational and recreational activities.

[1] The placement criteria can be found here: http://www.asam.org/publications/patient-placement-criteria/ppc-2r

Transition Services: Adequate preparation for discharge (release) or the step down to a less intensive level of treatment will maximize the investment of RSAT treatment. The reality for many institutions is effective step-down programs and aftercare options, which are contingent upon many factors, such as inmate movement, housing, and the availability of services in the community; however, effective transition is often determined as much by the quality of the partnerships corrections develops with community-based treatment and other health and human services providers as it is the quantity of available services. RSAT programs that connect offenders to resources prior to their release can strengthen the continuum of care.

For example, in Essex County, Massachusetts, there is a pilot project with the jail and the Office of the Commissioner of Probation that places a probation officer inside the jail to work with re-entry staff. In Illinois, the Sheridan Treatment Prison contracts with agencies that provide dedicated case managers and employment specialists to work with prison staff and inmates, pre-release, on developing a re-entry plan.

Remember: Resources to help offenders minimize exposure to people, places, and situations that can trigger relapse are important, but having a solid plan when they do encounter them is equally important.

B. Recovery-Oriented Continuum of Care

For many years, the majority of substance abuse research examined what went on in treatment programs (community-based as well as institutional-based). Very little research looked at the years and decades that followed treatment, what mechanisms worked to sustain addiction recovery, and how people managed to rebuild their lives in the community. Treatment was defined by an admission and a discharge, and recovery was measured by abstinence alone (White, Kurtz and Sanders, 2001).

By early 2000, the substance abuse rehabilitation field began to shift its focus away from an acute care system. The underlying premise that addiction would respond to a hospitalization or a 28-day treatment, the way an acute condition would, like a broken leg or a heart attack, was not supported by the data. The data revealed that more people entering the publically-funded treatment system were returning to it for their second admission than entering it for the first time. Almost 12% had five or more prior treatment admissions (TEDS, 2009). Obviously, acute care treatment alone was not sufficient.

The addiction treatment field responded to this challenge, and shifted to a model of ongoing recovery management, similar to how we deal with chronic health conditions such as diabetes or asthma. The result has been the development of a more recovery-oriented system of care (ROSC) that recognizes treatment as the beginning of an extended recovery process. For some, that process may involve periods of returning to substance use, which, in turn, requires regrouping and identifying steps to prevent a reoccurrence. Recovery management can be a lifelong process. Successful management of any chronic health condition requires active participation in one's own care. Addiction recovery is no different.

> *Rather than cycling individuals through multiple self-contained episodes of acute treatment, recovery management provides an expanded array of recovery support services for a much greater length of time but at a much lower level of intensity and cost per service episode.*
> *–White, 2004*

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines "recovery" as a process of change through which individuals work to improve their own health and wellbeing, live a self-directed life, and strive to achieve their full potential.

Essentials for Recovery

SAMHSA has delineated four major dimensions that are essential to a life in recovery:

- Health
- Home
- Purpose
- Community

RSAT programs can work with inmates, pre-release, to help them achieve success within each of these four domains after release. During the re-entry phase of the program, offenders should begin to lay the ground work in each of these areas.

Health

- *Health*: *Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way*

RSAT offenders returning to communities need healthcare services. Among pre-release offenders, half of all males and two-thirds of all females are diagnosed with one or more chronic conditions such as asthma, diabetes, and hepatitis; they have from five to eleven times the rate of HIV/AIDS as the general population (CDC, 2006; Kane and Visher, 2008; Maruschak, 2005; Sabin et al., 2001). The prevalence of Hepatitis C is six to seven times higher than in the general population (CASA, 2010).

Not only do RSAT offenders have primary healthcare needs, but they clearly have behavioral health needs. Ongoing post-release substance treatment in an intensive outpatient program may serve as a needed bridge to life in the community and can reinforce the recovery skills learned in RSAT programs. Offenders may also have co-occurring mental health needs. Some require medications and intensive mental health case management, while others only need periodic monitoring to make sure depression or anxiety do not reach sobriety-threatening levels.

Re-entry Phase Tasks: The state or local jurisdiction is responsible for the offender's healthcare needs while incarcerated, but upon release, the RSAT client will need to become engaged in finding services and caring for his or her healthcare needs. During the re-entry phase, RSAT programs can assist offenders to take steps to make sure transitional supplies of medications, a health discharge summary, lab results and other records needed for continuity of care and for benefit eligibility are all in place. Re-entering offenders with mental and physical health conditions need assistance to make a plan that includes the date, time and location of their initial post- release appointment.

Offenders who qualify for federal disability programs can usually begin the application process 90 days pre-release. At the link that follows, very useful publications from the Bazelon Center for Metal Health Law are listed. They include handy pamphlet titled "*Arrested? What Happens to Your Benefits If You Go to Jail*" along with a series of reports on securing benefits for re-entering offenders. http://www.bazelon.org/News-Publications/Publications/List/1/CategoryID/7/Level/a.aspx?SortField=ProductNumber%2cProductNumber

Inmates who were on SSI disability prior to incarceration will have benefits suspended for up to one year while they are in custody. However, once they are confined for a year or more, benefits are terminated. The process for reinstatement of suspended benefits for those serving less than one year is outlined in the publications from the Brazelon Center as are the guidelines for new applicants and for re-application.

Research suggests that the connection between health and other desirable outcomes should not be underestimated. ***Data from drug court programs that order probationers to substance abuse and mental health treatment have shown that also offering health and dental care results in a 40% lower recidivism rate as compared with programs that offer behavioral health services alone*** (NPC Research, 2010). More discussion of healthcare and health reform is included in the next module, along with related resources and links.

Home

- *Home: A stable and safe place to live*

RSAT offenders' re-entry housing accommodations play an important role in reducing criminogenic factors and providing the stability needed to implement a re-entry/aftercare plan. If your facility uses an actuarial risk and needs assessment at intake or prior to release, housing needs are likely to be assessed and may already be flagged as part of the client's case plan. As release approaches, suitable housing assumes center stage for high and medium risk offenders, but is an important part of stabilizing all re-entering individuals. ***Gender specific assessment tools for women offenders also evaluate housing safety as a factor critical to successful re-entry.*** This is particularly crucial if the offender was a victim of intimate partner violence before being incarcerated; however, housing safety for any re-entering offender with a substance use disorder must be an RSAT release planning priority.

Re-entry Phase Tasks: The answers to the following questions will inform the objectives and tasks the client needs to list under the goal of safe, sober, and stable housing in the pre-release plan.

- Is the housing accommodation free from substances, violence, and criminal associates?
- Are household members likely to drink or use drugs?
- Does the client qualify for any available housing programs?
- If family reunification is part of the re-entry plan, are there potential conflicts, and what preparations are needed to address them?
- Is there an outstanding restraining or protective order that bars the inmate from returning to a specific residence or household?
- What is the client's plan to cope with triggers and temptation if he or she is returning or moving into a high-risk neighborhood with lots of bars, dealers, and less than desirable associates?

Purpose

- *Purpose: Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.*

RSAT offenders need structured time. High-risk offenders do best when their post release time is filled with an intensive level of activities and programming for an extended period of time. But, large amounts of down time are not desirable for any offender in early recovery. Virtually every risk and needs assessment considers employment and education as key to preventing recidivism. Offenders can be encouraged to participate in GED programs, career and technical training, or employment readiness programs immediately upon release.

Re-entry Phase Tasks: In the re-entry phase, RSAT Programs can assist offenders to pull together copies of all their certifications, diplomas, transcripts, identification and documentation, along with letters of recommendation from jobs they might have held before or during their term of incarceration. Staff can help them prepare their list of local employment centers and contact programs or employers that work with offenders. Inmates can even complete their Federal Financial Aid Application for education and vocational training before release. State prisoners are not eligible for the Federal PELL grant program; however, once they are in a halfway house or work release center, that restriction is no longer applicable (the exception is a conviction for certain drug crimes committed while receiving federal student aid).

Offenders need to have a "Plan B" for activities in case employment is not readily available. Even those with secure employment will need to think about rounding out their lives with pro-social leisure and recovery oriented activities that mean something to them, beyond a paycheck. RSAT programs that encourage valued roles for inmates as

they approach release pave the way for transferring those pro-social roles into re-entry. Staff can encourage offenders to explore meaning, purpose, and recreation in re-entry groups. Some offenders will find satisfaction in recovery groups and peer support networks, others in faith based and/ or spiritually oriented gatherings, creative pursuits, family, animals, and some as activists advocating for ex-offenders!

Community

- *Community: Relationships and social networks that provide support, friendship, love, and hope.*[2]

Obviously, substance use is the most common risk factor shared by RSAT inmates and one that is addressed by RSAT programs. However, the most predictive risk factors for recidivism include criminal associates, criminal thinking and anti-social values and personality traits. RSAT programs work to address those risk factors as well. The absence of pro-social connections and activities leaves an anti-social vacuum. While RSAT programs isolate offenders from the rest of the prison or jail population, isolation, after release may become problematic as former inmates struggle to make pro-social connections in the community.

Re-entry Phase Tasks: This is the time to challenge offenders with these risk factors to demonstrate how they will cultivate pro-social relationships and contacts and what character building, value-based activities, and learning they will undertake. Whether it is membership at the YMCA or attending a church, ashram, reading group, or an AA meeting, positive engagements in the community after release are critical.

RSAT staff can actively coach offenders in the re-entry phase to consider their strengths, talents, preferences, and affiliations and build on their cultural backgrounds and extended networks. ***Developing friends, allies, contacts and relationships is supported in the re-entry phase of RSAT programs by "in-reach."*** Inviting appropriate community members into the institution to meet with RSAT offenders is an opportunity to establish essential connections. Community groups, recovering people, faith-based programs, and cultural groups with volunteers and mentors are all potential RSAT client supporters. Senior RSAT clients can take responsibility for lining up guest speakers and writing to agencies and groups to invite them inside the institution. Active coaching and role playing exercises in drug refusal skills and other situations that mirror real life dilemmas are also a valuable tool. Staff and peer leaders can assist with role plays, model how to set boundaries with negative peer or familial influences, and other real life problem solving scenarios.

Another important tool to help RSAT offenders focus on building assets is mapping. At the end of the module there are links to **Family Justice Tools** that help re-entering offenders map out their entire family and extended networks to locate people who are potential recovery supports. They can also map out available services and support agencies, sober clubs, and meeting places where they can get involved.

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[2] Source: http://blog.samhsa.gov/2011/08/12/recovery-defined-%E2%80%93-give-us-your-feedback

So, when does the re-entry phase begin for RSAT offenders?
At the point of intake, because it is never too early for RSAT offenders to take steps to build community assets.

C. Opportunities to Maximize Post-release Supports

When candidates for RSAT programs are assessed for substance abuse problem severity, the program has a picture of where they are in the progression of their addictive illness. In the re-entry phase, it also becomes important for the RSAT program to assess ***recovery capital.*** Recovery capital includes the internal and external assets an individual can draw upon to achieve and sustain recovery in the community (Granfield and Cloud, 1999). When an RSAT client has high problem severity and low recovery capital, a higher level of re-entry support is crucial. A transition to community-based treatment, a work release facility or a day reporting program, if available, can build recovery capital as well as provide a structured step down phase before release to the community at large. Indicators of recovery capital should be considered in re-entry planning. They include:

Family Support**:** Does the offender have family on the outside that supports him or her in attempts at recovery? Have those family members maintained contact? Are the relationships strained? Are family members also in recovery, currently using drugs or free of substance use issues?

Involving appropriate family members, spouses, and extended family in re-entry and recovery planning and pre-release can contribute to success for re-entering individuals. Two important considerations:
1) the client's terms for defining his or her family or extended family might not fit the typical definition, and
2) family violence and other familial dysfunctions, including criminal involvement and active drug use may rule family out as a pro-social influence.

Partners and spouses tend to be pro-social influences for male offenders, while the opposite is often the case for females. The Vera Institute offers training in **Family Justice Tools** that can help offenders map out their extended families and networks in terms of recovery support (see resource pages).

Education and Employment*: D*oes the offender have a good employment history? Have they had periods of stable employment? Have they worked at jobs that don't involve drugs or alcohol? Do they have an education and marketable skills, or are they motivated to pursue post-secondary education or job training? Therapeutic communities that are combined with work release programs have shown some of the lowest recidivism rates (DE Office of Management and Budget, 2009). Offering job training and work release opportunities in a treatment setting with both minimum security supervision levels and gateways to community integration allows RSAT offenders to build recovery capital. This type of program also makes it easy for the community to reach in with services as the offender begins to step outside.

In many cases, employment is restricted by the criminal record. There are a number of resources that should be included in the re-entry plan to assist former RSAT offenders in securing employment. For example, the U.S. Department of Labor offers a **Federal Bonding Program** to provide Fidelity Bonds that guarantee honesty for “at-risk”, hard-to-place job seekers, including ex-offenders, or anyone with a record of arrest, conviction or imprisonment, and anyone who has ever been on probation or parole. The bonds cover the first six months of employment. There is no cost to the job applicant or the employer. In most states the bonds are made available through the state agency responsible for workforce matters.[3] Follow the link for information explaining the program and a state by state listing of Department of Labor contacts for the bonding program: www.doleta.gov/usworkforce/onestop/FBP.PDF

In addition, people with Criminal Offender Records (referred to as “CORI” in some states) **do** have rights, including:

- Get a copy of their own CORI
- Try to fix mistakes on their CORI
- Decline to provide a copy of their CORI to anyone
- Specific rights regarding CORI and housing and employment also pertain but vary from state to state
- There may be a right to get one or more of their records sealed or expunged, if there was no conviction; and
- They may be able to get one or more of their convictions sealed or expunged, depending on the type of crime and how much time has passed since the conviction.
- Each state has laws and rules for clearing an offenders record (see Mass Legal Help link below).
- The Federal system has no such recourse short of a Presidential Pardon.
- The Second Chance for Ex-Offenders Act of 2011 has a provision for expunging criminal charges under certain specific circumstances. The criteria is available at: http://thomas.loc.gov/cgi-bin/query/z?c112:H.R.2065.IH:

Every state has offender advocacy organizations, or in some cases, agencies that are affiliated with state or county criminal justice, that work with ex- offenders on employment and general advocacy issues. In Massachusetts, one agency called Mass Legal Help provides an array of information online (http://www.masslegalhelp.org/cori) and also provides in-person and telephone assistance about CORIs.

