

RSAT Promising Practices Guidelines: 2025 Learning Community Series

Treatment Interventions

Wednesday, May 28, 2025

Bureau of Justice Assistance (BJA)







Residential Substance Abuse Treatment (RSAT)
Program for State Prisoners

Training and Technical Assistance Resource

This project was supported by grant No.15PBJA-22-GK-01132-RSAT awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Point of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Justice.



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RSAT-TTA Presenter



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Learning Objectives

Upon completion of this webinar, the participant will be able to:

- 1** Participants will be able to name at least three evidence-based treatment interventions used in RSAT programs.
- 2** Participants will be able to name at least two characteristics of a modified therapeutic community.
- 3** Participants will be able to describe two types of cognitive behavioral interventions used in RSAT programs.

Today's Agenda

- Presentation by RSAT-TTA staff
- Best Practice Highlight
- Peer Learning Opportunity
- Breakout Discussion

Today's Topic

RSAT Treatment Interventions



Cognitive
behavioral
therapy/
techniques



Motivational
interviewing



Standardized
curriculum



Contingency
management



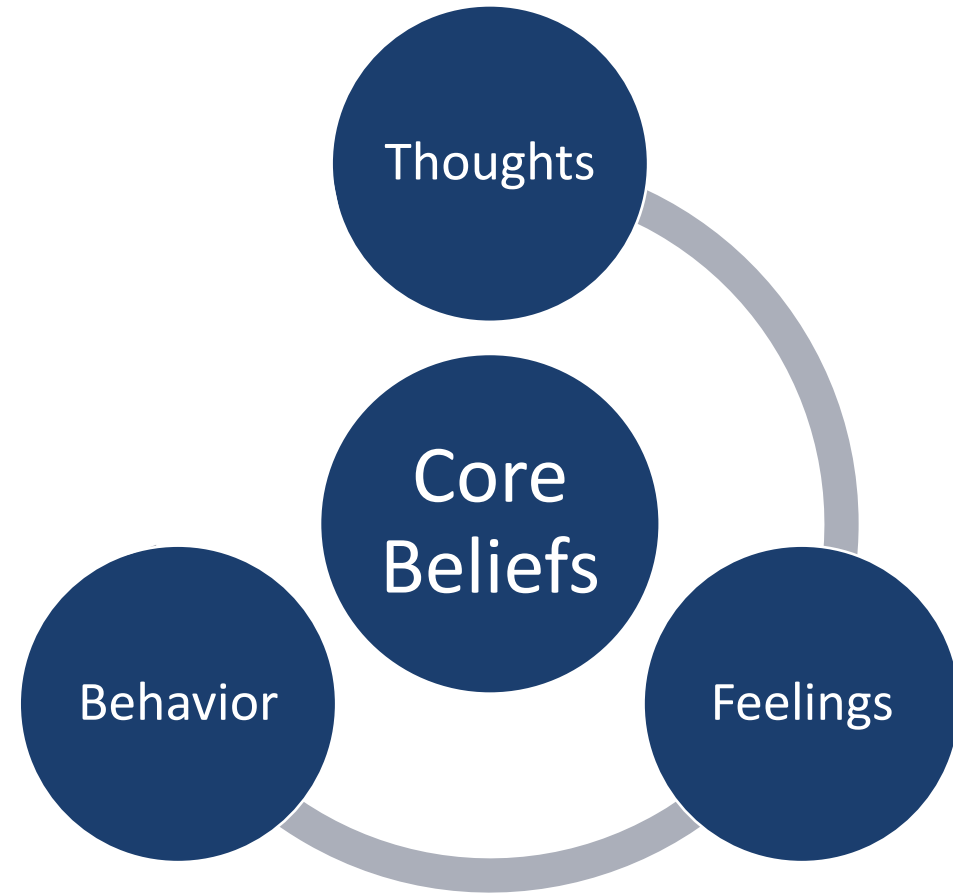
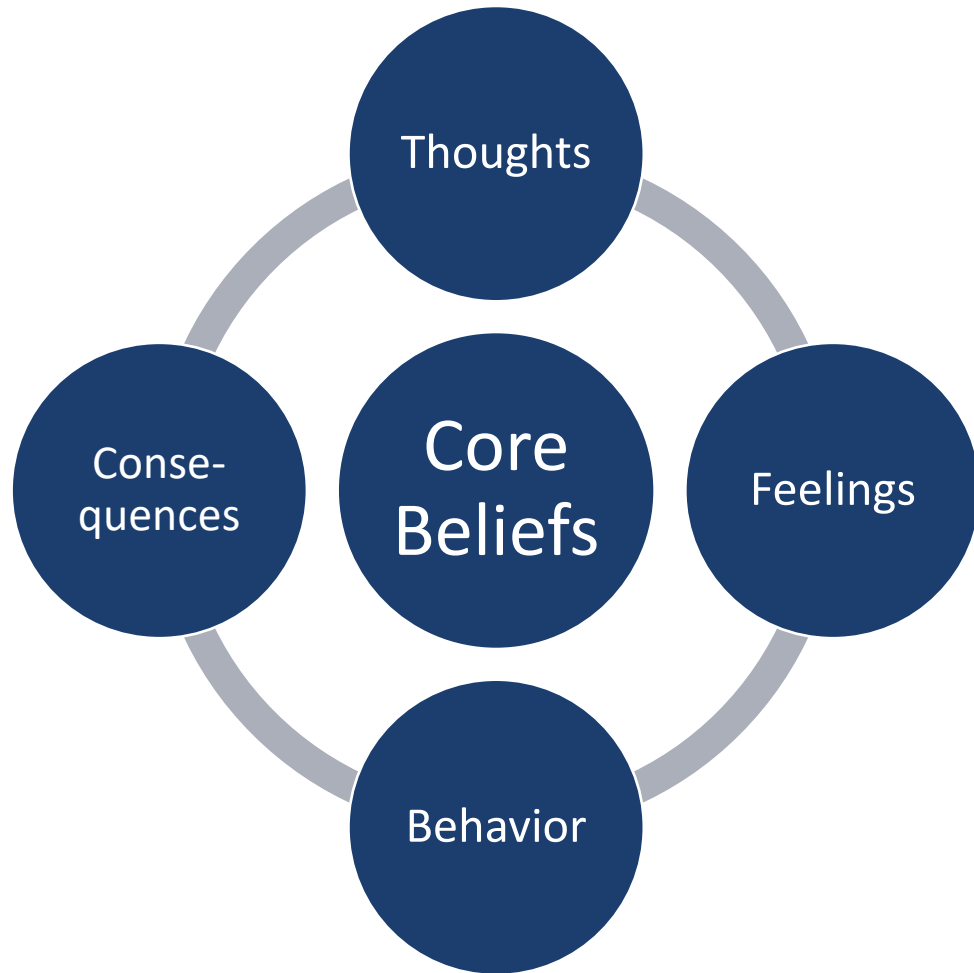
Therapeutic
community
standards



