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Promising Practices Guidelines for Residential Substance Abuse Treatment

Promising Practices Guidelines for Residential Substance Abuse Treatment

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Introduction

The Residential Substance Abuse Treatment (RSAT) for State Prisoners Program (42 U.S.C. § 10421 et. seq.) assists states and local governments in the development and implementation of substance use disorder (SUD) treatment programs in state, local, and tribal correctional and detention facilities. The Program also provides funds to create and maintain community-based aftercare services for individuals who are released from incarceration.

Congress last amended the RSAT statute in 2018, 34 U.S.C. Ch. 101, Justice System Improvement. The act (§ 10421) authorizes the U.S. Attorney General to make grants to states, for use by states and units of local government for the purpose of:

1. Developing and implementing RSAT programs within state correctional facilities, as well as within local correctional and detention facilities in which inmates are incarcerated for a period of time sufficient to permit substance abuse treatment.
2. Encouraging the establishment and maintenance of drug-free prisons and jails.
3. Developing and implementing specialized RSAT programs that identify and provide appropriate treatment to inmates with co-occurring mental illness and substance abuse.

States that demonstrate that they have existing in-prison drug treatment programs that comply with federal requirements may use funds awarded under this subchapter for treatment and sanctions both during incarceration and after release.

At least 10 percent of a state or U.S. territory grant must be used for local correctional and detention facilities, if they exist, for the purpose of assisting jail-based SUD treatment programs that are effective, science-based, and established by those local correctional facilities.

Congress has set limited basic requirements for all RSAT grantees (§ 10422):

- Require urinalysis or other proven reliable forms of drug testing, including both periodic and random testing before entering RSAT, during RSAT, and after release if the person remains in custody of the state.
- Assist participants with aftercare services, which may include case management services and a full continuum of support services that ensure providers furnishing services to provide medical treatment or other health services. State aftercare services must involve the coordination of the correctional facility treatment program with other human service and rehabilitation programs, such as educational and job training programs, parole supervision programs, halfway house programs, and self-help and peer group programs, that may aid in the rehabilitation of individuals in the RSAT program.

- Coordinate with federal assistance for SUD treatment and aftercare services currently provided by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA).

RSAT programs must provide 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. Treatment services may include the use of pharmacological treatment, where appropriate, that may extend beyond such period.

However, the statute also allows states to make grants to local correctional and detention facilities in the State (provided such facilities exist therein), for the purpose of assisting "jail-based substance abuse treatment programs that are "effective and science-based" established by those local correctional facilities. As such, a "residential treatment program" (as defined in statute) can qualify as a "jail-based substance abuse treatment program," and so can other jail substance abuse treatment programs, including those that are less than 6 months, as long as they are "effective and science-based." RSAT jail funded programs no longer need to be restricted to "sentenced" offenders.

As of September 2019 (FY 2019), all but 2 states and 1 U.S. territory received RSAT grants, which were used to make approximately 54 awards for RSAT jail programs, including 1 for juveniles, 49 for state prison programs (including 3 for juveniles), and 12 for aftercare programs (including 4 for juveniles), in total serving nearly 30,000 participants.

Available Research on RSAT Programs

The National Institute of Justice's CrimeSolutions registry lists studies of only four RSAT programs that have been rated "promising," meaning the programs show some evidence to indicate that they achieve their intended outcomes. None received enough study for a rating beyond "promising." (Programs rated "effective," the highest rating, have strong evidence to indicate they achieve their intended outcomes when implemented with fidelity.) However, CrimeSolutions makes it clear that its resources are not intended "to replace or supersede informed judgment and/or innovation. . . . Rigorous evaluation evidence is one of several factors to consider in justice programming, policy, and funding decisions. We also recognize the importance of encouraging and supporting innovative approaches that may not yet have extensive evidence of effectiveness."¹

The four RSAT programs recognized as "promising" are:

- **Minnesota Department of Corrections prison-based chemical dependency treatment**, based on the therapeutic community (TC) model.²

- **The Forever Free program at the California Institute for Women**, which follows a cognitive-behavioral curriculum that stresses relapse prevention.^{3*}
- **The Amity In-Prison Therapeutic Community**, located in a medium-security prison in San Diego that uses workbooks, teacher’s guides, and videotapes as well as psychodrama groups and “lifer mentors”—highly committed individuals with criminal histories who are recovering substance users.⁴
- **The Delaware Department of Correction KEY/Crest programs**, which begin with a prison-based TC and continues with post-release treatment in the community.⁵

These four programs vary considerably, reflecting the diversity of RSAT programs around the country and across U.S. territories. The Minnesota RSAT program provides 15–25 hours of programming each week for participants, with a staff-to-participant ratio of 1:15. The state Department of Corrections (DOC) abandoned its 90-day program after it was found to be less effective than two longer-term programs: one that lasted 180 days, and the other that lasted a full year. The 180-day program proved to be the most effective in reducing recidivism.

A therapeutic community (TC) is a participative, group-based approach to long-term mental illness, personality disorders, and substance use disorders. The approach is historically long-term and residential, but increasingly TCs offer short-term residential or outpatient treatment.

The Forever Free program in California is 6 months long and is reserved for women at the end of their sentences. It provides 4 hours of programming per day, 5 days a week, in addition to 8 hours of daytime work or educational assignments, individual SUD counseling, special workshops, educational seminars, 12-step programs, parole planning, and urine testing. The curriculum was designed to assist participants in identifying symptoms of post-acute withdrawal and relapse and teach them skills and strategies to better manage these symptoms.

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

The Delaware RSAT program includes 12–18 months in the KEY program, which is a prison-based TC treatment program. It includes constant staff oversight and treatment programming 7 days a week, with group sessions twice per week. Aftercare includes 6 months at a Crest Outreach Center, which is a residential work release center based on the TC model. The last 3 months of Crest

* The CENAPS® Model of Relapse Prevention Therapy (CMRPT®) is a comprehensive method for preventing chemically dependent clients from returning to alcohol and other drug use after initial treatment and for early intervention, should chemical use occur. The CMRPT is a clinical procedure that integrates the disease model of chemical addiction and abstinence-based counseling methods with recent advances in cognitive, affective, behavioral, and social therapies. The method is designed to be delivered across levels of care with a primary focus on outpatient delivery systems. The CMRPT is an applied cognitive-behavioral therapy program. See <http://archives.drugabuse.gov/ADAC/ADAC4.html>.

include daily work release. While KEY/Crest programs were found to be effective in general, findings were mixed in the KEY component—some studies found the prison-based component effective and others did not.

The studies reviewed above show that promising RSAT programs vary in terms of gender served, geographical locations, treatment modalities, length, structure, and aftercare. As a result of the limited study of RSAT programs and the diversity of the few evidence-based RSAT programs documented, the following guidelines in this paper are thus, too, considered “promising,” rather than evidence-based practices. In other words, they are compiled as guidelines and not standards.

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

Goal of This Paper

Promising Practice Guidelines for Residential Substance Abuse Treatment is intended to assist correctional administrators and practitioners at the state and county levels to establish and maintain Residential Substance Abuse Treatment (RSAT) programs that adhere to the promising practices suggested by existing research and related standards developed for substance use disorder treatment and criminal justice programming. In 2019, the Bureau of Justice Assistance launched a national program to assess RSAT program adherence to these guidelines. These fidelity assessments will be employed to determine the training and technical assistance individual programs and grantees may need to meet the goals and requirements of the RSAT for State Prisoners Program as enacted by the U.S. Congress.

Reading the Guidelines

Each of the following seven sections begins with a general guideline, followed by specific practices that have been found to constitute promising practices relating to that guideline. The guide describes the rationale for each promising practice and a brief description of the practice. It may also include a summary of the major relevant research that suggests the evidence behind the practice and an example of a state DOC or local facility that currently incorporates that practice in its official protocols and procedures.