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[3] Fidelity Bonding insurance is generally considered a good business management practice, and is purchased by most employers. However, while other types of commercially purchased insurance set premiums that vary according to the degree of risk (e.g., life insurance), Fidelity Bond premiums are always low due to being based upon taking low risk. As a result, insurance companies usually will not cover at-risk persons under commercially purchased Fidelity Bonds, a practice that has created a special barrier to employment for the very large and growing number of individuals who have encountered the criminal justice system in the U.S., as well as other persons whose personal credibility is questionable. For more information, go to http://www.bonds4jobs.com/index.html

States also have Offices of the Appellate Defender that work with ex-offenders to seal and expunge records. For example, New York's Appellate Defender website can be accessed through this link: http://www.appellatedefender.org For a state by state listing of points of contact for expunging or sealing records click on the link: http://criminal.findlaw.com/expungement/expungement-and-criminal-records-state-specific-information.html

Community and Social Support*:* Is the offender isolated? Does he or she have close friendships or affiliations with people who are not involved with drugs and alcohol, and who have no involvement with the criminal justice system? Are they connected to cultural, community, faith or recovery groups?

If RSAT offenders have been able to connect with faith-based or recovery groups while incarcerated, they can leverage those connections during re-entry. Group affiliation is ideal, but individual support is also helpful and more readily received by some offenders. Mentorship programs, faith community volunteers, cultural connections, and sponsorship are enormously helpful to offenders who may tend to trust individuals rather than institutions and groups. If family members maintain contact and visitation with children is consistent, preparation for re-entry should include them, as appropriate.

Health and Well-being Resources*:* Can the offender afford transportation, safe housing, and medical care? Are survival issues a challenge? Is their neighborhood impoverished, with a high crime rate and few available services? Is the inmate responsible for supporting children? RSAT inmates may require benefit enrollment, connections to community-based case management, housing supports and other social service programs. RSAT may want to maintain a list of all categories of assistance inmates may qualify for and any transitional options available. In some jurisdictions, released inmates may qualify for Access To Recovery (ATR) vouchers to assist in their reintegration into the community and treatment.
For information on availability of ATR in each state, go tohttp://aspe.hhs.gov/hsp/11/incarceration&reentry/Inventory/SubstanceAbuseandMentalHealthServicesAdministration.shtml#_Toc281921619

Filing the necessary paper work and helping offenders work on acquiring needed documentation may help make benefits immediately available upon release. Note: the application process can be lengthy for offenders qualifying for Medicare, Medicaid, SSI or SSDI. Agencies serving veterans, people with HIV, and other specific programs that an inmate may qualify for sometimes offer pre-release assistance with applications.

Low recovery capital is more the rule rather than the exception with RSAT offenders. In the next module we will look at ways RSAT programs can assist offenders to build recovery capital pre and post release. But, first we will look at some tools and resources that can assist RSAT programs in locating post-release supports for RSAT graduates.

D. Review and Resources

Review

The RSAT program model has been shown to be effective at reducing recidivism; however, RSAT's do better when offenders complete follow up treatment and aftercare in the community and/or step down to transitional facilities and/or work release centers that offer some level of treatment services and connect offenders to community support.

RSAT programs that incorporate evidence-based substance abuse interventions and other data driven approaches, such as rewards and incentives, cognitive behavioral groups, while targeting criminal risk factors are most effective. For this reason, RSAT Programs should integrate re-entry planning and preparation into all phases of treatment, but should also offer a distinct pre-release, re-entry phase.

Building a continuum of care for RSAT programs involves collaborating with local and regional providers, the recovery and peer support community, and other state and local agencies. A phased approach to treatment allows offenders to work on establishing connections and building recovery capital and support in the final phase of treatment.

Resources for re-entering offenders may involve multiple agencies, their families, and community members. It is especially important to have outside agencies and community groups involved with offenders during the final phases of treatment. Clients should be directed toward re-entry planning, and should remain occupied with a number of tasks in several areas to prepare for release.

Re-entry planning for RSAT offenders begins at intake when assessments tell us substance abuse is a central risk factor. A distinct re-entry phase re-focuses the client on building recovery capital, increasing community connections and assets, and completing foundation footwork. As staff helps inmates organize release plans and priorities, they also monitor responsivity factors, encourage stability and point the client to resources across systems.

Many initiatives offer extensive support for re-entering offenders. Although they are not in every state, there are sites across the country developing services in many areas. Re-entry resources, tools and information can be accessed online by using the links on the resource pages.

Resources Pages

Funding Opportunities

Every year, the federal government provides funding to a variety of programs relevant to re-entry. The following listing has links to agencies that have been awarded funds to develop services in various states and localities that may be particularly helpful to RSAT staff assisting inmates returning to the community.

1. ***The Bureau of Justice Assistance***

   Second Chance Act Funding: Projects specifically to help offenders transition successfully back into the community, including adult and juvenile projects:

- Re-entry demonstration projects
- Mentoring programs
- Treatment for co-occurring disorders
- Family-based substance abuse treatment
- Re-entry courts
- Career and technical training

To view a list of all awards 2009-2011, by state and category:
http://reentrypolicy.org/documents/0000/1208/11.2.11_SCA_Grantee_Chart_2009-2011_LK.pdf

Justice and Mental Health Collaboration Grants: Planning grants, implementation grants and other initiatives to support programs for offenders with co-occurring disorders:
http://www.consensusproject.org/programs?sort=date&tags=JMHCP+Grantee

2. ***Center for Substance Abuse Treatment***

   Recovery Community Services Projects: Up to three years of funding to develop peer to peer recovery support services, including sober housing, drop in centers, recovery coaching, phone support and advocacy. To view 2011 funded projects:
   http://www.samhsa.gov/grants/2011/awards/ti_11_016.aspx

   Pregnant and Post-Partum Services for Women: Provides multi-year funding to programs that serve pregnant and parenting women with their children in residential treatment programs. To view 2011 funded projects:
   http://www.samhsa.gov/grants/2011/awards/ti_11_009.aspx

   Projects to Benefit Chronically Homeless: Provides multi-year funding for housing and treatment services for homeless individuals, especially those with co-occurring mental health disorders. To view 2011 funded projects:
   http://www.samhsa.gov/grants/2011/awards/ti_11_008.aspx

Minority AIDS Initiative: Provides funding to regions with the highest rates of HIV to projects that target minority populations at-risk for or living with HIV/AIDS, offering treatment and prevention services as well as testing and medical care. To view 2011 funded projects:
http://www.samhsa.gov/grants/2011/awards/sm_11_006.aspx

Offender Re-entry Program: Three years of funding directed toward substance abuse treatment for re-entering offenders, beginning with in-reach services and post-release services. To view 2010 awards:
http://www.samhsa.gov/Grants/2010/awards/TI-10-006.aspx

Recovery Oriented Systems of Care: Three years of funding to build a continuum of treatment and long term recovery sport services. To view 2010 awards:
http://www.samhsa.gov/Grants/2010/awards/TI-10-007.aspx

Access to Recovery: Four years of funding to states to develop a voucher system offering people a choice of services including recovery community and peer support, faith-based recovery services, housing, job training, transportation and other non-traditional recovery enhancements. To view 2010 awards:
http://www.samhsa.gov/Grants/2010/awards/TI-10-008.aspx

Re-entry Tools and Resources

Re-entry Policy Council

- Housing Tools: http://tools.reentrypolicy.org/housing
- Assessment Tools: http://tools.reentrypolicy.org/assessments/chart#row1

Re-entry Resource Center

- 50 state listing of re-entry guides and publications including **veterans' resources guides for all 50 states:** http://nationalreentryresourcecenter.org/states
- Federal Benefits Chart: http://tools.reentrypolicy.org/benefits_chart
- Federal Benefits Access: http://tools.reentrypolicy.org/benefits_keys

Legal Action Center

- HIRE - Helping Individuals with criminal records Re-enter through Employment Network-information and 50 state listing: http://hirenetwork.org/resource.html
- Legal Action Center Criminal Justice Resources - helpful publications on voting rights, housing, record expunging records, gathering evidence of rehabilitation etc.:http://www.lac.org/index.php/lac/criminal_justice_publications

Department of Labor

- Link to locate One-Stop Career Centers in your area and other state services: http://www.servicelocator.org/onestopcenters.asp
- Federal Bonding Program: **www.doleta.gov/usworkforce/onestop/FBP.PDF** (with State contacts)

Mapping

Family Justice Tools- From the Vera Institute of Justice and

- Genograms of Family Support: http://www.vera.org/files/u9/genogram-key-2010.gif
- Ecomaps of Support Services and other Tools: http://www.vera.org/centers/family-justice-program/tools-methods

Institute of Behavioral Research, Texas Christian University

- *Mapping Your Reentry Plan: Heading Home*: http://www.ibr.tcu.edu/pubs/trtmanual/MappingReentry.html

Treatment Improvement Protocol 30: Continuity of Offender Treatment for Substance Use Disorders from Institution to Community: http://www.ncbi.nlm.nih.gov/books/NBK64384/

Re-entry Coaching Packets- Center for Effective Public Policy: 11 packets developed as part of the Presidential Prisoner Reentry Initiative of 35 state grantees. *Series 3, Implementing Evidence-Based Practices includes:* http://www.cepp.com/documents/A%20Framework%20for%20Offender%20Reentry.pdf

- Effective Case Management
- Shaping Offender Behavior
- Engaging Offenders' Families in Reentry
- Building Offenders' Community Assets through Mentoring
- Reentry Considerations for Women Offenders
- Families in Re- entry

State-by-state listing of points of contact for expunging or sealing records: http://criminal.findlaw.com/expungement/expungement-and-criminal-records-state-specific-information.html

Module II: Re-entry Planning Priorities

A. An Inventory of Implementation Strategies

B. Timeline for Pre-release Planning, Re-entry, and Aftercare

C. Evidence-based Strategies to Improve Release Outcomes

D. Resources and Review

Learning Objectives

After completing this module, participants will be able to:

- Identify strategies to incorporate re-entry preparation into treatment activities
- Learn to use motivational approaches to assist RSAT offenders with re-entry planning
- Explain the importance of hand-offs and linkages with supervision and community providers
- Discuss case management approaches, responsivity factors, and considerations for women offenders and offenders with CODs

Knowledge Assessment Test

True False Questions

1. Ideally the re-entry phase should begin 90 days prior to release
   False

2. More than 40% of admissions to publically funded substance abuse treatment are criminal justice referrals.
   True

3. Reward has a stronger influence on shaping behavior than punishment.
   True

4. Advantages of having a re-reentry phase includes letting those who have participated in the treatment program the longest focus on re-entry preparation.
   True

5. When offenders receive medication-assisted treatment, the CDC reccomends they discontinue other therapeutic inteventions to get the full effect of the medication. False

6. Methadone is the reccomended course of treatment for pregnant women who use opioids. True

7. Since 2004, the FDA has approved two medications for the treatment of alcoholism and alcohol abuse. True

8. The Federal Bonding program allows private insurance companies to rate offenders. False

9. Contingency management is an evidence-based practice that uses surprise "drills" to keep staff prepared. False

A. An Inventory of Implementation Strategies

This section is intended to serve as a guide to evaluating the strength of each RSAT program's re-entry components. It is not intended to serve as a prescriptive set of requirements or a complete package appropriate for re-entry in every community. RSAT administrators and staff know their population, their needs, and the capacities of their receiving communities. RSAT administrators know the barriers they face all too well.

Going through the check list in Exercise I may help RSAT staff and administrators identify the low hanging fruit that will strengthen re-entry planning activities during the final phase of treatment. The purpose of walking through this exercise is to generate

new ideas and options for enhancing each RSAT offenders' efforts to prepare for release. Comprehensive RSAT programs incorporate a myriad of evidence-based practices and strategies to guide inmates through a distinct set of programmatic phases.

Exercise One: Reviewing Strategies for RSAT Program Pre-release Preparation

Instructions: Check off the items that already take place within your RSAT program. Circle the items your program needs to implement or expand. For each circled item, discuss with other staff members realistic steps your RSAT program might consider to enhance its re-entry phase.

Planning and Assessment

- ☐ **Reassessment**: Assessments are repeated as offenders approach release. Tools or versions are designed to assess re-entry and community supervision needs and risks. The client and staff note progress and determine pre-release case management goals and objectives from the assessment.

- ☐ **Responsivity:** These factors take center stage, considered in light of the realities of the client's re-entry environment. Individual and group problem solving and skill rehearsal are applied to barriers like stigma, transportation, employment, and childcare. Other issues are mapped out in advance of release.

- ☐ **SMART Goals**: **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime-limited goals determined ***with*** the client and noted in written re-entry plans. Overwhelming goals are broken down into objectives and action steps, with a time frame for completion; client and case manager tasks are clearly assigned. Completed steps are checked off and offenders are reinforced and encouraged.

- ☐ **Mapping:** Staff facilitates use of mapping templates, which help offenders produce and understand visual representations of complex relationships, family and social support networks, re-entry service plans, responsibilities and goals. (see resource page)

- ☐ **Risk and Intensity:** Criminal risk factors and addiction severity are reviewed with the client to inform the intensity levels of post-release supervision, treatment and aftercare. Residential treatment upon release is reserved for the highest risk offenders and for those re-entering without parole supervision.