Fidelity
Monitoring



Behavioral Change Cycle



Cognitive Behavioral Cycle



When a person acts in a certain way long enough, the **thoughts** and **feelings** that support the **behaviors** will strengthen.



Feelings, beliefs, and a change in self-perception can follow **behavior** change rather than precede it.

CBT Principles

Brief and Time Limited

Present Centered

Thought Focused

Practice and Homework

Sound Therapeutic Relationship

CBT Critical Tasks

Increase Motivation

Build Critical Thinking Skills

Change Reinforcers

Build Tolerance for Emotions

Rehearse Skills for Pro-Social Connections

Cognitive Behavioral Therapy (CBT)

Common Interventions

- Homework
- Role Play / Behavior Rehearsal
- Journaling
- Thinking Reports
- Reframing / Cognitive Restructuring

Common Standardized Curricula

CBT Intervention Modalities and Curricula

- Aggression Replacement Training® (ART®)
- Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change (SSC)
- Moral Reconciliation Therapy® (MRT®)
- Reasoning and Rehabilitation (R&R and R&R2)
- Relapse Prevention Therapy (RPT)
- Thinking for a Change (T4C)
- Helping Women Recover (Covington)
- Change Company interactive journals
- Hazelden

Discussion Question

What standardized curricula are you using in your program?