Promising Practices Guidelines for Residential Substance Abuse Treatment

I. Intake, Screening, and Assessment

A. RSAT programs should have clear eligibility criteria, primarily based on substance use and co-occurring mental health disorder screening and assessments and criminogenic risk assessments.

The primary criteria for an individual's admission into an RSAT program should be the existence of a moderate to severe substance use disorder (SUD), with or without co-occurring mental health disorders and who pose a medium to high criminogenic risk (i.e., the likelihood of reoffending). These determinations should be based on evidence-based assessments.

Correctional facilities should have protocols in place to screen and assess for substance use, mental health disorders, and criminogenic risk.

Multiple validated screening and assessment instruments are available.† The results of these screens and assessments should guide decision-making about eligibility criteria for RSAT programs.

Research shows that, in general:

- The overlap between persons with SUDs and those with mental health disorders is substantial. Mental health disorders can sometimes result in SUDs as some people may misuse drugs and alcohol as a form of self-medication. Substance misuse and SUD can also contribute to the development of mental health disorders.⁶
- People with SUDs, despite even long periods of abstinence while incarcerated, still are at risk for relapse and reoffending.⁷
- Addressing criminogenic needs is essential to responding to offender substance use, as is addressing personal and social determinants of criminal behavior, including antisocial cognition, antisocial associates, family and marital relations, employment, and leisure and recreational activities.⁸

In addition, people with SUDs leaving correctional facilities face an increased risk of death from an opioid overdose after release, especially in the first 2 weeks.⁹ Individuals showing a medium to high criminogenic risk would thus benefit most from cognitive and skill-building interventions designed to address their criminogenic needs.

† See SAMHSA's review of different screening and assessment instruments for co-occurring disorders, *Screening and Assessment of Co-Occurring Disorders in the Justice System* (2019), at <https://store.samhsa.gov/product/Screening-and-Assessment-of-Co-Occurring-Disorders-in-the-Justice-System/PEP19-SCREEN-CODJS>.

B. Individuals should receive a full biopsychosocial assessment to inform the development of individualized treatment plans and case management.

Once screened for admission into RSAT, individuals should be more comprehensively assessed for SUDs, criminogenic risk and need, and responsivity factors such as mental health, trauma, physical health, literacy, and any other factors that will affect their ability to remain abstinent from substance use and reduce their chances of recidivism.

RSAT program staff should complete individualized assessments to define subgroups of participants with similar needs so that programming can better target their specific need areas. This is especially important with the more limited duration of many jail RSAT programs, which may impede the provision of more intensive individualized treatment programming. For those who are detained and may only remain in jail for a matter of weeks, full assessments are essential to establish continuing care treatment, case management, and referrals—which in turn are essential for relapse and recidivism prevention.

Programs should create policies and procedures that include information on what is included in the comprehensive assessment.

According to the National Institute on Drug Abuse's *Principles of Drug Abuse Treatment for Criminal Justice Populations*, assessment is the first step in treatment.¹⁰ A good guidance document on what constitutes comprehensive assessment, developed by the American Society of Addiction Medicine (ASAM), outlines the following:

THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

The ASAM Criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

- 1. Acute Intoxication and/or Withdrawal Potential:** Exploring an individual's past and current experiences of substance use and withdrawal.
- 2. Biomedical Conditions and Complications:** Exploring an individual's health history and current physical condition.
- 3. Emotional, Behavioral, or Cognitive Conditions and Complications:** Exploring an individual's thoughts, emotions, and mental health issues.
- 4. Readiness to Change:** Exploring an individual's readiness and interest in changing.
- 5. Relapse, Continued Use, or Continued Problem Potential:** Exploring an individual's unique relationship with relapse or continued use or problems.
- 6. Recovery/Living Environment:** Exploring an individual's recovery or living situation and the surrounding people, places, and things.¹¹

C. Participation in RSAT should not depend on an individual's motivation for change.

RSAT staff should assess potential participants' readiness to change and adapt programming to match their stage of readiness. Multiple validated and reliable readiness-to-change screening and assessment tools are available in the public domain.[‡] After admission, the RSAT program should provide motivational enhancement therapies that help participants address their SUDs and commit to treatment.

Research suggests that SUD treatment does not need to be voluntary to be effective. Individuals should not be referred to RSAT based on rewards or consequences for institutional behavior or plea/sentencing agreements that are antithetical to eligibility for RSAT programming.

II. Core Treatment Components

A. Treatment (§ 10421): RSAT programs should provide a course of comprehensive individual and group substance abuse treatment services that are effective, based on the evidence.

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.¹² 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. Many of the evidence-based SUD treatment programs have been implemented in the community, as opposed to in correctional settings. However, there is growing body of research based in residential jail and prison settings that shows certain treatment modalities have better outcomes in terms of recidivism, retention in treatment, reduced use or discontinuation of alcohol and other substances, and medication compliance.^{13 14 15}

In the last two decades, research has consistently found that involvement in substance use treatment reduces recidivism for people in the criminal justice system who have SUDs.¹⁶ Research has also shown that substance use treatment can be effective even when an individual enters it under legal mandate.¹⁷

In general, alcohol use disorder and SUD treatment should address issues of motivation, problem solving, and skill building for resisting alcohol, substances, and criminal behavior, and introduce coping skills such as stress and anger management. Lessons aimed at supplanting alcohol and substance use and criminal activities with prosocial activities, and at understanding the consequences of one's thoughts and actions, are also important to include. Tailored treatment

[‡] See SAMHSA's TIP 35, which includes many public domain readiness-to-change instruments: *Enhancing Motivation for Change in Substance Use Disorder Treatment*. (2019). Treatment Improvement Protocol (TIP) Series No. 35. <https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003>

interventions for alcohol use disorders and SUDs can facilitate the development of healthy interpersonal relationships and improve a participant’s ability to interact with family, prosocial peers, and supportive others in the community.

Cognitive behavioral therapy (CBT), Motivational Interviewing (MI), and modified therapeutic communities (TCs) have been found to be effective treatment methods for RSAT programs. The National Institute on Drug Abuse (NIDA) has listed as helpful the following behavioral therapies intended to engage people in alcohol use disorder and SUD treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to substance use, and increase their life skills to handle stressful circumstances and environmental cues that may trigger relapse:

- CBT
- TCs
- Contingency management (CM) interventions/motivational incentives
- Community reinforcement approach (CRA), plus vouchers
- Motivational enhancement therapy (MET)
- The Matrix Model
- Twelve-step facilitation therapy
- Family behavior therapy (FBT)
- Behavioral therapies, including multisystemic therapy (MST)¹⁸

See appendix B for descriptions of these approaches, along with a list of other evidence-based programs from the Substance Abuse and Mental Health Services Administration (SAMHSA).¹⁹

1. CBT and cognitive behavioral interventions (CBIs) should not be limited to specific CBT sessions, but should be practiced and reinforced by all program staff, including treatment personnel and correctional officers.

CBIs are designed to directly address the risk factors that are closely related to the likelihood of an individual reoffending, as well as to address the individual’s substance use and co-occurring mental health disorders. Treatment should target factors associated with criminal behavior in addition to SUDs because, for most incarcerated people, the two are intrinsically linked. For instance, “distorted cognition” is a characteristic very often found in people with criminal offenses as well as in people with SUDs. This can include a combination of thought patterns, attitudes, and core beliefs that support criminal behavior and substance use, such as feeling entitled to have things one’s own way, feeling that one’s criminal behavior and substance use is justified, failing to accept responsibility for one’s actions, and consistently failing to anticipate or appreciate the consequences of one’s behavior.