- ☐ **Progress and Efficacy:** Offenders are positively reinforced for completion of plans, for making recovery contacts and for working on applications. Public announcement of commitments; feedback on release plans is offered from staff and peers. Formalized graduation ceremonies boost client confidence; increasing levels of privileges, contingency management and other reward based re-enforcers.

- ☐ **48 Hour Plan**: A detailed presentation of pick-up and drop-off arrangements, including first contact with supervision and or recovery contacts. Offenders are accountable for plans, for seeking and incorporating feedback; progress is closely monitored as release dates approach. Corrective actions are executed promptly.

Overall Program Structure

- ☐ **Distinct Re-entry Phase**: The pre-release program differs from the core clinical treatment track. It focuses on release planning and building recovery capital, as well as more identification of relapse triggers. It involves role playing, skill rehearsal, and community in-reach. It is designed to increase self-efficacy among offenders prior to release.

- ☐ **Managing Critical Information**: This includes the well-organized tracking of release dates, phase changes, release status (unsupervised releases flagged and monitored) and supervision assignments. RSAT offenders should have ways to notify staff of changes so an accelerated re-entry phase can be orchestrated as needed. Critical RSAT and field services data should be shared.

- ☐ **Leadership Roles for Offenders**: Offenders take on responsibilities for organizing in-reach activities and planning graduation ceremonies. Treatment satisfaction questionnaires are administered. Successful RSAT graduates may be invited to return to speak and encourage offenders, when and where possible.

- ☐ **Mentoring**: Mentor/coaching programs match offenders pre-release. Matches for high-risk and unsupervised release offenders should be prioritized. Faith-based or recovery community volunteers, 12-Step sponsors, business community members and prospective employers can all work with offenders in the re-entry phase. RSAT clients who have almost completed the program can also mentor new RSAT clients, conduct orientations and chair in-house meetings.

- ☐ **Peer Assistance:** All aspects of an RSAT should include peer involvement, such as role modeling, coaching, skill rehearsal, assisting with treatment and recovery groups, employment assistance and organization and structure of RSAT programs.

- ☐ **Dedicated Staff**: Specialized case managers will be versed in housing and benefit enrollment, including signing up for expanded federal health insurance as it becomes available. They can serve as points of contact for providers, parole, and family members. Dedicated staff develops contacts with employers, medical, behavioral health and family services and leverages resources such as disability navigators, veterans' justice coordinators (VJOs) from the VA and Ryan White services, especially for graduates without parole supervision.

- ☐ **Contact with Assigned Agent/Officer**: Processes are put into place for client introduction, hand-off's, pre and post release two-way staff communication, planning and information sharing with parole or probation officers who will be supervising inmates after release. RSAT staff confer with post-release supervisors on post-release plans, graduated sanctions and incentives to encourage offender compliance in the community.

- ☐ **Health services:** Appointments for ongoing care of chronic conditions, gap medication supplies, medical homes (one stop primary care coordination), and other resources are coordinated. Prevention, wellness and public health benefits, and entitlements can be maximized.

- ☐ **Child Welfare and Family Services:** Pre-release family conflict resolution, reunification planning, and support are available. Domestic violence and child welfare partners can help determine visitation arrangements pre-release. Cultural and community groups can help RSAT staff.

In-reach & Collaboration

- ☐ **Community partners:** Community partners are increasingly involved in the re-entry phase. HIV prevention, parenting and other groups can be initiated by public and nonprofit agencies that may continue upon release. Information sessions on community resources are held regularly and employment and economic development partners are actively engaged.

- ☐ **Peer support:** 12 Step meetings conducted on site by community members; veterans' and mental health peer support are encouraged. RSAT graduates can be visible role models. Offenders benefit from attending outside meetings, as permitted. Staff can make contact with the AA Hospitals and Institutions Committee, the Bridge Program, and Oxford Houses (see resource page).

- ☐ **Community-based Treatment**: State Substance Abuse Authority (SSA) is a standard RSAT program collaborator, includes RSAT staff in relevant trainings and conferences and encourages community treatment providers to conduct pre-release admission interviews and to designate an agency contact for RSAT referrals. RSAT staff use and promote phone and video hand-offs, connecting offenders to community-based treatment, rather than refer them.

- ☐ **Linkages to the Faith Community:** Chaplains should be active in RSAT. They can cultivate welcoming congregations, faith-–based support, mentoring, mindfulness, study groups, employment support, and fellowship.

- ☐ **Fun and Enjoyment**: Leisure activities and drug-/alcohol-free social and recreational events should not be overlooked. 'Sobriety sampling' should be encouraged (trying new things in sobriety). Pre-release family events can be

coordinated for offenders working toward reunification. Community groups, recovery centers, and faith and advocacy organizations may also organize events.

Now that you have completed the exercise, consider:

1. What are the pre-release elements of your programs that you feel are most effective?

2. Could they be expanded, enhanced or improved?

3. Which item from the list might be a good fit, goal, or addition for your program?

4. What are some immediate barriers that must be overcome in order to expand, enhance, or improve pre-release elements of your program? Who are the necessary partners that are not currently involved that would be helpful?

B. Timeline for Pre-release Planning, Re-entry and Aftercare

Preparing for Re-entry

RSAT graduates require a seamless transition to a continuation of structured programming that addresses criminal thinking and other risk factors as well as substance treatment services that build community connections and recovery management skills.

Post-release programming should be specified in the release/probation order for those under supervision. For those who have completed their sentence, RSAT staff should arrange for the programmatic intake prior to the inmate's release. Specialty courts within the county most likely have relationships with local programs, and RSAT staff may be able to leverage these relationships to ensure swift admission for RSAT clients, when possible. Since most jail offenders, unlike state prisoners, will remain in the general vicinity upon release, RSAT programs can build a network among local providers and benefit from the increased community outreach and involvement.

- Community corrections programs include: correctional halfway houses, transitional living programs, work release programs, and correctional residential treatment centers.
- Community-based treatment programs include: treatment halfway houses, recovery homes, outpatient, and intensive outpatient and residential treatment programs addressing substance use and/or mental health disorders.

Some offenders may be released to specialized jail-based community supervision, post-sentencing diversion programs, or drug and mental health court supervision that includes intensive case management, electronic monitoring, home detention, weekend or day reporting, work release, and community service. These options are desirable for high-risk RSAT offenders, and provide critical transitional structure. Mental health courts

and similar alternatives to incarceration have proven effective at reducing recidivism and hospitalizations for offenders with serious and persistent mental illness (Steadman et al, 2010).

When Should Offenders Enter the Re-entry Phase?

The re-entry phase prepares offenders for re-integration into the community with attention to aftercare services they will need to make a successful transition. ***Ideally, the re-entry phase should begin approximately 150 days before release, if possible.*** Each program should define its re-entry phase and designate the most useful activities. Naturally, these will vary according to state and jurisdiction, release and supervision policies, and community service capacity. Once the length of the re-entry phase is determined, a protocol for tracking offenders' release dates and scheduling the start of the re-entry phase can be managed by program staff and/or correctional personnel.

Building opportunities for RSAT offenders in jail-based programs involves both preserving existing supports while they are incarcerated, if possible, and cultivating a local network of recovery oriented care.

For those released to supervision, a combination of community corrections programs and community-based substance treatment should help provide a recovery network. For those released without supervision, and for all offenders, involvement with recovery community support, pro-social family and faith community connections are essential to success. High-risk offenders, released without supervision will need recovery supports and an intense level of substance abuse treatment to lay the foundation for re-entry success.
The first 48 hours to 14 days of release should be mapped out by the offender prior to release, along with a solid plan for the first 3-6 months of re-entry.

Note: Within just two weeks of release from prison, a study had documented the risk of death among former inmates was 12.7 times that among other state residents, with a markedly elevated relative risk of death from drug overdose as well as homicide and suicide (Binswanger, et al 2007). I., M. Stern, R. Deyo, P. Heagerty, A. Cheadle, J. Elmore, & T. Kopsell (2007). Release from Prison — A High Risk of Death for Former Inmates, New England Journal of Medicine, 356, 157-165.

1. Preliminary Discharge Staffing

One of the practices programs use to mark the entry into a final phase of treatment is a preliminary meeting to discuss re-entry needs. This is often referred to as a "staffing" (ideally 150-120 days prior to release). The purpose of the staffing is to discuss re-entry aftercare recommendations and review pre-release planning priorities such as housing, employment, mental , and medical care. Ideally, all stakeholders should be invited to the preliminary discharge staffing, including:

- Client
- Family members (with client's agreement)
- Correctional counselors or case managers
- Treatment providers (onsite and community-based)
- Correctional medical staff or nursing
- Mental health staff
- Recovery supporters
- Faith-based supporters
- Community supervision staff

Enlist the client's help determining who to invite, with the understanding that the group will meet first to arrive at consensus regarding aftercare needs and recommendations before the client joins them. Note: permission for release of information by the inmate should be obtained to allow RSAT staff to share information pertaining to the inmate with the group. Also note: such meetings are generally **not** the time to allow confrontation from angry family members.

If a client sincerely thinks a family member is not supportive, it probably won't help to insist they attend. Conversely, if a client insists on including a family member who does not want to get involved, allowing the client to use the opportunity to pursue a personal agenda is unwise. If there is a family history of violent or sexual victimization, whether the client was perpetrator or victim, inclusion may not be appropriate.

It is also important to learn who has fulfilled the role of "family support." Cultural differences can influence family composition. For example, if a client's parents immigrated to the United States, biological family members may be living in another country. An open-ended question, such as "*Tell me who you like to spend holidays with,"* may reveal alternative close connections to cousins or to friends that also emigrated from the same town.

Meeting with all parties prior to bringing in the client resolves issues that could derail pre-release plans *before* offenders include unrealistic re-entry goals in their plan. Some questions that may identify potentially derailing issues include the following:

- Is there an order of protection in place that would that prohibit a client from living with or near a former intimate partner? Will women offenders remain safe from batterers or stalkers without an order of protection upon re-entry?

- Does the client intend on living with family members that have criminal records or are under parole or probation supervision? What are the policies in these cases?
- Does the client require hospitalization or care transitions for management of chronic or acute medical conditions such as hepatitis, HIV, or kidney failure?
- Is an uninterrupted supply of psychiatric medication required? Will mental health issues preclude admission to substance treatment programs that are not dual diagnosis capable?
- Does the client have a source of payment or are treatment options limited to publically-funded behavioral health providers?
- Has the client had previous treatments, eligibility to participate in other aftercare services, involvement and contacts in 12 Step fellowships? In which areas is the client able to draw upon recovery capital?

It is also important to make sure offenders understand 12 Step meetings are not treatment, just like a support group for diabetics does not constitute a medical intervention to regulate insulin levels. However, attending treatment along with Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) has been shown to be more effective than treatment alone (Sheedy and Whitter, 2009). If treatment is not available to offenders requiring higher levels of care, it is best to encourage meeting participation without implying it is an adequate substitute, lest it result in a client who relapses and assumes that AA and NA are not effective or valuable. By the time RSAT offenders reach the re-entry phase, they should understand what AA, NA, and similar recovery support groups are and are not.

2. Individual Re-entry Counseling Sessions

Individual sessions are an opportunity to review strengths, assessed needs, risks, and recommendations. Offenders will benefit from going over release plans with staff that specialize in re-entry planning. Planning should include the following tasks:

- Review all discharge and aftercare options and discuss client preferences for community based treatment. Preferences should guide decisions that pertain to responsivity issues like location, transportation and treatment approach, but not level of care. A release of information may be required for each program.
- Review any barriers to the re-entry/aftercare plan by walking the client through a typical day. Medical, mental health, housing, and vocational placements should all be compatible with recovery goals and supervision requirements. Enlist the client in securing intake appointments for treatment, housing, etc., whenever possible.
- Offenders should specify the recovery support contacts that can be involved in re-entry; staff efforts can include contacting the supervising parole agent or officer to review the plan, solicit recommendations, and share information (for those released to supervision).

3. Post Release Criminal Risk Factors

Several assessment tools have pre-release and post-release supervision versions that can inform re-entry planning. These include public domain tools available for use at no charge such as the Ohio Risk Assessment System (ORAS) and the I-PASS , from the Texas Christian University-Institute of Behavioral Research (see resource pages), which are specifically designed to measure risk of relapse and recidivism for offenders leaving institution-based treatment and entering the community. Higher scores indicate a need for more intensive structured services upon release.

4. Final 30 Days of Treatment in Prison

During the final 30 days, the client will be working on closing out individual treatment goals and finalizing the discharge/continuing care plan. A **Parole Discharge Staffing (30-day staffing)** provides a structure for staff and others to support those efforts. One of the keys to successful re-entry and engagement in aftercare is a defined plan with scheduled aftercare appointments within days of release. RSAT programs should be aware of their State's parole requirements regarding release and re-entry and schedule appointments accordingly. For example, in Illinois, parolees must be seen by parole before they can leave their "host" site. This is required to happen within three days of release, so aftercare appointments should be scheduled on the fourth day following release. ***One of the keys to successful re-entry and engagement in aftercare is a defined plan with scheduled aftercare appointments during the first 48 hours post release***.

Ideally, participants in the staffing should include the same types of stakeholders as the initial staffing, but in the case of offenders released under correctional supervision, parole/probation participation is essential, along with the agencies that will be involved with the client's post-release care. The purpose of this staffing is to ensure a smooth transition into the community, iron out any wrinkles, and to highlight the client's progress and accomplishments. It works to build client self-efficacy and to present a united front of reassurance and support from enforcement and treatment. It is a last opportunity to firm up the details and make sure the client is clear on expectations and requirements.

As offenders approach the final 30 days of treatment they wrap up their participation in smaller release planning work groups and should take responsibility for scheduling a presentation of their plan to the appropriate community group for review and feedback. Feedback may be structured to include one strength, one suggestion or resource and one concern or question from each member; otherwise the client may become overwhelmed. Note takers or flip chart recorders can be offered along with group members to help incorporate plan revisions, as necessary.