Motivational Interviewing

“Motivational Interviewing (MI) is a **collaborative, goal-oriented** style of communication with particular attention to the **language of change**. It is designed to **strengthen personal motivation** for and commitment to a specific goal by **eliciting** and **exploring** the person’s own reasons for change within an atmosphere of **acceptance** and **compassion**”

-Miller and Rollnick (2013)

Miller, William R., and Stephen Rollnick. Motivational Interviewing: Helping People Change. 3rd ed. New York, NY: Guilford Press, 2013

Motivational Interviewing

- MI compares well to other evidence-based approaches in formal research studies.
- It can be used on its own or combined with other treatment approaches.
- MI is an evidence-based practice used around the world, with an international network of trainers – [Motivational Interviewing Network of Trainers \(MINT\)](#).
- MI has **observable practice behaviors** that allow practitioners to receive clear and objective feedback from a trainer, consultant, or supervisor.

Miller, W.R. & T.B. Moyers (2017) Motivational Interviewing and the clinical science of Carl Rogers. *Journal of Consulting and Clinical Psychology*, 85(8), 757-766. <https://motivationalinterviewing.org/>

MI Applications

MI is particularly useful to help people when:

- **Ambivalence is high** and people are stuck in mixed feeling about change
- **Confidence is low** and people doubt their abilities to change
- **Desire is low** and people are uncertain about whether they want to make a change
- **Importance is low** and the benefits of change and disadvantages of the current situation are unclear



Substance Abuse and Mental Health Services Administration. (2019). Enhancing motivation for change in substance use disorder treatment. Treatment Improvement Protocol (TIP) Series, No. 35. Understanding Motivational Interviewing <https://motivationalinterviewing.org/understanding-motivational-interviewing>

Underlying Assumptions in Motivational Interviewing

- Clients have an inherent drive toward health and wholeness.
- The client is the expert about how to change their circumstances.
- The client's experience of choosing and investing in their intended change is indispensable to success.



Moyers, T. B. (2014). The relationship in motivational interviewing. *Psychotherapy*, 51(3), 358–363.

The Four Aspects underlying the Spirit of MI (PACE)

Partnership

- Collaboration and working together toward shared goals – shared decision making.
- A guiding style - both practitioner and client are recognized as having “expertise”.

Acceptance

- Empathy and interest in understanding the client’s perspective and looking for their strengths and positive aspects.
- A nonjudgmental respect and honoring of the client’s autonomy – their freedom to choose.

Compassion

- This is not feeling for or with the client (sympathy).
- An intention and commitment to the client’s well-being as the prime directive.

Empowerment, also called Evocation

- Knowledge that the client has within them their own wisdom and strength that the practitioner can help them draw out.
- The message and Spirit of MI is, “You have what you need, and together we will find it.” not “I have what you lack and I will give it to you.”

Ambivalence and Discrepancy

- In group a facilitator will have clients in different stages of change, use that to help encourage change!
- Clients with more change talk can encourage clients who use more sustain talk.
- MI should also be used to highlight discrepancy
- Example: a client who claims to want to successfully complete treatment, however, is consistently breaking facility rules.
- Do not do for the group what the group can do for itself



What is Contingency Management?

- Form of behavioral therapy
- Also known as: behavior modification, contingency contracting, token economy, behavioral reinforcement
- Involves a system of rewarding or punishing specific behaviors in order to change those behaviors over time
- Research states that rewards work better for more lasting impact in shaping new behavior (as compared to punishments) – positively recognize achievements rather than applying negative sanctions for lack of achievement

Source: Bandura, A. (1974). Behavior theory and the models of man. American psychologist, 29(12), 859.

What is Behavioral Contingency Management?