RSAT programs should provide specific cognitive skills training to help individuals recognize patterns of thinking that lead to alcohol and substance use and criminal behavior; these increase the likelihood of improved outcomes. The use of CBI for people involved in the justice

system is based on the idea that an individual’s cognitive deficits and criminal-thinking patterns are learned, not inherited behavior. Therefore, CBIs typically use a set of structured techniques that attempt to build cognitive skills in areas in which individuals show deficits. CBIs can also help “restructure” cognition in areas where people show biased or distorted thinking. They are designed so that a well-trained non-clinician could provide the intervention to clients. Examples of such programs include Thinking for a Change, Reasoning and Rehabilitation, and Good Intentions, Bad Choices.[§]

CBT is a problem-focused set of therapeutic approaches provided by a clinical professional. It helps people identify and change dysfunctional beliefs, thoughts, and patterns of behavior that contribute to their problem behaviors, criminal and otherwise. CBT programs emphasize individual accountability and attempt to help RSAT participants understand their thinking processes and the choices they make.²⁰ Examples of CBT include rational emotive behavior therapy, cognitive therapy, and dialectical behavioral therapy.

All RSAT staff should understand the program’s basic CBT approach and key terms. RSAT staff, officers, and treatment staff should teach participants to become aware of their thinking, verbalize their thoughts, stop reacting to automatic thoughts, and understand how their thoughts and beliefs can trigger criminal and addictive behaviors. Staff should provide skills training and opportunities for modeling and behavior rehearsal.

CBT sessions should be monitored periodically to ensure that proper techniques are employed, principles or skills are being reinforced outside of CBT sessions, other treatment tools and program rules are consistent with CBT principles, and participants are held accountable.²¹

RELATED RESEARCH

Aggregating the results from 32 studies to examine the impact of CBI and CBT on crimes committed by moderate- and high-risk adult offenders, researchers found a significant effect size (-0.14) favoring the treatment group, meaning that moderate- and high-risk adult offenders who received CBT were significantly less likely to commit a crime, compared with adult offenders who did not receive intervention.²²

[§] SAMHSA’s Evidence-Based Practices Resource Center lists more than 20 CBT-based programs. See <https://www.samhsa.gov/ebp-resource-center>. The CrimeSolutions registry (<https://crimesolutions.ojp.gov/>) also finds CBI to be “promising” for moderate- and high-risk adult offenders.

2. MI for SUDs can help strengthen participants’ motivation to stop using substances and make other prosocial changes. It is an important component of RSAT programming.

MI, which CrimeSolutions has rated “effective” and which the National Institute of Corrections considers to be an evidence-based practice, is a person-centered communication method of fostering change by helping a person explore and resolve ambivalence. Rather than using external pressure, MI looks for ways to access internal motivation for change.²³ It has four fundamental processes:

- Engaging a person using empathy and supporting their autonomy.
- Focusing on a shared purpose that directs a conversation about change.
- Evoking the person’s own reasons and motivations to change, normalizing ambivalence, and listening for change talk.
- Planning that involves supporting a person on how to change and consolidating a commitment to change.²⁴

MI and motivational counseling approaches can be brief. A growing body of evidence indicates that early and brief interventions demonstrate positive treatment outcomes in a wide variety of settings, including continuing care/outpatient clinics, inpatient facilities, correctional facilities, emergency rooms, and behavioral health care settings. When provided to individuals with SUDs, the long-term goal is to help them reduce or stop using substances and alcohol. The practice helps a person address the common problem of ambivalence about change.

MI can be integrated into groups, classes, assessment interviews, case management sessions, and daily interactions between all staff—including correctional officers—and participants to help move them toward desired prosocial change. Although there are specific MI counseling strategies, MI is not a counseling technique. It is a style of being with people that uses specific skills to foster motivation to change.²⁵

RELATED RESEARCH

A review of 42 meta-analyses that reviewed the utilization of MI, brief MI, and MET (based on MI) showed MI to be most effective for stopping or preventing unhealthy behaviors such as binge drinking, smoking, and substance abuse, as well as for reducing the quantity and frequency of drinking.²⁶

3. TCs should be adapted to function within a prison or jail without sacrificing their essential components.

TCs use a comprehensive, structured, residential drug treatment program model for treating individuals with SUDs to foster changes in attitudes, perceptions, and behaviors related to substance use. Incarceration-based TCs for adults have been found to be effective for multiple crime and offense types. The CrimeSolutions registry rates the practice as “effective,” showing reduced rates of recidivism for participants after release.

The defining feature of TCs is their emphasis on the power of the community and residents as agents of change, which necessitates participation by all members of the program in the overall goal of reducing substance use and recidivism. The TC theory proposes that recovery involves rehabilitation to learn healthy behaviors and “habilitation” to integrate those healthy behaviors into a routine.²⁷ TCs differ from other models of treatment by their focus on recovery, overall lifestyle changes, and the use of the “community”—which includes peers and facility staff—as the key instrument for that change.²⁸ TCs use a stepping-stone model, in which participants progress through several levels of treatment. As they progress through each treatment level, their level of responsibility also increases. TCs are implemented in a residential setting to help participants adjust to the idea of a community working together toward a common goal.²⁹ Treatment includes aftercare and reentry services as means of providing continued support and relapse prevention after leaving the TC.³⁰

The Therapeutic Communities of America, a membership organization of more than 650 SUD and mental health treatment centers, recommends the following factors to be included for TCs to be most effective. It is noted that modified TCs for individuals with co-occurring mental illness and substance abuse have also been found to be “promising” in the CrimeSolutions registry.³¹

1. It is most desirable to have at least some staff who can serve as persons in recovery/formerly incarcerated role models, or at least some persons in recovery/formerly incarcerated role models involved in the program in some capacity, even as outside guest speakers—especially peers.
2. There must be a prevailing culture of positive peer pressure that counteracts the “inmate code” of the general population.
3. There must be a strong sense of community, with common language, rituals, and rites of passage, that prevents a “we/they dichotomy.”
4. There must be a shared locus of control, with residents involved in running the program but with staff maintaining ultimate control and applying it with rational authority and acting as prosocial role models.
5. Cooperation and continuous communication with security and administration personnel (e.g., warden) is essential to the autonomous functioning of the therapeutic community.
6. There must be a prosocial code of morality—“right living”—that promotes empathic relations between staff and clients along with open communication, honesty, trust, positive work ethic, and community responsibility.
7. Members should be organized by job functions in a hierarchical structure with corresponding rewards.

8. The community must adhere to strict behavioral expectations with certain consequences and sanctions applied in a mutual effort by other members and staff.
9. To ensure there is no corruption or programmatic drifting, it is essential to have regular TC-specific monitoring and training from outside the community.³²

TREATMENT AND SERVICE INTERVENTIONS: STATE EXAMPLE

The men's RSAT program at West Tennessee State Penitentiary is a TC that uses evidence-based practices including CBT, MI skills, and dialectical behavior therapy. The staff are trained in the use of evidence-based manualized curricula, screening, and assessment instruments. The RSAT program has a strong Certified Peer Recovery Specialist program. Family reunification is a strong aspect of the program for those men who are being released upon completion of the RSAT program.

4. **Although all RSAT participants are engaged in treatment for SUDs, other needs, especially treatment for co-occurring mental health disorders, must be addressed while they are incarcerated to prepare them for reintegrating into the community (see D on page 15).**

Examples of compatible treatment and services include the following, also identified by drug court researchers:³³

- Mental health treatment.
- Clinical case management.
- Housing assistance (sober/drug-free).
- Trauma-informed and specific services.
- Criminal thinking interventions.
- Family and social support and interpersonal counseling.
- Recovery community support.
- Peer recovery support.
- Prosocial and recreational activities.
- Vocational and educational services.
- Medical and dental treatment.
- Overdose prevention and reversal, including provision of naloxone to individuals (and/or family members/partners) after they are released.