5. The Final Seven days in the Institution

Finally, within the seven days prior to release from incarceration, appropriate staff should usually meet with the client for an **exit interview**. Many programs also administer a client satisfaction survey and use the results to improve programming. The final days before release from an institution can be very difficult for offenders. During the exit interview RSAT staff can offer reassurance by walking the client through the 48 hour plan and reviewing treatment gains. The RSAT graduation ceremonies should reinforce this and encourage positive community activities beginning immediately upon

release. The RSAT graduation ceremony reinforces and rewards on many levels. Certificates or other tangible symbols of completion may be the first "diploma" an offender has ever received.

Significant research has shown that public declaration of intentions strengthen motivation and commitment (CSAT, 1999). Celebrating accomplishments, rewards and incentives have proven more powerful than punishment in shaping behavior. Research also highlights the importance of establishing a "recovery identity." People who report an identity transformation have a concept of themselves as a recovering person and feel a sense of belonging to a community of people in recovery. These people are more successful at maintaining abstinence from substances (Baker, 2000; Veysey et al., 2009). It is also easier to replace a behavior than to extinguish it. Often addicts that have highly ritualized routines and behaviors associated with drinking or using, replace them with the rituals of recovery. For example, the happy hour drinker may gravitate to a 5:30 p.m. AA meeting on weekdays.

6. Following Release

Program staff in some jurisdictions contacts offenders by telephone within two days of release, providing policies allow it. Program administrators may consider allowing offenders to maintain contact with staff during the initial transition into the community. Some states also contract for post-release recovery coaching by phone. Preliminary outcomes in states like, Connecticut, suggest two post-release phone contacts weekly from a trained peer coach in recovery can have a positive effect on reducing recidivism among drug and alcohol involved offenders (personal communication Phil Valentine, CCAR, February, 2009; Godley and White, 2011). In other states, connecting with providers, parole, or other case management agencies—such as TASC—allows for continuity of service and tracking of aftercare admissions. Some rural RSAT programs are even experimenting using Skype to stay in contact with released inmates.

7. Establishing a Community-Based Treatment Network

Because immediate access to aftercare is critical to offenders' success, RSAT programs should work to establish a network of community-based treatment providers for RSAT graduates released to the community. There are a number of places to start if your program does not have an existing referral network.

Some possible strategies include:

- Contact your SSA to access a list of programs or to coordinate a provider meeting
- Work with parole to access their provider network
- Host regional provider meetings to develop partnerships

Programs that are willing to provide aftercare services to RSAT offenders should agree to the following procedures to facilitate the process:

- Schedule intake appointments 45 days prior to release
- Streamline admission to treatment; work with RSAT staff to schedule an initial appointment within 48 hours of release

- Transport and immediate entry for “residential” offenders, including those entering treatment, halfway houses, and recovery homes

Remember, RSAT programs have a lot to offer community providers. About 42% of admissions to publically funded substance abuse treatment are criminal justice referrals (Crime and Justice Institute, 2008). RSAT graduates have already completed a term of treatment. It is helpful to point this out to providers who may be reluctant to accept client re-entering directly from prisons and jails. Unlike clients off the street, RSAT graduates can point to months of verified abstinence prior to their release.

C. Evidence-based Strategies to Improve Release Outcomes

Motivational Strategies

Many RSAT graduates will not be under correctional supervision upon release. In such cases, RSAT staffs face different challenges. Once the client is no longer mandated to treatment, under supervision, or confined in a facility, intrinsic motivation becomes critical. Treatment is effective when it is reinforced by sanctions, rewards, or coercion; however, the treatment professional’s job is to build some degree of intrinsic motivation during periods of mandated treatment that will outlast the mandate. This entails finding out what matters to the client. **If treatment is only effective when the client is ready to change, then it isn’t effective treatment.**
Motivational approaches are particularly appropriate when the RSAT client is ambivalent about changing his or her behavior. The inmate may be in denial about having a drug or alcohol problem. However, at the same time, that same inmate also recognizes that continued drug and alcohol use can result in a return to prison. This leads to ambivalence.

There are many strategies to increase motivation, including coercion and the certainty of immediate sanctions. For offenders under correctional supervision, graduated, certain and swift sanctions work best when they

Reflections on Motivational Interviewing in Correctional Settings by Bill Miller, Developer of Motivational Interviewing

“Prisoners” and “criminals” are among society’s most despised and rejected members. …Among nations, America has one of the world’s highest rates of incarcerated citizens, ranking with the most oppressive societies; yet the building of new prisons remains a growth industry.

It reminds me of how things once were in the addiction treatment field in the United States. The boot camp atmosphere of Synanon. The in-your-face screaming of insults and obscenities. Denial busting. The hot seat, “tearing them down to build them up.”… It seems like a bad dream now, but it was very common just two decades ago. There are far too many places where these things still occur….

It’s no surprise, given this treatment, that there arose the impression that defensiveness is a natural concomitant of substance use disorders.

Something happened. In a relatively short period of time, treatment has changed. Is it too much to hope, then, that the field of corrections could see a similarly major change in the next twenty years? Offenders are the last major group in our society whom it is generally acceptable to abuse because they “need” and “deserve” it— because it is good for them and for society, and is “the only language they can understand.” All evidence to the contrary, we collectively imagine somehow that it makes them better, and makes us a safer and more just society….What if we assumed that the central purpose of correctional systems is not to enact vengeance, but to change behavior? I know it is possible.

Source: Motivating Offenders to Change: A Guide for Probation and Parole. (2007) NIC, USDOJ (pp. xiii-xiv).

are administered on a pre-determined continuum, with revocation as the end point, rather than a response to every infraction *(see resource pages).*

However, research also reveals that rewards have a greater effect on shaping behavior than sanctions. In regard to supervised release, one group of experts recommends a ratio of four rewards to one sanction (Vera Institute, 2011). They also recommend "half back" programs combined with an intensive treatment recharge (Burke, Gelb and Horowitz, 2007). Immediate transport to jail for a weekend, or a term of monitored home confinement that starts right away are more powerful motivators than longer terms of incarceration after several weeks of hearings. The length of time from when the behavior is detected until the sanction is given matters (Yeres, Gurnell and Holmberg, 2005). While RSAT programs are not in control of community supervision policies, RSAT staff can and should assess and increase client motivation. Several tools actually measure readiness to change and increased motivation. Links to some of these tools are listed on the resources pages. **Motivational Interviewing techniques can be especially helpful**.

The National Institute of Corrections has developed two handbooks to assist RSAT counselors and program administrators with implementing motivational approaches. They are also listed at the end of this module. Even if training resources are limited, staff with a basic understanding of motivation as a dynamic, changeable characteristic and of the elements of change theory can utilize prompts during pre-release sessions with RSAT offenders (see exercise two).

Contingency Management (CM)

CM is a system of pre-determined rewards used to acknowledge and reinforce ***target behaviors*** and increase client motivation. In community-based programs, negative urine screens and other target behaviors are reinforced through the use of non-monetary rewards. Water bottles and T-shirts are examples of low cost incentives that are supplemented with chances to win a drawing for larger prizes, such as a bus pass. The combination of incentives and intermittent rewards are powerful and significantly affect treatment retention and abstinence rates. The combination is so significant that the National Institute of Drug Abuse (NIDA) sponsors a large scale project through the Blending Initiative to promote awareness of their effectiveness and products for implementation *(Available in resource section)*. After extensive research NIDA has concluded: "When providing correctional supervision of individuals participating in drug abuse treatment, it is important to reinforce positive behavior. Nonmonetary "social reinforcers" such as recognition for progress or sincere effort can be effective" (2006, p 21).

A detailed analysis of the use of CM in prisons from 1964–2004 conservatively estimated the effect size at 60–70%, a relatively high-level of magnitude (Gendreau, Listwan and Khuns, 2011). Recognition, privileges, leadership roles, earning early release, and reductions in intensity of supervision are “no cost” incentives RSAT programs and post release aftercare can utilize. Operant conditioning uses rewards to teach offenders desired behavior; punitive consequences teach client what not to do (or what not to get caught doing!). Note: Once offenders are released, undesirable behavior will be more difficult to identify and detect, but desirable behaviors can be more readily monitored and reinforced.

Medication Assisted Treatment (MAT)

Medication Assisted Treatment (MAT) is pharmacotherapy used to support recovery efforts for people seeking to overcome addictive disorders. It combines prescribed medications **with** counseling and behavioral therapies, monitoring, community-based services, and recovery support. As suggested in its name, MAT is designed to **assist**, not replace other treatment and recovery efforts.

Some of the medications provide significant relief from craving and withdrawal symptoms, reducing the preoccupation with using or drinking, and allowing the offender to derive maximum benefit from supportive services such as counseling, mental health treatment, medical services, vocational rehabilitation, and community support. MAT for opioid addiction has effectively helped to facilitate recovery for many offenders.

There is a great deal of research on the effectiveness of opiate replacement therapy in reducing criminal behavior, decreasing recidivism, reducing institutional disciplinary infractions and contraband, decreasing fatalities, relapse rates and negative health consequences. The spread of infectious diseases, including HIV and Hepatitis, among offenders is also reduced. These effects have been found to be many times greater than the effect of behavioral treatments (Marlowe, 2003).

Despite the research, use of MAT in the US criminal justice system is limited, mainly due to attitudes and beliefs. MAT for justice-involved individuals remains one of the most under-utilized tools for reducing recidivism (Prendergast, 2009).

Regardless of the future of MAT inside correctional facilities, its use in community-based treatment is increasing. The availability of buprenorphine through private physicians along with FDA approval of long–acting, injectable naltrexone (Vivitrol®), first for alcohol and now for opioids, has brought MAT options to many individuals who would not or could not access methadone treatment for opioid addiction. Acamprosate (brand name Campral®), was approved by the FDA in 2004 for alcohol dependence. Along with Vivitrol®, it is becoming more widely utilized to treat alcohol problems (Abraham, Knudsen & Roman, 2011).

FDA-Approved Medications for Substance Use Disorders

Medication Brand name	Use(s)	FDA Approval	Effects	Delivery	Controlled Substance	Warnings
Acamprosate Calcium Campral®	Alcohol	2004	**Anti-craving:** cravings decrease as the medication relieves symptoms of protracted alcohol withdrawal or post-acute withdrawal	Swallowed in pill form three times a day	No	Increases in suicidal thoughts and depression possible; may be contraindicated for those with kidney problems
Disulfiram Antabuse®	Alcohol	1951	**Aversive:** causes severe physical discomfort if patient consumes alcohol, including severe nausea	Swallowed in pill form once a day	No	Risk of liver damage, drug interactions, and negative effects for people with certain mental disorders
Naltrexone Pills: Depade® ReVia® Injectable: **Vivitrol®**	Alcohol Opioids Alcohol Opioids	1994 1984 2006 2010	**Antagonist** or blocker: acts on opioid receptors, blocks cue-triggers and craving and decreases the euphoric effects of alcohol. Blocks euphoric and analgesic effects of opioids; initiates withdrawal symptoms if taken while opioids are in the body. Safe to take 7–10 days after last opioid use.	Swallowed in pill form daily. Prescribed by any medical provider Injectable form once a month from any provider	No	Black box liver warning. High risk of overdose during relapse due to decreased tolerance or using large amounts of opioids to override the blocking effect. Risk of drug interactions during a medical emergency
Buprenorphine Subutex® Suboxone®	Opioids single drug formula Compound formula with naloxone	2002	**Partial Agonist**: Long-acting partially synthetic opioid; relieves withdrawal and craving; prevents other opioids from working. Does not have full euphoric effect of other opioids- may not eliminate withdrawal for heavy users. Suboxone® is formulated with antagonist to prevent abuse/ IV use and is not safe to use with other opioids. Subutex® only, is safe for pregnant women. Safe to take 12–24 hours after last use.	Tablet dissolved under the tongue daily or every other day. 30 day supply by can be prescribed by physicians trained in its use Tablet **or film** dissolved under tongue; also available by prescription; all forms available through opioid treatment programs	Schedule III	Moderate to low risk of overdose. Potentially fatal interaction with benzodiazepines. Moderate to high risk of overdose when combined with other substances
Methadone	Opioids		**Full Agonist**: A long-acting synthetic "full" opioid that relieves withdrawal, blocks craving, and may prevent euphoria if other opioids are used. At proper dosage adequate normal functioning without impairment or intoxication. Action similar to body's endorphins. Can be taken at any time and used with other opioids. Most effective, retention in long term treatment. Best researched and safest during pregnancy.	Typically, as an oral solution dispensed once a day only at federally certified opioid treatment programs	Schedule II	Black box warning about heart problems. High risk of overdose during initial phases of treatment or if combined with other drugs. High risk of overdose when combined with other substances. Potentially fatal interaction with benzodiazepines

The quick reference chart has information about each the medications that have been approved by the FDA to treat addiction to opioids and alcohol abuse and alcoholism.

Opioids and Addiction

All Opioids, whether legal or illegal, synthetic or natural, have certain unique effects on the brain and body. Opioids relieve pain and give people a sense of well-being or euphoria by **changing the body and brain chemistry.** Narcotic drugs are extremely effective medications, for this reason. But, the very mechanisms that make them effective also produce neurological alterations and physiological adaptations that make them seem extremely difficult to give up.

Opioids are produced three ways:

- **Your body makes its own opioids** that kill pain and produce feelings of joy and well-being, sometimes called *endogenous opioids.* Endorphins, for example, can be released by acupuncture, resulting in pain relief.
- **Opioids are derived from the plant-based alkaloids** related to the opium poppy, including codeine, morphine, and laudanum. These *opiates* emulate the effects and travel the same pathways as your own endorphins, but they are much more potent.
- **Opioids are partially or completely synthesized** in a lab to produce the opioid response. Examples are heroin, oxycodone, and fentanyl. The synthetic and semi-synthetic *opioids* are formulated to more efficiently target and intercept specific brain chemical processes and alter them.