Specific to SUD Programs

The purpose is to **encourage pro-recovery behaviors** (*examples: abstinence, session attendance, working toward voc/social/ed goals*) by **giving reinforcement** when such behaviors are performed or by withholding reinforcement when such behaviors are abandoned (*i.e., drinking/using drugs, missing appointments, etc.*)

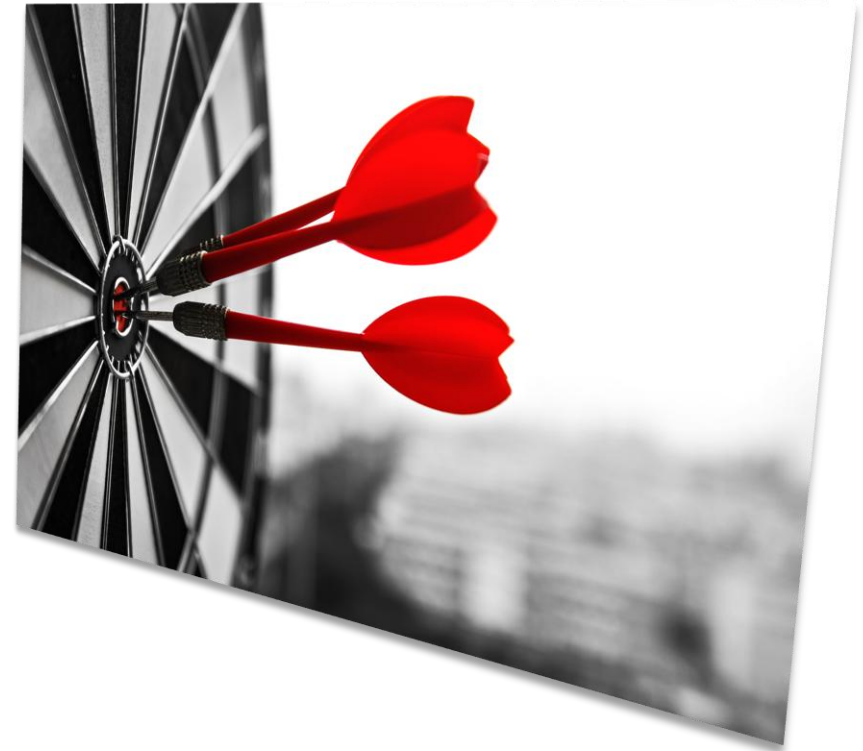
Specific to Corrections Population

The purpose is to **encourage pro-social behaviors** (*examples: compliance with rules, session attendance, competency with utilizing pro-social skills*) by **giving reinforcement** when such behaviors are performed or by withholding reinforcement when such behaviors are abandoned (*i.e., violating rules, missing appointments, etc.*)



Seven Principles of Motivational Incentives

1. Target Behavior
2. Choice of Target Population
3. Choice of Incentive/Reinforcer (contingent link)
4. Incentive Magnitude
5. Frequency of Incentive Distribution
6. Timing of Incentive
7. Duration of Incentive



Source: Budney, A. J., Higgins, S. T., Mercer, D. E., & Carpenter, G. (1998). *A community reinforcement plus vouchers approach: Treating cocaine addiction. (NIH Publication No. 98-4309). Washington, DC: US Government Printing Office.*

Discussion Question

What are the most popular reinforcers or rewards in your RSAT program?



Therapeutic Communities and the Requirements for RSAT Programs

From BJA's RSAT FAQ:

What is a Therapeutic Community?

This refers to use of residential treatment facilities that are set apart from the general correctional population in either a separate facility or a dedicated housing unit that is used exclusively for RSAT and/or other SUD treatment programs. Within these units, residential SUD treatment programs may utilize the variety of evidence-based SUD treatment modalities as specified in the Promising Practice Guidelines for RSAT at: https://www.rsat-tta.com/Files/Manuals-Curricula/RSAT-PPG_February2023



<https://bja.ojp.gov/doc/rsat-faq.pdf>

What is a Therapeutic Community?