COMPATIBLE TREATMENT AND SERVICES: STATE EXAMPLE

The RSAT Dual Diagnosis Treatment Program at Illinois' Logan Correctional Center offers groups to residents on topics including Socialization, Self-Help and Recovery Support, Building Social Networks, Families in Transition, Legal Aid, and a variety of women's health topics. A vocational program is available, as are literacy and advanced educational classes. The program's month-long reentry phase prepares residents for reintegration into the community and offers meetings with treatment staff, an Illinois Department of Corrections (IDOC) counselor, and a field services representative to help residents plan their reentry. Clients are put in contact with community-based treatment providers and the Placement Resource Unit of Parole, which is specifically designed to assist reentering men and women with special needs, including those with mental health or substance use issues. Source: <https://illinois.westcare.com/what-we-do/corrections-based-programs/dual-diagnosis-treatment-program/>

5. RSAT programs have also found evidence-based, manualized treatment interventions (those that are implemented according to instruction manuals) to be effective, offering structure and consistency.

These are also easy to use and can help focus sessions, although they can be restrictive and counselors need to incorporate personal style and creativity in their use.³⁴ The quality of the interpersonal relationships between staff and the participants, along with the skills of the staff, are as important to risk reduction as the specific programs in which offenders participate.³⁵

B. There should be more rewards than sanctions to encourage prosocial behavior and treatment participation.

It is important to reinforce positive behavior when providing correctional supervision of individuals participating in SUD treatment. Non-monetary "social reinforcers," such as recognition for progress or sincere effort, can be effective, as can graduated sanctions that are consistent, predictable, and clear responses to noncompliant behavior. During the development of an RSAT program, especially if it is a TC, rewards for prosocial behaviors and interactions, program and treatment progress, and achieving other accomplishments are built in to the program. Participants will get called out for "being caught" doing something exceptional such as helping another RSAT resident with homework or showing a newcomer how to keep his area clean for inspection. When participants transition to another phase in the program, earn their GED, or complete an extracurricular program (e.g., a parenting class) residents and staff recognize the accomplishment during a community meeting. Many times, a sincere recognition of a participant's efforts and/or behavioral improvement by an officer or by RSAT staff will be a valuable reward in and of itself.

All consequences for noncompliance need to be clearly written and reviewed as part of the orientation when an individual enters the RSAT program so there is no misunderstanding of program expectations. Generally, less punitive responses are used for early and less serious noncompliance, with increasingly severe sanctions issued for continued problem behavior. Rewards and sanctions are most likely to have the desired effect when they are perceived as fair and when they swiftly follow the targeted behavior. Consequences for participants' behavior should be administered in accordance with evidence-based principles of effective behavior modification. Moreover, confrontation should focus on negative behavior and attitudes, and not on the individual.

RELATED RESEARCH

As summarized by NIDA, research has demonstrated the effectiveness of treatment approaches using CM principles, which involve giving patients tangible rewards to reinforce positive behaviors such as abstinence and continued treatment. Studies conducted in both methadone programs and psychosocial counseling treatment programs demonstrate that incentive-based interventions are highly effective in increasing treatment retention and promoting abstinence from drugs.³⁶ Research shows that implementing a higher number of incentives to sanctions, particularly in a ratio of four or more rewards for every sanction, achieves the best outcomes for people on community supervision.³⁷

C. RSAT programs should be trauma informed. Trauma-specific services should be provided for those in need or referrals made to such programming, if available, outside of the RSAT program.

As part of the principle of responsivity, RSAT programming should be accessible to participants who have experienced trauma. All programming should be trauma informed to the extent possible, given that prisons and jails present challenging settings for trauma-informed approaches. At least one third of males and two thirds of females in RSAT programs may be experiencing lasting effects of trauma exposure that play a role in their continued use of drugs and alcohol.³⁸ During incarceration, there may be scores of unavoidable triggers for an individual with post-traumatic stress disorder (PTSD)—shackles, overcrowded housing units, lights that are on all night, loudspeakers that blare without warning, and severely limited privacy. Pat downs and strip searches, frequent discipline from authority figures, and restricted movement may all mimic certain dynamics of past abuse. All of these factors are likely to aggravate trauma-related behaviors and symptoms that can be difficult for staff to manage.³⁹ Some individuals with PTSD may have used alcohol and other substances to cope with trauma responses and triggers, and with the removal of these coping mechanisms from the individual's life, trauma-related symptoms may worsen.⁴⁰

Integrating trauma stabilization and coping-skills training into an RSAT program will make substance use and co-occurring disorder treatment more accessible for individuals who have experienced trauma. Trauma-informed programs and cognitive behavioral trauma-specific interventions can help participants learn the skills that will set the stage for engagement in effective recovery programming.

Trauma-informed RSAT programs should include:

- Staff who understand trauma and its impact on substance use and co-occurring disorders and the recovery process.
- Services designed to enhance safety, minimize triggers, and prevent re-traumatization.
- Relationships between staff and participants based on equity and healing.
- Staff and services that empower those who have experienced trauma by providing them with information, hope, and appropriate referrals upon release.
- Trauma-specific services that offer specific groups and interventions aimed at coping with the aftermath of trauma, decreasing symptoms of trauma-related disorders while in the program, and increasing knowledge about trauma.
- Services that empower participants with skills and techniques to manage and decrease the symptoms of trauma in their ongoing recovery.

Although there cannot be true equity in relationships between staff and RSAT participants due to the inherent power differential, participant councils can be formed to give participants some input into how the RSAT programs or pods operate (in such a way that does not compromise the security and safety of the institution).

TRAUMA-INFORMED SERVICES: STATE EXAMPLE

The Dual Diagnosis Treatment Program at Illinois' Logan Correctional Center is designed to serve female residents with co-occurring substance use and mental health disorders in an integrated manner. Many of the residents also receive treatment for their experience(s) of trauma. Mental health staff meet with participants on a regular basis according to their needs. Many of the program's groups are focused on the mental health and co-occurring needs of the female residents. Specialized groups use Stephanie Covington's *Helping Women Recover* and Lisa Najavits's *Seeking Safety*, both of which help women attain feelings of safety through using coping skills, identifying triggers, and journaling. Treatment personnel and IDOC officers are both trained in trauma-informed treatment. IDOC is committed to annual booster training in trauma-informed services for all officers and staff. The Dual Diagnosis Treatment Program day officer has gone through trauma-informed and de-escalation training and has also become a crisis counselor for women residing in the Logan Correctional Center with increasing symptoms of mental health issues and trauma. He is also coaching other Logan Correctional Center officers in this model.

D. RSAT programs should offer integrated treatment for participants with co-occurring SUD and mental health disorders.

According to the National Institutes of Health and SAMHSA, SUD and mental health disorders are both brain conditions that respond better to integrated approaches that combine elements helpful to both mental health and SUDs in a comprehensive treatment program.

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

PRINCIPLES OF CO-OCCURRING INTEGRATED TREATMENT

Recovery is an individualized process informed by the levels of severity, needs, strengths, and preferences of each client. Increased coordination translates into more realistic expectations that recognize there is no point at which one treatment should end and the other begins. Experts agree on the following integrated treatment principles:

1. Co-occurring disorders are the expectation; clinical services should incorporate this assumption into screening, assessment, and treatment planning.
2. Within the treatment context, both disorders (i.e., substance use and mental health) are considered primary.
3. Empathy, respect, and a belief in the individual's capacity for recovery are fundamental provider attitudes.
4. Treatment should be individualized to accommodate the unique needs and personal goals of individuals at different stages of their recovery.
5. The role of an individual's community in treatment, post-release reintegration, and aftercare is a major factor in recovery.⁴¹

1. Given the frequency of co-occurring disorders among participants, RSAT programs should have standard procedures for collaboration with mental health treatment staff.