Both the plant-based and the synthetic versions bombard the brain and body with powerful chemicals that dramatically alter primitive brain functions responsible for our natural reaction to pain. Once this occurs on a regular basis, lasting changes result (Volkow, 2004). With continued use, the “factories” that manufacture, distribute, and process our own internally produced opioids shut down and cease operations. The system begins to rely on the externally introduced substance in order to function at normal levels. Once this adaptation has taken place and a person is physically dependent, there is a reaction to not having the substance—withdrawal (NIH, 2010).

Opiate replacement therapy (ORT) normalizes brain function, reduces withdrawal symptoms and, when combined with counseling and behavioral changes, provides relief from cravings that are mediated by neurological activity at the receptor sites within the brain and stimulated by a variety of environmental and internal queues that are not fully understood (WHO, 2004).

Methadone

Methadone is a long-acting opioid medication that reduces cravings and withdrawal symptoms. It is usually given daily, in a liquid form. It satisfies the areas of the brain that opioids act on, stopping withdrawal symptoms and reducing craving. It can do this without the euphoric effects that short acting opioids produce. Since it controls withdrawal symptoms and blocks craving, people tend to stick with it and can continue to work or care for their families while being treated. Methadone is the recommended course of treatment for pregnant women. It has been thoroughly researched, is safe,

with no long term effects and considered the most effective treatment for opioid addiction.

Buprenorphine

Buprenorphine is a partial long acting opiate-like compound (agonist) that can be prescribed in a doctor's office, although now it can also be administered by a clinic licensed to dispense methadone. Although it has some potential for abuse, it is a partial agonist and does not fully bind to the receptor sites, has less of a reinforcing effect than methadone and is available in a formula that contains naloxone, an opioid blocker to prevent it from, being injected.(SAMHSA, 2012). It cannot be started until 12–24 hours after the last dose of opioids. It is also a very effective treatment, especially for those with mild to moderate opioid problems.

Vivitrol®

Vivitrol is a long acting injectable form of Naltrexone, an antagonist that blocks the opiate receptors. It can block both the euphoric and the pain relieving effects of opiates for up to 30 days, and may reduce craving in some people. It is not a controlled substance and has no potential for abuse or diversion, making well-suited to correctional environments. Using heroin with Vivitrol produces an adverse reaction, so individuals need to be free of opiates for 7–10 days before receiving an injection of Vivitrol®. Vivitrol® was approved to treat alcoholism and alcohol dependency before it was approved for opioids. There have been more studies completed with alcohol. Several studies indicate significant results, including increased ability to abstain from drinking and decreased craving. Its "efficacy" has been cited by SAMHSA as "established when given in conjunction with behavioral support (SAMHSA, 2012)."

Naltrexone also comes in pill form, but is limited in its use due to patient compliance. Many of those treated with the pill form, simply stopped taking them.

Disulfiram (Antabuse®) has been in use for many years. Its action interferes in the processing of alcohol, resulting in aversive physical responses to any intake of alcohol. National Institute on Alcohol Abuse and Addiction (NIAAA) clinical guidelines state: "The utility and effectiveness of disulfiram are considered limited because compliance is generally poor when patients are given it to take at their own discretion" (2005, p. 2). Its use is limited to highly motivated patients and those who can be directly observed while they take the medication. It is contraindicated for patients that are still drinking.

Acamprosate (Campral®) acts on the GABA and glutamate neurotransmitter systems. Post-acute withdrawal from alcohol is characterized by depression, anxiety, restlessness and insomnia, among other complaints. GABA moderates and maintains balance of the excitatory neurotransmitters that lead to anxiety. Too little GABA tends to result in anxiety disorders. Acamprosate is thought to control the anxiety, restlessness, and dysphoria that lead to relapse in abstinent alcoholics. U.S. trials failed to confirm the significant results of the European studies, but there were several conditions that were not replicated. For example, the European subjects had more severe alcoholism and were abstinent longer prior to beginning the medication. Some medications tend to show a greater effect with more severely addicted patients (NIAAA, 2005).

A few facts and considerations related to re-entry and MAT:

- If a client discontinued methadone or another type of ORT when became incarcerated and wants to continue, a referral to a provider is appropriate, unless there are parole policies that prohibit it.
- Unless the client does not meet the criteria for opiate dependence, choice of treatment is appropriate. Just as in the case of a client with cancer, the attending physician and the informed client should weigh the treatment options and review the risks and benefits.
- One study estimated an offender's risk of death in the first two weeks following release from prison is estimated to be 12.7 that of the general population (Bingswanger et al., 2007). Another study found death rates 40 times higher among newly released offenders, with 90% of the deaths due to drug overdose (Stover & Michels, 2010).
- Prolonged opiate use leads to physiological tolerance necessitating larger and more frequent doses to achieve an effect. That tolerance is reversible after a period of abstinence; a dosage that might have been tolerated months earlier can be fatal.
- Recent research found that 53% of the opiate dependent ex-offenders studied had overdosed at least once; 80% had witnessed an overdose; 28% witnessed a fatal overdose and 72% knew someone who had died from an overdose (Wakeman et al., 2009).
- Because people who choose medication assisted recovery are often stigmatized, sometimes even within sectors of the recovery community, it is important to connect re-entering offenders who may choose this course of treatment to recovery support and drug counseling, especially those receiving buprenorphine from a private physician.

RSAT staff should stay informed about MAT options and offer unbiased information to inmates, including facts on tolerance changes and education on overdose measures.

Note: For a comprehensive look at MAT for offenders visit the RSAT website at http://www.rsat-tta.com/Home and download the RSAT manual- **Medication Assisted Treatment (MAT) for Offender Populations** and watch for the eLearning-coming soon.

D. Integrated Treatment

According to the National Institute on Drug Abuse, no one treatment is effective for all individuals (2006). The same applies to aftercare. The wrong aftercare regimen can backfire. For example, when low risk offenders with low to medium addiction severity and high levels of recovery capital (a profession, family support, pro-social associations and activities) are mandated to day reporting centers and high intensity outpatient or residential treatment upon re-entry, research has found that are more likely to recidivate due to the disruption of their pro-social networks and activities. Natural supports that influence their behavior, such as work and family, are replaced by exposure to high risk offenders and levels of clinical care that may not be indicated (Crime and Justice Institute, 2005).

Although it is beyond the scope of this manual to review all the individual factors that can influence re-entry and recovery success, information on gender and co-occurring disorders follows. Unfortunately, less information is available on re-entry practices and behavioral health tailored to cultural, ethnic and racial sub-groups. Nor is there enough information on addiction treatment and recovery, especially the effects of pharmacological interventions for all races and ethnicities. Deep disparities in behavioral health services continue to affect people of color, coupled with disproportionate rates of incarceration. Research in these areas is evolving, especially on protective factors associated with cultural and community connections and the effects of historical trauma among groups like Native Americans and on their susceptibility to addiction.

Note: Download the RSAT manual-**Trauma informed Approaches in Correctional Environments** for more information on the relationship between addiction and trauma among offenders at http://www.rsat-tta.com/Home and watch for the eLearning-coming soon.

Co-Occurring Disorders

Some RSAT graduates will need to establish linkages with community mental health services prior to release, especially if they need ongoing medication management and other treatments. Following is a brief discussion of principles and practices that have resulted in effective collaboration between mental health and corrections on behalf of re-entering offenders with CODs. As you can see, many of these approaches rely on open communication between providers. The treatment team approach is central to integrated treatment of CODs. As RSAT graduates leave the facility, it becomes increasing important that service providers are on the same page.

Integrated Treatment Practices

- **Comprehensive:** Treatment considers all needs, not just one set of symptoms or the most obvious issues. It also incorporates the needs of family members, including children, and family of choice.

- **Collaborative:** Substance abuse treatment providers listen to the mental health provider's views about the client and ask questions in an open and curious manner. If differences in viewpoints exist, acknowledge that they may stem from the different focus of the two professions. If conflict is inevitable, better to try to resolve it than risk asking the client to manage it.
- **Assertive:** Providers make every effort to engage offenders in services and make services as accessible as possible. Communicate your desire to work collaboratively on behalf of the client. Although offenders with CODs do best when they take a proactive role in their own treatment, it is still important to continually provide opportunities to access services.
- **Focused on reducing harm:** Although abstinence may be a long-term goal, it's important to reinforce reductions in unsafe use and behavior in the short term to continue him/her on the road to recovery. Communicate specific observations about the client using clinical terms, withholding conclusions and interpretations unless asked. Clarify expectations.
- **Long-term in perspective:** Recovery includes both progress and setbacks. Treatment focuses on improvement over time rather than immediate results. For offenders with CODs, learning to manage both chronic conditions is a process.
- **Based on motivation:** Treatment planning considers the client's readiness to change in different areas and seeks to motivate and empower positive changes. Communicate unconditional respect for the client and reinforce their capacity to improve.

For a more on **Co-occurring Disorders and Integrated Treatment Strategies for RSAT** inmates go to http://www.rsat-tta.com/Home and download the manual or access an ELearning course.

Exercise Two: Open-ended Questions for Re-entry Planning

How you approach re-entry is just as important as what you recommend.

Many parole and probation departments have trained staff in motivational interviewing (MI). Once offenders leave custody, intrinsic motivation is what gets them to the field services office to report. It is important to develop it during the pre-release phase of RSAT programs.

OARS stands for the different MI responses that can be used during exchanges with the client: O=open ended question; A= Affirmation; R=reflection and S=summary

Instructions: Read each section of questions and statements. Use the OARS initials to identify the comment. For example, "Tell me more about your childhood" is an open ended question. You would put and O in the space provided. If you find a closed question, put a C in the space provided (4 of the answers are combinations).

Permissions

(These questions can be applied either in an individual or a group setting.) If the client(s) respond with a "no," follow up with: "What else would be helpful?"

__ *Would you like to get some feedback?* C
__ *So, what you are saying is at this time, additional information is not helpful?* R
__ *What is it like for you to talk about your children?* O
__ *Alright if we discuss this violation?* C

Change talk to reduce recidivism

__ *So there are things you have to watch out for to stay out of jail.* S
__ *What do you think you might find hardest to comply with?* O
__ *You did well with the wedding. I particularly like that you arranged for your mom to have a ride home.* A
__ *Why do you think your girlfriend is concerned about your drinking?* O
__ *I see there are a lot of things you are doing differently this time but a couple areas where you think you could improve. Is that accurate?* R

Screening and assessment questions

__ *So, you have been able to stop using and drinking for periods.* S
__ *I am hearing you have been on lots of mental health medications.* R
__ *How old were you the first time you got drunk?* C
__*Tell me about what you do with your friends that don't drink.* O

Expanding support systems

__*Who are the people in your life who want you to succeed on probation?* C
__ *I think it's great that you took the initiative on your own to find the help.* A
__*You have a lot of numbers, but you don't use them. Why not?* R/O
__ *So, you know about the places in your community you could go for help.* S
__ *Tell what has helped you the most when you wanted to use in the past?* O

Increasing self-efficacy

__*How did you manage to do so well for the months you were on parole?* O
__*Tell me one thing you successfully changed since you started the program?* C
__*I am impressed that you saved up for an apartment. How did you do it?* A/O
__ *Why do you think the board felt you would be able to succeed on parole?* O

Developing Discrepancy

__ *You said getting your daughter back was part of your release plan, but I see she can't visit the place you intend to live. Tell me how visitation will work?* S/R
__ *You said you had no guilt about things you did while using, but this lie to your wife seems to bother you a lot.* R

Review and Resources

Review

RSAT programs with a distinct re-entry phase are structured to prepare offenders for release. Some of the elements that make them effective are:

- Pre-release assessment of risks and needs, addiction severity, motivation, and recovery capital
- Re-entry planning based on assessments; matching levels of supervision/treatment intensity
- Attend to responsivity – transportation, COD's, employment, and cultural considerations
- Family involvement, preparation for re-unification, and gender responsive services for women
- Aftercare continues for at least 90 days and builds ongoing support for recovery management through pro-social peer and community connections
- Collaboration at systems, program, and community levels between enforcement, treatment, and recovery support stakeholders
- Drug and alcohol testing and monitoring with incentives and graduated sanctions
- Self-efficacy increases through role play, skill rehearsal, recognition for completion and announced commitments
- Tangible supports are maximized- benefit enrollment, housing, medical, job training, and community-based case management resources for diverse offenders

- Dedicated staff that develops contacts with parole, community providers, and recovery support networks can gain specialized case management knowledge about benefits and resources. They facilitate two way communication and hand-offs to community corrections and providers, serving as a point of contact for families, employers, and the faith and recovery communities.
- Motivation during the re-entry phase is essential. The client should assume responsibility for re-entry planning work, with support from staff and peers. Motivational interviewing, positive reinforcement, incentives, peer support, and community recognition help increase pre-release engagement and self-efficacy, along with approaches that are responsive to gender and culture.
- Collaboration is most effective when the Single State Agency(s) for substance abuse communicates with RSAT administrators, and works with providers to facilitate transitional planning. RSAT programs can offer motivated offenders that have made significant treatment gains, with the understanding that gains must be preserved during the initial hours post-release, through the first few months of re-entry transition.

Resources

Jails

- *The Jail Administrators Toolkit for Re-entry.* Mellow, J, Mukamal, D., LoBuglio, S, Solomon, A & Osborne, J. (2008). The Urban Institute, John Jay College & BJA. The Toolkit is practitioner oriented and contains examples of strategies used in jails throughout the country https://www.ncjrs.gov/pdffiles1/bja/222041.pdf

- *Life after Lock-up: Improving Re-entry from Jail to the Community.* Mellow, J, Mukamal, D., LoBuglio, S, Solomon, A & Osborne, J. (2008). The Urban Institute, John Jay College & BJA. http://www.urban.org/UploadedPDF/411660_life_after_lockup.pdf This publication is the research focused companion to the Toolkit, and also contains examples from model programs.