- RSAT-based therapeutic communities (TCs) are **separate residential SUD treatment programs in prisons or jails** for treating substance use disorder.
- The defining feature of TCs is the emphasis on participation by all members of the program in the overall **goal of reducing substance use and recidivism**.
- TCs differ from other models of treatment by their focus on recovery, overall lifestyle changes, and **the use of the “community”** as the key instrument for that change.
- Rated “Promising” in reducing recidivism rates after release by [National Institute of Justice Crime Solutions](#)

What does it mean to be a *Modified* Therapeutic Community

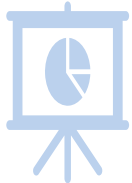
Characteristics of a Modified Therapeutic Community



Less confrontation, more reflection.



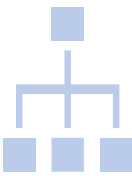
Meetings and activities are shorter in duration, with more breaks or down time.



Information is broken into small units, presented gradually, and fully discussed.



Emphasis on helping participants to understand mental health issues, to identify, avoid or cope with triggers.



Work hierarchy is more horizontal than vertical, and work task assignments are more individualized



Emphasis on empowerment, communication, and compassion

What does it mean to be a *Modified* Therapeutic Community

- Trauma-informed care
- A focus on co-occurring disorders
- More individualized services and treatment
- Considering learning differences
- Culturally responsive
- Gender responsive
- Corrections-based



RSAT MTC Characteristics

Emphasis on participation by all members of the program in the overall TC Mission: in general, remain substance free and committed to program standards

Use of **community and peers** (sometimes facility staff) as **agents of change** or key instrument of change

Utilizes a **phase model** in which participants progress through several levels of treatment. Increased progress = increased opportunities

Takes place in a **residential setting apart from others**. The community eats, has recreation, meals, and activities as a closed group

Treatment includes **aftercare and reentry services** as a means of providing support, relapse prevention

Rituals and traditions, daily / weekly community-wide meetings with a common language to promote strong sense of community

TC's usually have **leaders / mentors / elders** in the last treatment phase who help orient new participants

The **locus of control is shared** between participants running the Unit, and staff and Officers acting as the "rational authority" and pro-social role models

There is a **pro-social code of morality** that is usually outlined in the TC's rules and regulations –"right living"

TC participants may be referred to as residents, brothers/sisters, participants, **but rarely ever inmates or offenders**

Role of MTC Staff



- Promote **community as method**.
- Encourage self-help by not doing the work for participants even when staff members have a need to “help”.
- Be a role model since participants observe staff members’ work habits, and how they relate to other staff, manage their emotions, address work-related conflicts.
- Educate and explain what is expected of participants.
- Promote the community as method approach and mutual self-help.

Fidelity in Implementation

*“Implementation science suggests that **to be successful, interventions must be evidence based and delivered in a way that mirrors the original design or maintains fidelity to the intervention in complex settings. The research also shows that implementing an intervention with fidelity to the original model increases the likelihood of achieving positive outcomes, while not doing so can undermine the effectiveness of the intervention and may even produce harmful effects.**”*

Promising Practices Guidelines for Residential Substance Use Disorder Treatment,
2023

Standardized Training

Questions to Consider



What training, knowledge, and skills are necessary to deliver the intervention correctly?



Do certain skills or interventions require certification or training on a regular basis?



How do we keep track of training, measure training effectiveness, and determine topics for future training?



How does our organization support staff training? What barriers to adequate training exist?

Standardized Training

RSAT Specific Training Needs

CBT

Regular training – at least once every three years

Training should be for anyone implementing CBT interventions such as thinking reports

Motivational Interviewing

Annual training or regular “community of practice”