Co-occurring mental health conditions among individuals with SUDs should be considered the rule rather than the exception, as evidenced by a Bureau of Justice Statistics study revealing that 74 percent of people incarcerated in prison and 76 percent of people incarcerated in jail who use substances also report having a mental health disorder.⁴² For many RSAT participants, the justice system may be their first exposure to SUD treatment. Others might have attempted treatment but had their periods of recovery "sabotaged" by untreated mental health issues, resulting in a revolving door of recidivism. Still others may have accessed mental health services while substance use problems went unaddressed, eventually contributing to criminal justice involvement.

2. RSAT treatment and correctional staff should receive training on the signs and symptoms of mental health disorders and information on how the presence of one disorder can impact treatment and recovery of another.

Although program participants may have already been screened for mental health disorders, symptoms can emerge or develop during the course of SUD treatment. All RSAT staff should know how to identify those who may require further screening and assessment by a qualified mental health professional.

The challenge for RSAT staff is to understand how SUDs and mental health disorders interact, so they can provide RSAT participants with tools to manage recovery from both and ensure that prerelease planning facilitates connections to the full range of required services and supports. Fortunately, a number of evidence-based approaches have proven effective both for SUDs and for mental health disorders, including pharmacotherapies as well as motivational approaches such as MI, MET, CM, and mental health symptom management and recovery. The latter refers to a set of practices that teach people with mental health disorders how to manage symptoms and how to work with treatment providers, friends, and family to help sustain recovery. These strategies align with current SUD treatment principles, which impart information, tools, and resources that empower people to effectively manage ongoing recovery.

SAMHSA has developed the following practice principles for integrated treatment:

- Treatment for mental health disorders and for SUDs is integrated to meet the needs of people with co-occurring disorders.
- Integrated treatment specialists are trained to treat both SUDs and serious mental illnesses.
- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages.
- Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage.
- SUD counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages.
- Multiple formats for services are available, including individual, group, self-help, and family.
- Medication services are integrated and coordinated with psychosocial services.⁴³

Research demonstrates that people in integrated treatment programs show more improvement in the following areas than those in non-integrated programs: reduced substance use, improvement in mental health symptoms and functioning, decreased hospitalization, increased housing stability, fewer arrests, and improved quality of life.^{44 45}

STATE DEPARTMENT OF CORRECTION PROTOCOL

The Georgia Department of Corrections operates integrated treatment programs at two facilities. The 9-month program is highly structured and actively combines interventions intended to address both mental health and SUD issues. The intent is to treat the whole person effectively in a residential TC that includes a balance of individual and group sessions. Program elements include screening and assessment (including risk-need responsiveness), individualized treatment, ongoing monitoring of mental health symptoms, cognitive-behavioral treatment, illness management, trauma-focused treatment, psychoeducational therapy, medication-assisted therapy, problem-solving skills, and a reentry plan that includes a Wellness Recovery Action Plan (WRAP). WRAP was listed as an evidence-based program on the SAMHSA National Registry of Evidence-Based Programs and Practices. Although initially utilized and supported by research as a manualized group intervention for adults diagnosed with mental health issues, many correctional agencies have found it equally effective for adults experiencing various life challenges such as addiction, co-occurring disorders, reentry as well as those seeking to create a healthier way of life. It guides participants through the process of identifying and understanding their personal wellness resources (“wellness tools”) and then helps them develop an individualized plan to use these resources on a daily basis to manage and overcome challenges.

E. Treatment plans must be assessed and modified periodically to meet changing needs of participants and must incorporate a plan for transition into the community.

Definable and measurable outcomes must exist to assess and determine individual participant treatment progress through treatment plans. Documentation of case information—including a formal, valid mechanism or mechanisms for measuring individual outcomes—should be required.

RSAT treatment staff and correctional staff should work together to regularly assess participants’ progress or change in cognitive development and skills and in other goals based upon screenings and assessments conducted upon entry into the facility and the RSAT program. Other goals agreed upon in a collaborative manner between the participant and staff should also be evaluated in the same manner. Treatment planning must also incorporate continuing care needs with the participant’s transition to SUD and mental health disorder treatment (and referrals to other necessary services) in the community to support a prosocial recovery. Ongoing coordination between courts and parole officers is another important factor in addressing the complex and changing needs of RSAT participants.

III. Core Program Components

A. Program Length and Location (§ 10424): [RSAT] programs must provide 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. In local correctional and detention facilities program length is not specifically defined by the statute, but shorter programs, under 90 days, have not been found to be effective.

Prior to the latest amendments to the RSAT statute, only state RSAT programs in adult prisons and juvenile correctional facilities had to be at least 6 months. RSAT programs in jails were required to be at least 90 days, given the much shorter sentences of persons sentenced to jail. However, the statute also allows states to make grants to local correctional and detention facilities in the State (provided such facilities exist therein), for the purpose of assisting “jail-based substance abuse treatment programs that are “effective and science-based” established by those local correctional facilities. As such, a “residential treatment program” (as defined in statute) can qualify as a “jail-based substance abuse treatment program,” and so can other jail substance abuse treatment programs, including those that are less than 6 months, as long as they are “effective and science-based.”

RSAT program participants should be housed in a separate facility, housing unit, or pod. The physical layout of a facility may require creative scheduling, closed classrooms, or similar efforts to separate RSAT participants from the general population. The point is to keep persons in the program away from the negative influence of peers who are not engaged in treatment, may not be periodically drug tested, and will not reinforce the treatment goals of the RSAT program. While not all RSAT programs function as formal therapeutic communities (TCs), they all should seek to provide a supportive and encouraging community for the length of the program. It is important that participants are positively influenced and encouraged by their peers, as well as by specially trained correctional officers and other treatment staff.

B. RSAT programming should be offered in phases based on participants having reached specified behavioral and recovery milestones. RSAT programming should be considered the first phase of ongoing treatment that continues upon release.

The treatment RSAT programs provide should be considered the first phase of *ongoing* treatment that begins in prison or jail and continues after release. Institutional administrators, paroling authorities, and judges should be advised to allow participants to remain in RSAT programs at least for program minimum lengths. Potential RSAT participants should be advised in advance, however, if RSAT program completion will impact their eligibility to be considered for early release. (See “Related Research,” below.)

RELATED RESEARCH

Two studies of a jail RSAT program found that those who did not complete their RSAT program, including those who did not complete because they were granted early parole, had significantly higher recidivism rates post-release than those who did complete the program.⁴⁶ Graduation from one phase of the treatment to the next should be based on behavior, not on time elapsed.

RSAT programming should be designed so that participants receive services in phases.

Generally, there is an orientation phase followed by a main treatment phase and ending in a reintegration phase prior to program completion. There are various models that RSAT programs may follow when identifying treatment targets for each phase.

One model similar to the recommendations made by the Adult Drug Court Best Practice Standards Committee describes the first phase as an orientation to the rules of the RSAT program as well as to a participant’s mental health symptoms, substance-related cravings, withdrawal, anhedonia, readiness to change, and motivation. In the next phase, services target criminogenic needs, including criminal thinking, anger management, and more in-depth substance use disorder (SUD) treatment. In the last phase, the program provides services to maintain treatment gains by enhancing RSAT participants’ long-term adaptive functioning.⁴⁷

Another model is based upon the American Society of Addiction Medicine (ASAM) placement criteria, used to determine level of treatment needed. This model provides a more individualized treatment plan for each RSAT resident and recognizes that a person may need more intensive services at some point in the program. In this model, phases are more flexible and based upon an individual resident’s treatment needs. Although all residents must stay the minimum length of time within the RSAT program, some may stay longer to achieve treatment goals.

Some RSAT programs seem to be a combination of the two models described above. In all models, transition from one phase of the treatment to the next should be based on the achievement of treatment and behavioral goals, not on time elapsed.