National Directory of Re-entry Programs

- Re-entry Policy Council Searchable database of re-entry programs http://reentrypolicy.org/ Look up re-entry initiatives, programs and resources in your state.

Benefits

- *Helping Inmates Obtain Federal Disability Benefits: Serious Medical and Mental Illness, Incarceration, and Federal Disability Entitlement Programs* by Catherine H. Conley. https://www.ncjrs.gov/pdffiles1/nij/grants/211989.pdf

- *After Prison: Roadblocks to Reentry, A Report on State Legal Barriers Facing People with Criminal Records* Legal Action Center (2004). Laws and regulation effecting employment, housing and other benefits and state by state information *:* http://www.lac.org/roadblocks-to-reentry/upload/lacreport/LAC_PrintReport.pdf

Brazelon Center for Mental Health Law (series includes staff training)

- *Finding the Key to Successful Transition from Jail to the Community: An Explanation of Federal Medicaid and Disability Program Rules.* Technical explanation of federal Supplemental Security Income (SSI), Social Security Disability Income (SSDI) and applicable Medicaid and Medicare rules.

- *Arrested? What Happens to Your Benefits If You Go to Jail Or Prison?* This booklet is a guide to federal rules on SSI, SSDI, Medicaid, Medicare and Veterans benefits written for adults with disabilities..

- *Creating New Options: Training for Corrections Administrators and Staff on Access to Federal Benefits for People with Mental Illnesses Leaving Jail or Prison.* Manual and accompanying PowerPoint presentation.

Contingency Management

- National Institute of Drug Abuse (NIDA) Blending Initiative lessons from the NIDA Clinical Trails Network: http://www.bettertxoutcomes.org
  - *Promoting Awareness of Motivational Incentives*- Introductory training
  - *Motivational Incentives: Positive Reinforcers to Enhance Successful Treatment Outcomes*- Online course to implement evidence-based incentive programs.
- Texas Christian University-Institute of Behavioral Research. *Contingency Management Strategies and Ideas:* http://www.ibr.tcu.edu/evidence/evi-mapcoun.html

Motivational Approaches

- Motivation Offenders to Change: A Guide for Probation and Parole. (2007) National Institute of Corrections http://static.nicic.gov/Library/022253.pdf
- Motivational Interviewing in Corrections: A Comprehensive Guide to Implementing MI in Corrections. (2011). National Institute of Corrections: http://static.nicic.gov/Library/025556.pdf
- Center for Substance Abuse Treatment (1999). *Enhancing Motivation for Change in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 35. William R. Miller, Ph.D. *http://www.ncbi.nlm.nih.gov/books/NBK64967/*
- Texas Christian University-Institute of Behavioral Research. Targeted Interventions for Corrections (six manual suite)
  - *TCU Mapping-Enhanced Counseling* and *Getting Motivated to Change* http://www.ibr.tcu.edu/evidence/evi-mapcoun.html

Medication Assisted Recovery

- Center for Substance Abuse Treatment. (2004). *Clinical Guidelines for the use of Buprenorphine in the Treatment of Opioid Addiction,* Treatment Improvement Protocol (TIP) Series 40: http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf
- SAMHSA Advisory*: An Introduction to Extended- Release Injectable Naltrexone for the Treatment of People with Opioid Dependence*: http://store.samhsa.gov/product/Advisory-An-Introduction-to-Extended-Release-Injectable-Naltrexone-for-the-Treatment-of-People-with-Opioid-Dependence/SMA12-4682
- *Legality of Denying Access to Medication Assisted Treatment In the Criminal Justice System* (2011). Legal Action Center: http://www.lac.org/doc_library/lac/publications/MAT_Report_FINAL_12-1-2011.pdf
- Center for Substance Abuse Treatment. (2005). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* Treatment Improvement Protocol 43: http://www.ncbi.nlm.nih.gov/books/NBK64164/
- Center for Substance Abuse Treatment. (1993). *Pregnant, Substance-Using Women* Treatment Improvement Protocol 2: http://www.ncbi.nlm.nih.gov/books/NBK64766/

Tools and Measurements

- The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) *Version 2:* http://casaa.unm.edu/inst/SOCRATESv8.pdf
- The University of Rhode Island Change Assessment http://alcoholrehab.com/alcohol-rehab/university-of-rhode-island-change-assessment-scale-urica/
- Inmate Pre-Release Assessment (IPASS) Texas Christian University-Institute of Behavioral Research http://www.uclapcrc.org/partners/IPASS/documents/CJDATS%20BR%20for%20IPASS%2007-17-06.pdf
- *Creation and Validation of the Ohio Risk Assessment System (ORAS): Final Report***.** (2009). Latessa. E. et al. University of Cincinnati Center for Criminal Justice Research: http://www.uc.edu/content/dam/uc/ccjr/docs/reports/project_reports/ORAS_Final_Report.pdf

Criminal Justice Sanctions and Incentives

- *Making Sense of Incentives and Sanctions in Working with the Substance Abusing Offender (2005).Yeres, S.,Gurnell, B. & Holmberg. M.* http://www.ncjfcj.org/sites/default/files/incentivesandsanctions5_0.pdf

- *Sanctions and Incentives* (2011) Power Point presentation from the Crime and Justice Institute Guevara, M., Butler M. and Rist, M. http://www.cjinstitute.org/files/CAWorkSession_SanctionsIncentives_Presentation_Oct11.pdf

Peer Support

- Bridging the Gap is an AA effort that provides temporary contacts to offenders in recovery who are re-entering the community. The link takes you to the information pamphlet from the AA Central Service Office http://www.aa.org/pdf/products/p-49_BridgingTheGap.pdf

- Link to the AA approved information pamphlet on AA contacts for re-entering offenders in recovery http://www.aa.org/pdf/products/f-162_AACorrectionsPreRelease_Outside2.pdf

- *Employing Your Mission: Building Cultural Competence in Reentry Service Agencies Through the Hiring of Individuals Who Are Formerly Incarcerated and/or in Recovery* (2011). Fortune Society and Prisoner Re-entry Initiative at John Jay College of Criminal Justice show how racially and ethnically diverse populations, ex-offenders and recovering community members strengthen re-entry programs: http://fortunesociety.org/wp-content/uploads/TOOL-KIT-2_Employing-Your-Mission_FINAL-Lo-Res-Emailable_110501.pdf

- Faces and Voices of Recovery – National listing of regions and recovery resources by state and Recovery Community Organizations. Publications on re-entry, advocacy and information on legislation and civil rights of importance to recovering people: http://www.facesandvoicesofrecovery.org/regions

- Oxford Houses – National Organization and Directory- House are democratically run, self-supporting and drug free homes with 6-15 residents in recovery. National site has charters, manuals and guidelines as well as a state by state searchable database: http://www.oxfordhouse.org/directory.php

******For resources and information regarding re-entry for people with Co-occurring Disorders, Medication Assited Treatment, HIV/AIDS or histories of Trauma see RSAT Curricula listed at http://www.rsat-tta.com/Home and related archived webinars.***

Supplemental Module: Women Offenders and Family Issues

Women incarcerated in US prisons and jails have travelled a distinct pathway to criminal activity that includes childhood trauma, poverty, intimate partner violence, substance use and mental health disorders, lack of marketable job skills, and physical health concerns (Women's Prison Association, 2005). Addictive disorders and mental health problems commonly co-occur, compounded by histories of complex trauma. Addictive illness has been identified as the driver of increasing rates of incarceration among women (Grella and Greenfield, 2007). **Moreover, drug use is the number one reason why they return to prison** after release (Miller and MacDonald, 2009).

Women differ significantly from men with regard to substance treatment needs, and benefit from modified therapeutic communities that create structured, safe environments and utilize non-confrontational empowerment approaches. Community and relationship building is foundational. Research demonstrates women are more likely to continue treatment if they feel staff and peers are caring, whereas men continue if they think it is effective (CSAT, 2009).

Sex-linked differences in physiological responses to substances are also significant. Women sustain more severe organ damage from lower levels of substance use over shorter periods. Women become addicted more quickly, do not metabolize substances as efficiently and experience more severe withdrawal symptoms (NIDA n.d.). Women offenders are less likely to have insurance, may not have accessed routine care prior to incarceration and more likely to have serious health conditions. They have three times the rate of HIV infection, as compared to male offenders, and high rates of Hepatitis C (De Groot and Uvin, 2005).

Women offenders, as compared to male offenders are more likely to:

- Report IV drug use prior to incarceration
- Test positive for substances upon arrest
- Report homelessness in the last six months prior to incarceration
- Report past suicide attempts and psychiatric hospitalizations

Women in SUD treatment are also:

- More likely to report onset of drug use encouraged by spouse and partners
- More likely to report ongoing use encouraged by spouse and partners
- More likely to report that family or friends used drugs in the past year
- Less likely to report pressure from spouse to enter treatment
- Less likely to report having supportive family or friends (CSAT, 2009)

More than three-quarters of women in residential substance abuse programs are from families involved in alcohol or drug-related activities (CSAT, 2009). For incarcerated women, rates of sexual victimization across the lifespan are highest in childhood (Blackburn et al., 2008; Clements-Nolle, Wolden & Bargmann-Losche, 2009; Raj et al., 2008). The woman offender is also more likely to have experienced intimate partner violence and more likely to be involved with someone who uses substances, and who is

engaged in criminal activities. Among male offenders, family and intimate partners tend to be supportive, stabilizing influences. But, re-entry goals for women may include rebuilding a support system from the ground up. Further, such rebuilding may be necessary not only to support sobriety but also help the female offender achieve personal safety upon release.

Women offenders' histories of victimization can result in complex mental health, medical, and addiction problems. Post-Traumatic Stress Disorder (PTSD) alone co-occurs in 33% to 48% of women offenders with SUDs (Chesney-Lind & Sheldon, 2004; Najavits, 2007; Tull, 2010). The correctional system has been unprepared for the influx of women in recent years, the depth of their behavioral health treatment needs and the complexity of their re-entry needs. Many RSAT programs serving women, however, are in the vanguard and all should be!

Criminogenic factors in Women:

Specific women's criminogenic risk and needs assessments have been developed. ***Risk factors associated with recidivism, specifically among women include mental health symptoms, past trauma and abuse, and current substance abuse*** (Van Voorhis, Salisbury, Wright & Bauman, 2008). Also indicated as recidivism risk factors for women:

- Anger/hostility
- Parental stress
- Relationship dysfunction
- Low self-efficacy
- Low parental involvement
- Housing safety

As correctional facilities look ahead to health reform they can consider the unique situation of incarcerated women. Many of these women are mothers, but are not actively parenting immediately upon release. In the past, single adults were ineligible for Medicaid and for many incarcerated women this effectively tied coverage to their parenting status, making access inconsistent. Prisons and jails that house women see the extreme case of these problematic policies among opioid addicted women who are treated with methadone during their pregnancy and tapered off within six weeks after giving birth at an extremely high-risk time for relapse.

In 2014, women will not only be eligible for health care coverage upon release, they will also have preventive care at no cost for themselves and their children. In August of 2012, the prohibition on co-pays for certain preventive services went into effect. New health plans are now required to cover additional prevention services for women with out cost sharing, including domestic violence screening and counseling, as recommended by the Institute of Medicine (National Women's Law Center, 2012).

Pre-enrolling women in Medicaid and moving them into minimum security pre-release facilities will allow and encourage them to use their benefits for behavioral health needs and for treatment and prevention of chronic conditions. In anticipation of these opportunities, correctional administrators may want to revisit women's risk and needs assessments. Newer gender responsive assessments are more accurate than those

developed for men, which tend to overestimate the risk women offenders present (Vanvoohris, Salisbury Wright, & Bauman, 2008).

Treatment Issues for Women

RSAT programs that offer trauma-informed care, assessment, services for women with co-occurring mental health issues, and connections to gender responsive services in the community provide the most opportunities for incarcerated women to succeed upon release.

RSAT programs that serve women need to rely on community partners to a greater degree than men's programs. RSAT administrators have proven successful in maximizing community support from public, non-profit, and faith and recovery community groups as well as women's organizations.
Interagency co-ordination encompasses:

- Agency contacts for RSAT case management staff
- Cross training and resource sharing
- Pre-release client contacts, introductions and interviews
- In-reach from volunteer groups, providers, peer, family, and community support

The good news is that although women are less likely to access treatment for substance use disorders than men, they are more likely to benefit from it (Najavits, 2007)!

Key partners, at minimum may include:

- Child Welfare and Family Services
- Single State Agency's Women Services Coordinator
- Family-based Treatment Providers
- Domestic Violence Coalition or Local Service Provider
- Women's Health/ Minority Health Organizations
- Early Childhood Services and Infant Mental Health Services
- Women's Counseling Centers and Mental Health Centers
- Housing Programs
- Employment /Workforce Development/Vocational Rehab
- Women's Peer Support/ Mentoring/ Faith/Recovery Support

Women with mental health and substance use disorders tend to be a highly stigmatized group. When referring them to services in the community, it is best to introduce them to a contact person they feel they can trust. During the re-entry phase, in-reach contacts and pre-release interviews help to bridge women to outside support. It is a mistake to underestimate the lengths to which these women will go to avoid the judgments of a service provider who treats them pejoratively.

Family Issues

Family and relationship issues are central for women offenders. Successful re-entry case management models should help the female inmate to expand her network of support and sort out her unsafe relationships from her supportive relationships.