Curricula & Assessment/ Screening

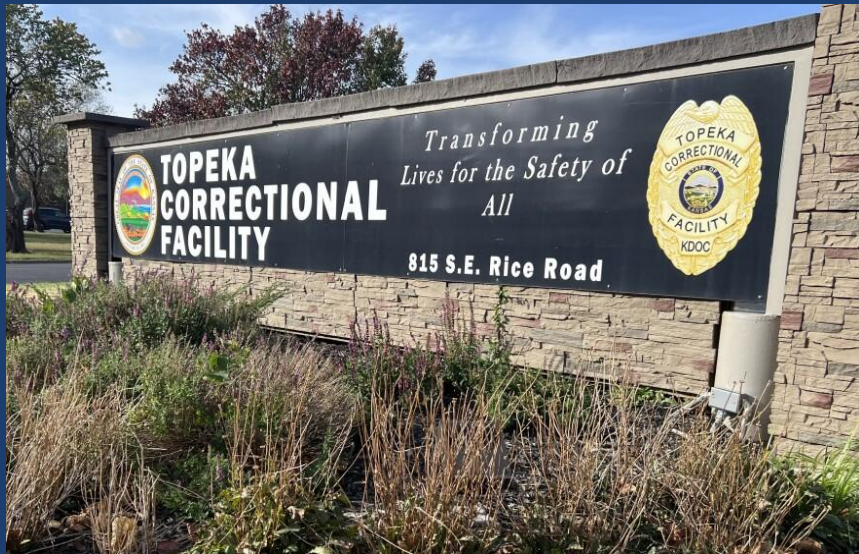
Training should adhere to publisher’s standards

When specific training is not required, internal training should still be provided – a facilitator’s handbook is not enough!

Therapeutic Communities

All staff need training on the model of therapeutic communities, as well as site-specific training

Facility Best Practice Highlight



About the Facility

Topeka Correctional Facility-Substance Abuse Recovery Program (SARP)

- **Topeka Correctional Facility**
 - Capacity: 903
 - Only women's prison in the State of Kansas
 - 48 bed dorm
 - Housed in minimum custody
 - Separate from all other living units
 - Start date June 2016
 - Trauma-informed care along with Substance use programming
 - 5-6 - month program



*SARP staff with blankets the residents and team made for the local cancer center

Cognitive Behavioral Therapy (CBT)

Substance Abuse Program (SAP)

- An evidence-based curriculum from the University of Cincinnati Corrections Institute that is offered to residents who are struggling with substance use and criminal activities.
- The program provides **cognitive-based instruction** to increase emotion regulation and self-awareness around risky thinking and risky behavior patterns. **Social skills** are taught to help participants build valuable support networks.
- The curriculum places strong emphasis on **communication, goal setting**, and building participants' overall **self-worth**. This group lasts typically around 5 months.



Motivational Interviewing (MI)



Services that Utilize MI

Recovery Support Specialist (RSS)

- A Heartland RADAC **employee who is in personal recovery** and meets with residents who want to further their recovery for **individual sessions and group support**. They can assist in crises, co-facilitate classes, assist with assessments, and care coordination.

Support groups

- For residents who are **waiting to start SAP** or who **need additional support** after completing SAP. They are led by HRADAC staff and peer mentors and are designed to **build skills related to recovery** from substance use disorders. Each location might title their group differently and are typically **open-ended** meaning there is not an end date.

Resident Peer Mentors

- An extension of HRADAC. They **assist the instructors** in managing their caseload and providing client support. They are available to the residents **living in their units 24/7** and have lived experience along with graduating SAP successfully. They provide services for intakes, co-facilitate during classes & support groups as well as prepare for class. Peer mentors are also able to **conduct individual sessions** with residents who missed class, need assistance with homework, or are struggling with recovery in their units after hours.

Motivational Interviewing (MI)

Services that utilize MI

Care coordination (CC)

- For residents who have completed SAP or other cognitive programs related to substance use disorders. **Care coordinators meet eligible residents in the facility or virtually**, supporting them in working towards their goals.
- They are able to help residents obtain housing, employment, and connect them with recovery coaches.

Medication Assisted Treatment (MAT)

- Involves the use of **medications to treat opioid and alcohol use disorders** to help participants sustain recovery.
- Our staff can refer clients to Centurion and offer support to these clients receiving this treatment



Therapeutic Community (TC)

Substance Abuse Recovery Program (SARP)

- Substance Abuse Recovery Program (SARP) is a **therapeutic living unit** that utilizes two curriculums to provide licensed outpatient substance use treatment to the female residents at Topeka Correctional.
- The two curriculums include the SAP curriculum and **Helping Women Recover** (HWR). The HWR curriculum is trauma focused to assist residents in addressing current and past trauma in their lives.
- The program staff include licensed addiction counselors, cognitive-behavioral instructors, recovery support specialists, and care coordinators.