RSAT PROGRAMMING MINIMUMS AND PHASES: STATE EXAMPLE

West Tennessee State Penitentiary’s men’s RSAT program is 9–12 months long, with three phases lasting 3–4 months each, depending on an individual’s progress in meeting the milestones required to progress to the next phase, as well as their individual goals and objectives. Tutors and mentors are available to assist with reading and writing. Some participants may be paired with another RSAT resident in a higher phase for additional assistance and motivation. RSAT residents are eligible for graduation when they complete all three phases, finish required pre- and post-tests and written work, meet their individualized treatment plan goals, and all RSAT staff agree they are ready to move on.

C. Prosocial programming should account for the majority of the participants’ day.

RSAT participants should be involved in positive, prosocial programming most of the day so that negative influences can be minimized, even though many RSAT participants are segregated from the general prison or jail population. It is imperative that correctional officers (who, in most facilities, spend more direct face time with participants than treatment staff do) reinforce behavioral standards and activities promoted by RSAT program expectations and treatment staff.⁴⁸ Cross-training officers and RSAT staff will encourage consistent positive reinforcement for

treatment. The need to keep RSAT participants positively engaged is one of the reasons why many RSAT programs employ modified TCs to address participants' substance use and co-occurring disorders. Some programs use activity logs to track participants' structured activities. Others provide participants with electronic tablets that can be monitored to measure time spent on specific activities and treatment exercises. In a TC, there are jobs within the Unit as well as "committees" that have weekly tasks, such as the "morale committee," the "newcomers committee," and the "recreation committee." These are examples of prosocial activities that take place outside of regular treatment or clinical group time.

D. RSAT programs should be culturally competent.

RSAT staff should learn and understand how identification with one or more cultural groups influences each client's worldview, beliefs, and traditions surrounding initiation of substance use, healing, and treatment.⁴⁹ Staff should also have an understanding of their own culture and how that affects interactions with clients from other and similar cultures.⁵⁰

The development of culturally responsive clinical skills is vital to the effectiveness of behavioral health services. According to the U.S. Department of Health and Human Services, cultural competence "refers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time."⁵¹ Culturally responsive skills can improve client engagement in services, therapeutic relationships between clients and providers, and treatment retention and outcomes. Cultural competence is an essential ingredient in decreasing disparities in behavioral health.⁵²

Knowledge of a culture's attitudes toward mental health, substance use, healing, and help-seeking patterns, practices, and beliefs is essential when considering an individual's "presenting problem" (initial symptom or symptoms for which they seek help). It is also essential for developing culturally competent counseling skills and formulating culturally relevant agency policies and procedures.

CULTURAL COMPETENCE: STATE EXAMPLE

The Wyoming Medium Correctional Institution — Intensive Treatment Unit (WMCI-ITU) provides a specialized curriculum for indigenous incarcerated men. "The Red Road to Wellbriety" offers hope and healing for Native Americans seeking recovery for alcohol and substance use disorders. The curriculum draws on the philosophies and practices of AA/NA and has a strong spiritual component. WMCI, as with other Wyoming Department of Corrections facilities, has sweat lodges on the grounds that are available for all men at certain times of the month.

E. Urinalysis (§ 10422): Urinalysis or other proven reliable forms of [drug] testing, including both periodic and random testing before entering and during RSAT and after release if the person remains in custody of the state, is required of all RSAT participants.

Participants should be carefully monitored for alcohol and substance use during treatment in the correctional facility. Those trying to recover from alcohol and substance use disorders may experience a relapse and return to use. Triggers for relapse are varied, but common ones include mental stress, associations with antisocial peers, and social situations linked to drug or alcohol use. An undetected relapse can progress to more serious issues with substance use, but, if detected, a relapse can present opportunities for therapeutic intervention. Monitoring alcohol and substance use through urinalysis or other objective methods as part of treatment or criminal justice supervision provides a basis for assessing and providing feedback on participants' treatment progress. It also provides opportunities to intervene to change unconstructive behavior—for example, determining rewards and sanctions to facilitate change and modifying treatment plans according to progress.

If RSAT participants are to be provided naltrexone (oral or injected) they must be tested first for opioids, as abstinence is required for at least 7 days before they can take the medication. Naltrexone blocks the effects of alcohol, too, but individuals do not have to be alcohol-free before taking it.

Multiple onsite urinalysis testing devices are available. It is important that the tests be observed to ensure the samples are not tampered with or substituted. If individuals know they will be drug tested, it can deter continued drug use and make it easier for a participant to reject pressure from peers who are not interested in recovery. In addition to urine testing, testing methods include testing saliva, hair, breath, and blood. Hair tests are particularly useful for determining substance use histories, as they reveal past use over a period of months, including the amount used.

IV. Provision of Medications and Health Care

A. Pharmacological Treatment (§10424): Medications should be considered part of the contemporary standard of care for the treatment of individuals with alcohol and opioid use disorders and those with co-occurring mental health disorders.

Medicines used in medication-assisted treatment (MAT), such as methadone, buprenorphine, and naltrexone for opioid use disorder (OUD), and naltrexone, acamprosate calcium, and disulfiram for alcohol use disorder, should be made available to individuals who could benefit from them.^{53 54}

Persons entering prison or jail with valid prescriptions for medication to treat opioid or alcohol use disorders or mental health disorders should be allowed to continue receiving the medication pending medical and psychiatric assessments. This is not only consistent with contemporary standards of care, but also increasingly seen as a legal mandate for jails and prisons

under the American with Disabilities Act and legal obligations to provide appropriate health care to incarcerated persons. Discontinuing the use of mental health medication has the potential to affect recidivism and health care costs after release, as well as the severity of symptoms of the mental health disorder, overuse of solitary confinement, and suicide within prisons and jails.⁵⁵

The provision of appropriate MAT for opioids and alcohol and appropriate medication for mental health disorders requires continuation beyond the length of the RSAT program.

Programs must arrange for medication to be provided as needed after the program ends and the participant is returned to the general population or another correctional unit or is released to the community with or without correctional supervision.

RSAT participants and their families should be informed on the availability of naloxone and its use to prevent overdose deaths. Where available, they should be encouraged to have the medication on hand in case of emergency.

If participants are not appropriate candidates for MAT or choose not to use it, the program should provide science-based withdrawal management to minimize risk for death and mitigate discomfort. To gain the trust and confidence of participants, programs must ensure participants do not suffer unnecessary, gratuitous, and potentially lethal detoxification. U.S. Food and Drug Administration (FDA)-approved medications for withdrawal management, including agonist medications for tapering and lofexidine to mitigate withdrawal symptoms, should be provided.⁵⁶

RELATED RESEARCH

A randomized clinical trial of prison-initiated buprenorphine provided to male and female individuals who were heroin dependent prior to incarceration found that those receiving the medication were significantly more likely to enter community treatment upon release (47.5% vs. 33.7%).⁵⁷

In a Baltimore prison, men who received methadone maintenance treatment and counseling with treatment continuing upon release were reported to show a much lower rate of subsequent illicit opioid use compared to those who received counseling only.⁵⁸

B. Health Coverage: Aftercare Services (§10422): RSAT programs must assist participants with aftercare services, which may include case management services and a full continuum of support services, including medical treatment or other health services.