More than three quarters of women offenders have children. Many are single mothers, and most were responsible for dependent children prior to incarceration, single or

married. Involvement with the child welfare system may have preceded incarceration for some women offenders with SUDs. Others may have placed their children with a relative, more likely to be the grandmother than the biological father. This is in contrast to male offenders, 90% of whom leave their children in the care of the biological mother. At least 11% of all women offenders have children in placement within the foster system and it is probably higher for female RSAT offenders (CSG, 2009). These mothers may face a finite number of months before the family court system seeks permanency and their parental rights are terminated. For this reason RSAT programs that serve women (and men) need a direct line of communication to the state's Family Division. Visitation, court dates and reunification plans should be monitored carefully as release approaches. Obviously, maintaining custody of their children may serve as a powerful motivator for treatment.

RSAT staff can assist women to be successful mothers upon release. Women in the re-entry phase may be able to increase pre-release contact with children through video visitation, participation in programs like Girl Scouts Beyond Bars and parenting groups, in order to promote reunification. Re-entry may bring with it the overwhelming experience of "shock" motherhood. Within hours of release, children, with their own adjustment needs, emotional responses and cadre of new limit testing behaviors, appear. Respite care, parent aides and other services may be available, if the state is involved. Re-unification planning prior to release can enlist any available family resources. Dedicated RSAT re-entry staff can assist in locating summer camps, weekend high school prep programs, prevention coalitions and mentoring programs for children of incarcerated women. Working with community programs is integral to the successful reintegration of both women and their children.

Treatment providers can also be recruited on the basis of their accommodations for children and family-based services. The resource pages list evidence-based parenting groups appropriate for women in SUD treatment, resources for the children of incarcerated parents, along with cross training on the child welfare system for substance abuse counselors.

Safety Planning

Studies also show that 40–80% of women with substance use disorders have experienced intimate partner violence (IPV) and that 47%–70% are current IPV victims Women in prisons and jails are even higher risk to have experienced IPV (Bennett & Lawson, 1994; Miller, Downs, & Gondoli, 1989; Stark & Flitcraft, 1996).

RSAT staffs can learn about IPV and help offenders also understand that successful substance abuse treatment is essential to safety. The research is clear. **The presence of substance use increases the severity of injuries and lethality rates of victims of IPV.** Substances are involved in 68% of IPV homicides of women. Homicide at the hands of an intimate partner is the leading cause of injury related deaths among pregnant women (Chang, Berg, Saltzman and Hendron, 2006). Abused women are also much more vulnerable if they have a substance use disorder. A coroner's report of IPV fatalities in New Mexico, for example, found that toxicological data collected from the autopsy records of the female victims found 33% had evidence of elevated ethanol (alcohol) at the time of autopsy. In addition, a quarter of the victims had cocaine,

marijuana, opiates and amphetamines in their systems at the time of their murders (Olson & Brody, 1999). Nearly, 83% of IPV homicides occur when women are separated or about to terminate the relationship (University of Cincinnati, 2005).

In referring RSAT offenders to community treatment providers, RSAT staff may want to make sure these providers have adequate policies in place regarding screening for IPV, assisting victims to obtain orders of protection and safety planning, especially in smaller communities. RSAT staff, through in-reach from domestic violence service providers or through training themselves, can help inmates by assessing the risk of intimate partner violence and potential for lethality upon release and ensuring they complete a safety plan during the re-entry phase.

Pregnancy

Approximately 6% incarcerated women were pregnant at the time of arrest (Fearn & Parker, 2004; Harrison & Beck, 2004). The correctional system is responsible for pre-natal care and obstetrical services through labor and delivery. Many states and jurisdictions have diversion and early release programs for pregnant inmates. When it is possible for these mothers-to-be to have community supervision arrangements, it is usually preferable for mother and baby and for the correctional facility, since more services are available in the community; however, that may not be possible. A proven practice for pregnant women in custody who are addicted to opioids is methadone maintenance therapy. Correctional facilities can provide this to pregnant inmates. The long acting opiate agonists regulate the blood pressure and heart rates, making the fetal environment more stable. Post-partum care ensures the infant is stabilized and the mother is then withdrawn from the methadone or may continue with replacement therapy. More information is available in the resource section. Your state substance abuse agency can also assist RSAT staff with services for pregnant women. Federal regulations for substance abuse block grant funds mandate pregnant women receive priority admission to treatment and pre-natal care.

Visit the RSAT website at http://www.rsat-tta.com/Home to download two publications relevant to women offenders:

1. RSAT Trauma Informed Approaches in Correctional Settings Manual. This site will also take you to an eLearning course covering detailed information on working with RSAT offenders who have experienced significant trauma,

2. Resource Guide for Staff Development – Women and Girls in Substance Recovery Programs in Correctional Settings. Encouraging workforce development through integrated, gender-specific behavioral healthcare information across disciplines. Miller, N (2011). http://www.rsat-tta.com/Library/Research-References-and-Related-Publications

Resources – Women

- Center for Substance Abuse Treatment (2008). *Substance Abuse Treatment for Women Offenders: Guide to Promising Practices* Technical Assistance Publication Series 23 (TAP23). Kassebaum, P. http://store.samhsa.gov/product/TAP-23-Substance-Abuse-Treatment-for-Women-Offenders-Guide-to-Promising-Practices/SMA08-3929

- National Institute of Corrections and Women's Prison Association. (2009). National Directory of Women's Correctional Programs (NIC). Fifty state searchable database of women's prison and jail programs, descriptions, practice and contact information: http://nicic.gov/WODP/

- National Resource Center on Justice Involved Women. Technical assistance center for programs working with adult women: http://www.cjinvolvedwomen.org/

- Best Practices Tool Kit: An Update on Gender Responsive Strategies – 2011, From the Criminal Justice Research Center at the Ohio State University: https://kb.osu.edu/dspace/bitstream/handle/1811/49080/TOOLKIT-Update-on-Gender-Responsive-Strategies-2011.pdf?sequence=1

- Women's Prison Association
  - Housing Manual: http://www.wpaonline.org/pdf/WPA_HousingManual.pdf
  - Matrix for Success in the Community: http://www.wpaonline.org/pdf/Success_in_the_Community_Matrix.pdf.

Family Programs

- Center for Substance Abuse Treatment. (1997).*Substance Abuse and Domestic Violence*. Treatment Improvement Protocol 25: http://lib.adai.washington.edu/clearinghouse/downloads/TIP-25-Substance-Abuse-Treatment-and-Domestic-Violence-68.pdf .

- Center for Substance Abuse Treatment. (2004). *Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues*. Treatment Improvement Protocol 36: http://www.ncbi.nlm.nih.gov/books/NBK64901/

- National Center on Substance Abuse and Child Welfare. *Understanding Child Welfare and the Dependency Court: A guide for substance abuse treatment professionals.* On-line tutorial: http://www.ncsacw.samhsa.gov/tutorials/tutorialDesc.aspx?id=1

- United Nations Office on Drugs and Crime, Vienna. (2010). *Compilation of Evidence-based Family Skills Training Programmes.* http://www.unodc.org/docs/youthnet/Compilation/10-50018_Ebook.pdf

Module III: National Health Reform and Corrections

A. Background to the Patient Protection and Affordable Care Act (PPACA)

B. Relevance to Corrections and Re-entry

C. Planning Strategies for County Jails

D. Planning Strategies for State Prisons

E. Resources and Review

Learning Objectives

After completing this module, participants will be able to:

- Explain the basic components of national health reform and its application to correctional populations
- Identify the necessary steps to plan for national health reform for correctional populations and reentering inmates
- List key partnerships and processes that can facilitate pre-release public benefit enrollment for re-entering offenders
- Discuss the potential benefits and challenges national health reform presents for correctional administrators and staff

Knowledge Assessment Test

True False Questions

1. A large portion of newly eligible Medicaid recipients will have a background of criminal justice involvement.
True

2. Currently, only adults with disabilities and some of those who have custody of minor children are eligible for Medicaid; the majority of the correctional population is not.
True

3. Parolees who are undocumented immigrants will have access to Medicaid under national healthcare reform. False

4. Healthcare reform means people who are incarcerated will have Medicaid benefits.
False

5. Medicaid and other benefit eligibility should be assessed at the point of entry into a correctional facility. True

6. The process of applying for benefits or reactivating suspended benefits can't be started until offenders know their release date.
False

7. In preparation for healthcare reform, screening at intake can include questions about benefit eligibility. True

8. Certain low cost surgical procedures performed in a prison are covered by Medicaid.
False

9. Those who were on SSDI prior to incarceration remain on the rolls indefinitely even though they may not be receiving checks.
True

A. The Patient Protection and Affordable Care Act

The Surgeon General's report of priorities for national healthcare designates the justice population as a cost containment opportunity for Medicaid and Medicare of tremendous magnitude (HRSA, 2007). It is believed that at least 35% of new Medicaid enrollees under the Affordable Care Act will have a history of involvement in the justice system (NIC, 2011). This offers RSAT programs a golden opportunity to ensure funding for continuity of care for RSAT offenders after release.

Corrections and the Current Medicaid and Healthcare Structure

As RSAT administrators and staff are well aware, justice-involved adults with SUDs tend to have significant physical and behavioral health issues. They have a number of preventable and treatable medical conditions and often one or more chronic conditions. They usually have had limited access to routine diagnostic services and medical care before they entered correctional facilities and often are diagnosed of medical conditions when they enter a facility (Hammett, 2001).

While jails and prisons are responsible for providing medical care during incarceration, there is an overall disconnect between correctional facilities and community providers. Since re-entering inmates often lack health benefits, they do not continue with the services they need upon release, which places them at risk for future justice involvement (Freudenberg, et. al., 2005; Visher, LaVigne, Travis, 2004). Currently even the small portion of re-entering offenders who are eligible for Medicaid, are not usually identified and linked to public benefits upon re-entry.

Prior to incarceration, many RSAT offenders experienced significant health problems, exacerbated by unmet service needs in underserved communities and deep disparities in the quality of care. Offenders with co-occurring disorders may have repeatedly cycled through emergency rooms, detoxes, crisis centers, and psychiatric hospitalization and may continue to do so without access to effective treatments. For many RSAT inmates, the care they received prior to incarceration was not only inefficient and uncoordinated, but also one of the costliest types of care, leading to repeated use and poor outcomes. In the healthcare field it is known as **high cost, low value care**.

Currently, Medicaid eligibility is limited to adults with disabilities those 65 and over and those who are actively parenting (eliminating incarcerated parents). RSAT offenders must rely on a hodge-podge of treatment resources typically funded through a combination of general state revenues, federal block grants, and county and municipal funds.

Although many criminal justice systems across the country, especially RSAT programs, do a good job of identifying and developing partnerships with existing treatment and recovery support resources for offenders after release, unfortunately, many of these programs are underfunded, time-limited and stretched to capacity, reaching only a tiny proportion of the population in need. Fortunately, healthcare reform should create an opportunity for all offenders to access primary care and behavioral health services upon

release. This presents an opportunity for RSAT programs to link up graduates with the essential treatment that will help preserve the gains made in RSAT programs.

Understanding Health Reform

In March of 2010, the Patient Protection and Affordable Care Act (ACA), Public Law 111–148 and the Health Care and Education Reconciliation Act, Public Law 111–152 were passed and signed into law. Together, they became known as the *Affordable Care Act*, or health care reform or Obamacare.

One of the most notable elements of the Affordable Care Act, which becomes fully enacted in 2014, is the **expansion of Medicaid eligibility to all individuals at or below 133% of the federal poverty level, regardless of their parental or marital status, disability determination, age, or justice-system involvement.**[4] For individuals who have a higher income level, but do not have benefits through a spouse or employers, it provides for participation in state-run health insurance exchanges.[5]

In short, expansion of Medicaid coverage to include single, low-income adults without disabilities, by 2014, means re-entering offenders will be covered by Medicaid or by a private insurance plan purchased through a state run exchange.

Exercise Three: The Health Reform Planning Table

Think about your state or county. Who needs to be at the planning table when you think about all of the necessary services RSAT inmates will need upon release? List these partners and begin to identify any contacts or partnerships within these agencies or organizations you might already have. This is the start of your planning matrix. Add in a **+** (plus) mark where you already have relationships, an (equal) **=** where you want to build them, and an **NA** where it is not applicable.

Partner	Relationship Status (+, =, NA)
State Police	
Local Police	
Sheriff Department	
Department of Corrections	
County Jail	
District Probation	

[4] "Inmates" will still be ineligible for Medicaid reimbursement, but can be screened, assessed and an application can be created during incarceration.
[5] A health insurance exchange is a federally subsidized, state-regulated, standardized health care plan from which individuals may purchase health insurance at a reduced cost.

Medicaid Authority	
Department of Human Services	
Insurance Commissioner	
County Health Department	
Governor/Executive Branch	
State Legislative Branch	
County/City Government	
Veteran's Administration	
Department of Aging	
Department of Public Health	
Providers (Behavioral Health, SUD, Community Health Centers)	
Other__________________________________	
Other__________________________________	

B. RSAT Program Planning for Health Reform

RSAT offenders in prison and jail based programs usually have a specified length of programmatic engagement (3–12 months) and a known release date. RSAT staff can work with them to prepare concrete plans for release from the time they enter the program. RSAT programs can provide Sheriffs and jail administrators an opportunity to improve linkages to community care. This helps RSAT offenders who receive medical workups and behavioral health assessments in jails and prisons continue their treatment without having to start over after release.

Jails and public health systems see a lot of the same people over and over again, at different points in time. National healthcare reform presents an opportunity for prisons, jails and communities to share health information, reduce duplicative assessment processes, and improve efficiency. The potential to build diversion and re-entry

programs that are linked with community services could have a significant effect on rearrests, recidivism and technical violations.

C. Integrating Benefit Planning into Pre-release Procedures

All of the phases discussed in Module II, including screening, assessment, pre-release planning and community linkages are relevant to health reform and its impact on former inmates. The following concrete action steps can prepare RSAT programs, states and counties for ACA enactment in 2014. To implement these steps, legislative, policy, administrative, operational and relationship building is integral for both county and state systems.