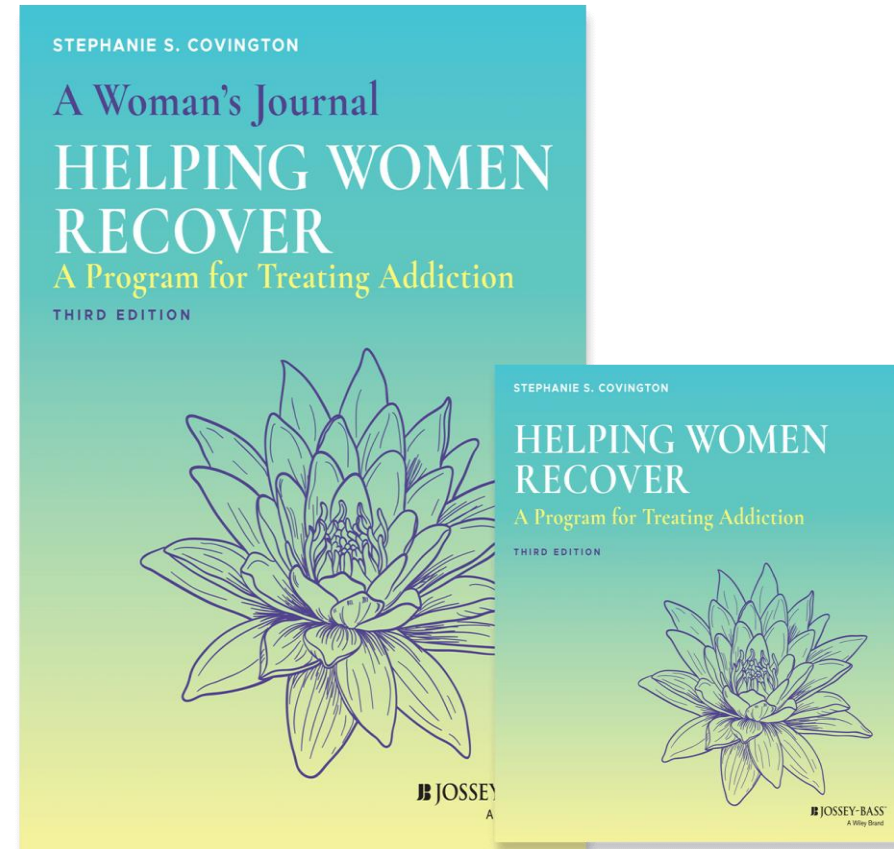
Manualized Treatment

Helping Women Recover (HWR)

Evidence-based program integrates theories of women's psychological development, trauma, and addiction to meet the needs of women with addictive disorders.

The comprehensive, twenty-session curriculum contains four modules that address the areas that women in treatment identify as triggers for relapse: self, relationships, sexuality and spirituality.

They include the issues of self-esteem, sexism, family of origin, relationships, domestic violence, and trauma



Topeka Correctional Facility

History leading to current best practice:

- Women's Risk Needs Assessment (WRNA) scores
- Recidivism rates

Treatment Team

- Bi-weekly meetings to discuss treatment process
 - Classification Administrator (CA)
 - Case Management and ReEntry Administrator (CMRA)
 - Substance Use Treatment Counselors
 - Director of ReEntry Services

Challenges faced before best practice was implemented:

- Lack of funding
- Lack of training and education on substance abuse/trauma
- Stigma from correctional staff
- Buy in from resident population

Topeka Correctional Facility

Decision making/Buy-in process

- Treatment team
- Annual trainings provided by treatment staff and HRADAC

Unintended outcomes

- Positive
 - Expansion to other services across the state (Helping Men Recover)
 - Professional growth of staff
- Negative
 - Limited capacity on the dorm

Responsive to facility or community specific needs:

- Residents complete Level 1 outpatient treatment prior to entering the community
- Connection to mental health, substance use, and other services

SARP Program

Kansas Department of Corrections (KDOC) data shows:

- Residents that complete SARP have a lower 3-year recidivism rates than general population.
- SARP residents have lower rates of disciplinary reports

Pre- and Post-SARP Assessments Completed this FY						
Level Of Care	NO TX	L-I	L-II.1	L-III	L-III.3	Total
Pre SARP	0	32	0	0	50	82
%	0%	39%	0%	0%	61%	100%
Post SARP Completers*	60	15	0	1	1	77
%	78%	19%	0%	1%	1%	100%

*94% (77 of 82) individuals completed the SARP program during this last fiscal year. The following table demonstrates the SUD level of care recommended for individuals at the beginning of the SARP program, and the recommendations for those individuals after they completed the program. 78% of individuals who were previously recommended for some level of SUD treatment when they began the SARP program were no longer in need of treatment after completion.

*5 individuals did not complete: 1 due to medical, 4 due to behavior

Breakout Session

Breakout Session

Two Groups—Prisons and Jails

Discussion Questions

- How are you implementing CBT in your RSAT program?
 - What training is provided?
 - What barriers have you encountered?
 - What success have you observed?
- What elements of a MTC are part of your program?
 - How are staff trained to implement MTC services?
 - How did you get buy in from facility leadership and correctional staff?
- How do you monitor fidelity in your program?

Breakout Session Report Back

Open Q&A

What questions do you have for:

- RSAT-TTA staff
- Facility practice highlight presenter
 - Larger RSAT community



Additional Resources

- www.lbr.tcu.edu/manuals/contingency-management-strategies-and-ideas/

Contact Information

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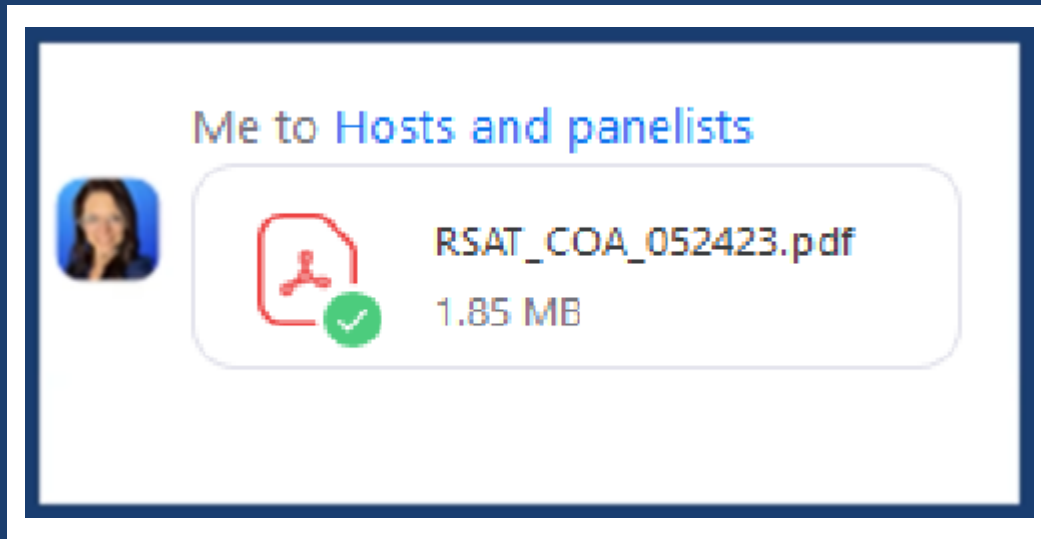
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You can download the certificate of attendance from the chat.





CERTIFICATE OF CONTINUING EDUCATION



1 Continuing Education Hour (CEH) approved by NAADAC, the Association of Addiction Professionals



Pass 10-question quiz with 7 correct answers



Download certificate upon completion of the quiz

May 28, 2025 RSAT webinar CEH quiz link:
<https://survey.alchemer.com/s3/8328211/May-28-2025-RSAT-Webinar-CEH>

Upcoming in this Series

- Continuing Care and Reintegration Wednesday, June 11
- Program Administration Wednesday, June 25
- Facility-Level Interventions Wednesday, July 9

CONTACT



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