RSAT programs should ensure that participants have whatever health insurance they are eligible for and other public benefits prior to release where possible and be referred for care coordination in the community upon release to assist with obtaining health and public benefits. In addition to substance use disorders (SUDs), many RSAT participants are likely to have other significant physical and behavioral health care needs that require regular access to care after release.^{59 60} Without access to health services immediately upon release, the physical and mental

health conditions of recently released individuals may deteriorate. Research shows that, during the first 2 weeks after release from prison, ex-offenders face a markedly increased risk of death (more than 12 times that of other individuals), especially death from drug overdose (129 times that of others).⁶¹ Research suggests that providing access to Medicaid upon release can promote more timely access to care, which may reduce that risk, particularly for individuals with chronic physical and/or mental health conditions.⁶² In addition, continuous access to health care immediately after release may reduce the risk of rearrest and reincarceration.⁶³

Medicaid managed care entities, including health homes, may be well positioned to help Medicaid enrollees quickly access necessary community-based services upon release from prison or jail. The State of Colorado, for example, requires behavioral health organizations to “collaborate with agencies responsible for the administration of jails, prisons, and juvenile detention facilities to coordinate the discharge and transition” of enrollees. In addition to ensuring that enrollees leaving incarceration receive medically necessary behavioral health services, these agencies are encouraged to propose innovative strategies to meet the needs of enrollees involved with the criminal justice system.⁶⁴

HEALTH COVERAGE UPON RELEASE: STATE EXAMPLE

The state of Florida requires Medicaid managed care plans to “make every effort . . . to provide medically necessary community-based services for health plan enrollees who have justice system involvement.” Among other things, these plans must (1) provide psychiatric services to enrollees and likely enrollees within 24 hours after release from a correctional facility, (2) ensure enrollees are linked to services and receive routine care within 7 days after release, and (3) conduct outreach to populations of enrollees at risk of justice system involvement, as well as to “Health Plan enrollees currently involved in this system, to assure that services are accessible and provided when necessary.” In addition, behavioral health organizations must work to develop agreements with correctional facilities that will enable plans to anticipate the release of individuals who were enrolled prior to their incarceration.⁶⁵

In Medicaid expansion states, eligible RSAT participants should be enrolled in their state’s Medicaid program (as should all eligible incarcerated populations). Correctional staff should identify inmates eligible for Medicaid and begin the enrollment process before release. There is no federal statute, regulation, or policy that prevents individuals from being enrolled in Medicaid while incarcerated. Notably, in 2004, the Centers for Medicare & Medicaid Services issued guidance reminding states that people “who meet the requirements for eligibility for Medicaid may be enrolled in the program before, during, and after the time in which they are held involuntarily in secure custody of a public institution.” Federal law requires states to allow individuals to apply for Medicaid at any time. In all states, incarcerated populations may be enrolled in available subsidized or nonsubsidized insurance plans offered through their state’s market exchanges.

All states, regardless of the scope of their Medicaid coverage, can use the following materials to ensure prisons and jails are positioned as effective hubs for helping eligible people get public health

care coverage, Social Security, and veterans benefits. This assistance can help facilitate easier access to treatment and help reduce recidivism as part of a comprehensive reentry effort.

In 2016, the Bureau of Justice Assistance and the American Correctional Association released *Health Care Reform: A Practical Guide for Corrections and Criminal Justice Professionals*, which outlines enrollment strategies, structure for delivery of Medicaid services within states, and, specifically, a section on reentry from jails and prisons to the community. The latter section describes important linkages to community health services, including Federally Qualified Health Centers and Medicaid health home referrals, as well as the need to establish processes for transmitting prison and jail health records to community providers.

Other innovative linkages for justice-involved populations are described in *Coordinating Access to Services for Justice-Involved Populations*, an issue brief published by the Milbank Memorial Fund in August 2016. In 2017, the Council of State Governments Justice Center and the National Reentry Resource Center released *Critical Connections: Getting People Leaving Prison and Jail the Mental Health Care and Substance Use Treatment They Need*, a discussion paper that identifies key questions and issues every policymaker should consider when seeking to help people leaving prison and jail connect to needed mental health and substance use treatment.

C. Hospitalization: If RSAT participants require hospitalization, RSAT programs should recommend out-of-institution inpatient care, as appropriate with security needs, to reduce institutional health care costs.

It is often recommended that states only suspend, rather than terminate, Medicaid enrollment for incarcerated populations. Although Medicaid will not generally cover RSAT participants while incarcerated, it will cover care received by them in an inpatient hospital or other medical institution outside the prison or jail. States may receive Medicaid reimbursement for care provided to eligible individuals admitted as inpatients to a medical institution such as a hospital, nursing facility, psychiatric facility, or intermediate care facility. Temporary suspension will facilitate reimbursement for these out-of-prison or -jail hospitalizations.

D. Health Literacy: RSAT programs should provide and encourage health literacy. Participants should be taught how to obtain, process, and understand basic health information needed to make appropriate health decisions and access health care services.

Consistent with federal and state laws, incarcerated individuals with alcohol and substance use disorders should be educated about and offered testing for infectious diseases and receive counseling on their health status and ways to modify risky behaviors. Testing and treatment for infectious diseases such as HIV, hepatitis B and C, tuberculosis, and COVID-19 for all individuals who enter correctional facilities is essential to the public health of the correctional population and staff. The rates of infectious diseases, such as hepatitis, tuberculosis, HIV/AIDS, and COVID-19 are higher among individuals with SUDs, incarcerated offenders, and individuals under community supervision than in the general population.^{66 67 68} Treatment planning for those

reentering the community should include strategies to prevent and treat serious medical conditions such as HIV/AIDS, hepatitis B and C, tuberculosis, and COVID-19. Released RSAT graduates should be linked with appropriate health care services, encouraged to comply with medical treatment, and reestablish their eligibility for public health services (e.g., Medicaid, county health department services) before release from prison or jail.

V. Continuing Care and Reintegration

RSAT programs must assist participants with post-release services, which may include case management services and a full continuum of support services, including medical treatment and other health services. Post-release services must involve the coordination of the correctional facility treatment program with other human service and rehabilitation programs (e.g., educational and job training, parole supervision, halfway house) and participation in self-help and peer group programs that may aid in the rehabilitation of individuals in ongoing substance use disorder (SUD) and mental health disorder treatment and services. Recovery support is a critical component of ongoing recovery success both during RSAT and after release.

A. Continuity of care is essential for people with SUDs and mental health disorders who are reintegrating back into the community. Continuing care includes case management services, support services, behavioral health and treatment programs, educational and job training programs, and parole/probation supervision programs.

It is imperative that the RSAT program work with each participant to develop a comprehensive case management and reintegration plan that takes effect immediately upon release. The plan should address survival fundamentals, including housing, finances, physical and mental health, family and social relationships, leisure time activities, and so on, as well as referral to SUD and mental health disorder treatment and support programs.

Information-sharing protocols must be established between treatment and security staff in correctional facilities and with post-release case managers and treatment staff in the community to facilitate connections between in-custody treatment and community-based treatment. This is important to ensure seamless transfer of information about an individual's behavioral health conditions, progress in treatment while incarcerated, and treatment needs that should be addressed in the community. People who complete prison-based treatment and continue with treatment in the community typically show the best outcomes.⁶⁹ Research shows how providing continuing care can improve outcomes.⁷⁰ Treatment in prison or jail can begin a process of therapeutic change, helping lead to reduced substance use and a reduction of criminal behavior post-incarceration. Continuing treatment in the community is essential to sustain these gains but can be hampered without communication between treatment providers and supervising agents.

Efforts by various correctional departments have demonstrated that improving the process of reentry referral can result in most participants entering aftercare.⁷¹ Through collaboration with community-based providers, volunteers, and other local services, barriers to accessing

treatment and continuing care can be decreased. Regardless of intervention type, positive outcomes from prison-based drug treatment programs are most likely to persist when people participate in post-release community treatment. The success of a continuing care model, in which prison treatment is followed by community treatment, is contingent on whether the released individual appears for admission to the community treatment program and continues to attend it. Unfortunately, many individuals do not do so, even in states where post-release treatment is a condition of release, parole, or probation. Efforts by various correctional departments have demonstrated that improving the process of reentry referral can result in most participants entering aftercare.⁷²

CONTINUING CARE MODEL: COUNTY EXAMPLE

The Baltimore County Detention Center's RSAT program has developed memoranda of understanding (MOUs) and referral agreements with treatment services and diverse recovery support and peer-based recovery support services within Baltimore and contiguous counties. Upon release, RSAT graduates attend appropriate community partner services and bimonthly aftercare groups. The aftercare groups are monitored by the Detention Center's Intake Aftercare Coordinator, who conducts motivational recovery management checkups for 12 months post-release. Released RSAT graduates are strongly encouraged to attend AA/NA or other self-help and support groups within their communities.