Intake/Pre-treatment

Step One: Standardize screens for behavioral health needs
All inmates should receive standardized, evidence-based screenings that indicate next steps. Screenings should be universal and help to eliminate the segment of the correctional population that does not require further assessment. Standardized screening tools, like the Brief Mental Health Jail Screen, are used in all facilities in certain states. Screening tools, like the GAIN-Q, are used in some jurisdictions by both the justice system and community providers. Some states require their provider networks and contractors to use specific screening and assessment tools. Meeting with State mental health and substance abuse offices on the subject can help guide protocols (see resource pages screening and assessment tools).

Step Two: Begin screening for benefit eligibility at intake
The initial intake for RSAT should include questions about prior and current (pre-incarceration) receipt of public benefits. Information about pre-incarceration income levels that confirms the 133% below poverty level requirement for Medicaid will become valuable. A “flag” should be added to each RSAT client’s file to reflect benefit status and eligibility to assist in enrollment during the pre-release phase, beginning at least 90 days prior to discharge.

Step Three: Preserving existing benefits
Federal Social Security policy currently allows states to suspend Supplemental Security Income (SSI), after one full month of confinement, rather than terminate it for inmates incarcerated for less than twelve consecutive months. However, after the twelfth month their benefits are terminated and they have to go through the lengthy process of reapplying. Social Security Disability Income (SSDI) is not terminated or suspended, although no payments are made. Survivor benefits may continue for minor children under 18. After two years on SSDI, recipients qualify for Medicare.

RSAT programs should develop a process to flag inmates receiving benefits and consider steps to preserve them. Inmates in work release programs may be able to re-open their disability case if they are no longer covered by correctional health services and if they have not been in prison for 12 consecutive months. This action step may necessitate collaboration with Social Security and the state agency that “switches on” Medicaid. In some states this is the Medicaid Authority, in others it is the Department of Human Services, and yet in others, it is the Department of Insurance.

The Legal Action Center has compiled a toolkit on restoring Medicaid upon release from prison. It is designed for criminal justice advocates, but provides valuable information that RSAT administrators can use to advocate for policies in their states to provide eligible individuals with immediate access to Medicaid upon release from jail or prison. The toolkit can be found at: http://lac.org/toolkits/medicaid/medicaid.htm.

Pre-release/Transition Phase

Step Four: Assist prisoners to complete applications for benefits
Pre-release planning staff should check if a benefit "flag" exists in the RSAT inmate's file. Once the ACA takes effect, the application for Medicaid will much shorter and will ask for basic information, including: name, address, social security number, employment and income status, number of dependent children. All applications for benefits should be completed within a designated time period prior to inmate release.

Step Five: Identify diversified payment strategies
Many inmates are eligible for federal benefits that supplement or enhance Medicaid benefits. They include veteran's benefits for those who have served in the military, Medicare or Ryan White CARE Act-funded services for people living with HIV. If inmates were receiving medical care prior to incarceration, planning can include moving them back to the familiar healthcare environment upon release whenever possible. Also, with the aging prison population, it is possible that some re-entering inmates will qualify for Medicare. However, this is far from an automatic process, and requires a work record that translates in sufficient credits. RSAT staff can help older offenders who have been gainfully employed to find out about eligibility by contacting Social Security.

Step Six: Engage in information sharing
At point of intake into the county jail or prison, all detainees should complete consent to share information and other necessary privacy documentation to allow for an information flow of health records. County jails should transfer health-related information for inmates who received screening, assessment and health services pre-trail or while detained. Additionally, with the advent of national healthcare reform, there will be new and expanded electronic record sharing requirements between justice and health and human services agencies and organizations. Health information technology (HIT), includes systems such as:

- Electronic Health Records (EHRs)
- Electronic Medical Records (EMRs)
- Personal Health Records (PHRs)
- Payor-based Health Records (PBHRs)
- Electronic Prescribing (e-Prescribing)
- Financial/Billing/Administrative Systems
- Computerized Practitioner Order Entry (CPOE) Systems (http://www.himss.org/2009calltoaction/himsscalltoactiondec2008.pdf)

Aside from reductions in duplicative information collection and data entry, the primary benefits resulting from HIT to RSAT programs include improved access to prior healthcare services information to inform the RSAT treatment plan and better communication between community providers and RSAT correctional staff to prepare for release. The ACA encourages the use of a statewide central health information technology system and provides incentives to states which comply. This is further detailed here: http://www.cms.hhs.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentiveprograms.

Step Seven: Facilitate enrollment
Inmates can complete the enrollment materials for Medicaid or the new subsidized insurance programs during incarceration, thereby reducing the wait time for enrollment once they are released. If inmates walk out the door with coverage, they can go straight into a treatment or re-entry program without having to worry about if the agencies have been funded and can provide enough spots. Documentation upon release is also a crucial component of securing benefits. This includes release documentation, medical summaries, and diagnostic information and treatment records.

Step Eight: Expedite processing of inmates' benefits applications
County and state correctional agencies should put inmates' applications on a fast track for processing to ensure completion prior to release. Medicaid staff can fax temporary Medicaid cards back to the jail/prison, so inmates have immediate access to Medicaid services upon release. This should also include necessary identification (State IDs) and documentation of residence required for Medicaid coverage. Some facilities have pre-release agreements with Social Security that allows this process to begin up to 90 days pre-release.

Post-release/Time Served or Parole

Step Nine: Build and enhance community partnerships
Jails and prisons must have strong relationships with community providers of substance abuse and mental health treatment and medical providers to care for people with chronic illness. Now is the time to initiate or solidify relationships with the community health resources. Making sure contact people are identified at each relevant organization or agencies and having dedicated transitional planning staff throughout the system are foundational steps.

Step Ten: Provide adequate medication to inmates upon release
In most states, inmates who are released with either time-served or onto parole status are given a supply of medication. Many times, once this medication is gone, former inmates do not refill prescriptions or have difficulty getting in to see a health care provider. RSAT administrators should build relationships with community health centers, and develop a strategy for using the ACA to support an uninterrupted medication regimen after release. For example, Alkermes provides the first thirty days of Naltrexone for opioid or alcohol-addicted inmates prior to their release, providing a window for releasees to find a community-based Naltrexone provider, such as a community health center.

Exercise Four: Planning Matrix for National Health Reform

Action	Responsible Staff	Tasks	Partners
Screen for health and behavioral health needs		Align screening and Assessment Tools	
Screen for pre-sentence benefits and eligibility		System for flagging and notifications	
For those on SSI, suspend (not terminate) benefits. Take steps to make sure they reactivated pre-release		Develop pre-release agreement with SS office	
Assist prisoners in completing applications for benefits		Transfer online application to secure computer	
Identify diversified payment strategies		Screen and flag system for Vets	
Engage in information sharing		Research Health Record compatibility, finalize releases	
Provide expedited service for processing of inmates' benefits applications		Develop pre-release agreement with state Medicaid office	
Ensure that inmates have a valid ID prior to release		Contact state motor vehicle office	
Secure interim coverage		Research retroactive payments	
Facilitate enrollment		Develop inmate education	
Build and enhance community partnerships		Attend and convene provider summits, active outreach	

Use this matrix to plan for healthcare expansion: *For each action item, decide the tasks and people involved. Examples of tasks are included in column 3.*

D. Recognizing Challenges

It would be unrealistic to plan for health reform without considering the challenges ahead, including:

- Share data across different disciplines and technological systems
- Get input on the types of services plans should cover: Planning is underway to determine the minimum services that will be included in plans. States may have to pay for any services not included, so criminal justice system partners should be providing input now on what should be considered essential.
- Increase capacity of community providers: the criminal justice system is a major source of customers for substance abuse and mental health treatment. It is important for jail and prison administrators and others to talk with them about the increases in the numbers they will be asked to serve once re-entering offenders have coverage.
- Plan for expanded capacity is difficult when states are struggling to meet the current needs of Medicaid recipients
- Develop new relationships with providers such as community health centers and providers who previously didn't serve individuals without private insurance

Remember, the benefit of the ACA to correctional facilities rests in the relationships correctional administrators build with community providers who support re-entry, thereby reducing the potential for relapse or recidivism. Correctional healthcare costs will not be reimbursed under the ACA. This is an opportunity to bolster post-release engagement and sustainment in health and human services for parolees and releasees. The cost savings for RSAT programs is the return on the investment from inmates not returning to jail or prison, and the improvement of programmatic outcomes for RSAT participants resulting from comprehensive, effective and adequate dosages of post-release services.

Exercise Four will help identify and structure productive planning conversations with colleagues. Think about the actions discussed above, and identify who is responsible for undertaking each action, what needs to take place, what is currently in place to help or hinder the accomplishment of the action. This is designed as a work in progress, which will grow as you move further into the planning process.

Exercise Five: Planning Examples

Consider the planning challenges and identify the "low hanging fruit" in beginning to address them. Remember, this is an iterative process, and planning for health reform, implementing the plan and making alterations based on lessons learned will be a work in progress for years to come. These are the types of issues you should expect to navigate as you implement national health reform in your jurisdiction. To make this more tangible, use the scenarios about John and answer the questions using practical solutions.

Scenario 1: John is arrested and booked into Winnebago County Jail for retail theft and possession of cocaine. At jail intake, it is apparent he has a substance use disorder; and during his medical intake, he reports he has taken medication for depression in the past. John reports that he was enrolled in mental health services, but hasn't attended in six months. John is referred and accepted into the RSAT county jail program.

Sample Planning Questions: Who is responsible for screening John for Medicaid eligibility? Who is responsible for providing him with information regarding Medicaid enrollment if he is released after his first court appearance without further justice involvement? Who is responsible for notifying the local Medicaid office that John is incarcerated if he is already a Medicaid recipient? Who will notify the treatment provider that John is incarcerated and needs to be reengaged in treatment? How will the treatment provider reengage John?

Scenario 2: John is sentenced to 18 months in the Department of Corrections (DOC). John will serve approximately 12 months for his conviction.
Sample Planning Questions: At intake into prison, in what way will the medical records from his prior jail intake be shared with DOC? In preparation for release, who will screen John for Medicaid eligibility and enroll him in Medicaid, if eligible? Will the screening be an electronic record? Who will identify and enroll him in behavioral health services? Who will inform his local Medicaid office he will soon be released into the community? How will this information be shared between the prison and the parole officer to ensure continuity in John's case?

Scenario 3: John is sentenced to 24 months in jail/prison with a requirement to enroll in a residential integrated treatment program with aftercare and drug testing following his release.

Sample Planning Questions: In what way can the information collected by jail intake and RSAT staff most efficiently be shared with the probation officer and treatment providers? Will Medicaid cover residential treatment, and if not, who will pay for it? How will the probation officer, the treatment provider and the Medicaid case manager work together on John's case to ensure he complies with his treatment requirements and maintains medication compliance? How will you identify an appropriate residential aftercare program? Who will pay for drug testing?

E. Review and Resources

Review

- Multiple studies have found that parolees and former inmates lack health insurance and do not seek preventative or reactive health care services; rendering them at risk for future justice involvement (Freudenberg,et. al., 2005; Visher, LaVigne, Travis, 2004).

- Many parolees and former jail detainees are eligible for Medicaid but not identified and linked to public benefits by the correctional facility at point of re-entry, increasing risk factors for reoffending or violating the conditions of community supervision.

- At least 35% of new Medicaid enrollees under the Affordable Care Act will have a history of involvement in the justice system (NIC, 2011).

- The Surgeon General's report of priorities for national healthcare designates the justice population as a cost containment opportunity to Medicaid and Medicare of tremendous magnitude (HRSA, 2007).

- One of the most notable elements of the Affordable Care Act, which becomes fully enacted in 2014, is the expansion of Medicaid eligibility to all individuals at or below 133% of the federal poverty level, regardless of their parental or marital status, disability determination, and age level or justice-system involvement.

- "Inmates" will still be ineligible for Medicaid reimbursement; however, they can be screenedand assessed, and an application can be created during incarceration.

- The part of healthcare reform that is most significant for this population is the expansion of Medicaid to finance treatment for single, low-income adults without disabilities, which is to occur by 2014.[1]

- With the expansion of Medicaid under federal healthcare reform starting on January 1, 2014, all parolees should be covered with private insurance, a health insurance exchange plan or Medicaid.

- Jail and prison administrators and RSAT staff can undertake numerous activities to prepare for national health reform. The enhancement of public health benefits will improve efficiency and outcomes and reduce incidences of relapse and recidivism.

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[1] The only exception is undocumented immigrants, which will impact different communities differently depending on how large the population.

Resources

Community Oriented Correctional Health Services (COCHS): a non-profit organization that works to build partnerships between jails and community health care providers. http://www.cochs.org

The National Commission on Correctional Healthcare (NCCHC): dedicated to improving the quality of health care in jails, prisons and juvenile confinement facilities. **http://www.ncchc.org**

The Council of State Governments, National Reentry Resource Center: Archived Webinar: National Health Reform 101 for Criminal Justice, Presenter: Maureen McDonnell. http://www.nationalreentryresourcecenter.org/events/webinar-national-health-reform-101-for-criminal-justice

The Substance Abuse and Mental Health Services Administration (SAMHSA): Discusses SAMHSA's role in health reform: Leading Change: A Plan for SAMHSA's Roles and Actions 2011 – 2014 or http://www.samhsa.gov/healthReform

The Council of State Governments, Consensus Project Frequently Asked Questions document which addresses the implications of the law for justice-involved adults. http://consensusproject.org/jc_publications/faqs-implications-of-the-federal-legislation-on-justice-involved-populations

The **TASC Institute for Consulting and Training** Presentation on Leveraging National Health Reform for Justice Populations
http://www.iadda.org/pdfdocs/Conference/handouts/McDonnell_6.pdf

A White Paper of the **Ohio Criminal Justice Diversion and Behavioral Health Workgroup,** Prepared by TASC of Illinois, February 17, 2012.
http://co.lucas.oh.us/documents/MHRSB/Misc/BH%20and%20CJ%20White%20Paper.PDF

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