Effective reintegration and continuing care require coordination with parole/probation. If participants will be under correctional supervision upon release, RSAT personnel should work with participants' post-release supervisors to plan for transition to community-based treatment and linkage to appropriate post-release services to improve the success of SUD and mental health disorder treatment and reintegration. Abstinence requirements may necessitate a rapid clinical response, such as more counseling, targeted intervention, or increased medication to prevent relapse. Ongoing coordination between corrections and treatment providers is important in addressing the complex needs of those reentering the community.

Preparing an individual for release to the community involves linkages to various departments and staff both inside and outside the correctional facility. Best practices indicate that initiation with community-based SUD and mental health disorder treatment should occur within 1 week after release from correctional custody. Yet one of the major obstacles many reentry programs face is poor follow through and follow up after release. Prior to release, it is important to accomplish as much as possible regarding recommended services. This includes ongoing communication with treatment staff, community-based providers, and supervisory personnel. Some of these tasks include:

- Making continuing care appointments prior to release.
- Having multidisciplinary meetings at regular intervals during treatment.
- Reassessing criminogenic needs at regular intervals.

- Collaborating with community corrections and community-based services/treatment staff to ensure continuity of care, including the transfer of treatment records.

RSAT programs should motivate those graduates who will not be under correctional supervision upon release to continue treatment on their own and help them put together a plan to get the supports they need to assist them in remaining drug- or alcohol-free after release. Whenever possible, allowing representatives from community-based providers, treatment facilities, the Department of Veterans Affairs, state health insurance, and others to come into the facility to meet with participants as a group or individually helps to increase the likelihood of them receiving continuing care once released.

For many years, RSAT funding for continuing care after an individual was released was limited to 10 percent of the grants provided. This was altered in fiscal year 2013 in recognition of the necessity of continuing care and treatment upon release. Mental health disorders and SUDs are serious problems that must be treated and managed throughout their course. Effective treatment engages participants in a therapeutic process, retains them in treatment for an appropriate length of time, and helps them learn to maintain abstinence and manage symptoms. Multiple episodes of treatment may be required. Treatment providers, social service agencies, and community supervision agencies can play a role in improving outcomes for people with co-occurring disorders in the community by monitoring drug use and encouraging continued participation in treatment.

STATE DEPARTMENT OF CORRECTION PROTOCOL

The Massachusetts Department of Correction mandates, under 103 DOC 445.05, “Continuity of Care” for individuals releasing from correctional custody, that “follow-up shall be conducted in a manner consistent with the recommendations of the treatment plan. . . . Upon impending discharge, parole or transfer to pre-release, staff shall update the [personalized program plan] and develop aftercare plans. . . . The plan shall be based upon the completed substance abuse specific assessment, input from program staff, the inmate, community-based treatment program staff and the institution parole officer, if applicable. All referrals and placements shall be entered in the designated (record) screen.”⁷³

B. RSAT programs must assist participants on medications for alcohol use disorder and OUD to immediately continue these medications upon release.

Effective MAT programming requires RSAT participants and community treatment and medical providers to make appointments and arrangements prior to a participant’s release date whenever possible. MAT has been found to significantly improve prospects for long-term recovery. For methadone, it is generally agreed that medications should be taken for at least a year.⁷⁴ While there is no consensus for how long buprenorphine or naltrexone should be taken, the research indicates longer is generally better.

As mentioned in section IV. B., research shows that, during the first 2 weeks after release from prison, ex-offenders face a markedly increased risk of death (more than 12 times that of other individuals), especially death from drug overdose (129 times that of others).⁷⁵

- **If an RSAT participant has continued on or been inducted on medications for OUD, alcohol use disorder, or a mental health disorder, it is crucial that a plan is put into use to allow them to continue to get prescriptions for their medication(s) from an appropriate medical provider and get them filled in a timely manner upon release.**
- **If they are released on methadone, they need to be enrolled into an accessible Opioid Treatment Program (OTP) prior to or as soon as possible after release.**
- **When possible, facilities should provide “bridge” doses for certain medications that will supply the released RSAT participant with the necessary dosages until they are able to attend their first psychiatric and/or MAT provider appointment within the community.**

In cases where participants are released to communities a long distance from the correctional facility, case management must identify the required community and correctional programs for post-release services and supervision that will be able to assist the released participant within their home community.

C. RSAT programs must involve the coordination of the correctional facility with other human service and rehabilitation programs, to include self-help and peer group programs.

RSAT programs should help participants connect to community resources, mobilize family and prosocial peers, and develop a prosocial peer network by encouraging peer-to-peer learning, involving peer reentry liaisons, and engaging participants in 12-step programs and mutual help and/or faith networks. The use of trained peers in the process of re-entry has been shown to reduce recidivism for those individuals with even the highest needs upon release.⁷⁶ All of this should occur in addition to specific treatment and service referrals.

Increasing RSAT participants’ connections to a prosocial peer support network that will support their efforts to reduce use of and abstain from alcohol and other substances begins in the treatment setting and is a key aspect of the therapeutic community (TC) approach. Connections to safe and supportive peers, other people in recovery from both addiction and mental health communities, and additional prosocial networks of support are important components of successful RSAT programs. Often individuals reentering the community who have long histories of substance use have very few contacts who are not connected with drug or alcohol use. Some have no contact with supportive family members or do not have a good friend who does not use alcohol or substances.

People with mental health disorders can also benefit from peer support in addition to ongoing concurrent treatment. Peer support specialists have the potential to expand access to care, prevent hospitalizations, and lower health care costs.⁷⁷ Due to shared experiences, people who

are having difficulties managing mental health symptoms and possibly a co-occurring SUD may find peer support especially approachable. This in turn increases clinical and medication compliance, which may also be conditions of supervision for many individuals reintegrating into the community.

Recovering peers have a role in treatment settings distinct from that of staff. In RSAT programs, an outside peer recovery presence is desirable; however, peers who have completed RSAT treatment and are awaiting release can serve a similar purpose. The unique contributions of peers fall into four categories that complement professional services.

Peers in addiction recovery can:

- Promote hope through positive self-disclosure, assuring others that recovery is possible.
- Model recovery thinking, reentry success, positive parenting, and gainful employment.
- Share knowledge, unwritten rules, resources, and prosocial “street smarts,” vital for navigating social services systems.
- Engage others in informal networks of support that provide an alternative to antisocial companions and activities.

Recovery coaching, mentoring, attendance at recovery support groups, and connections to local recovery community resources are examples of peer-led elements of successful RSAT programs. Multiple studies have verified the effectiveness of peer support programs—in addition to treatment—for adolescents in the juvenile justice system, incarcerated women, justice-involved veterans, and incarcerated adults.⁷⁸

RECOVERY SUPPORT: STATE EXAMPLE

A highlight of West Tennessee State Penitentiary’s women’s RSAT program is the availability of Certified Peer Recovery Specialists (CPRSs). These individuals are RSAT graduates who have been certified to provide support for others who have had similar experiences and need someone to listen without judgment. CPRSs are people with mental health disorders, SUDs, or co-occurring disorders who have completed a 40-hour training focused on recovery, communication, values, ethics, motivation, co-occurring disorders, trauma-informed care, and wellness. They also complete 75 hours of peer recovery services under supervision, such as leading peer support groups, teaching Wellness Recovery Action Planning (WRAP) or conducting one-on-one peer support sessions. After release, residents who complete the requirements are eligible for state certification, which makes them eligible to work as CPRSs in community-based programs. The CPRSs facilitate several groups a week in the RSAT program, providing peer education and support. They serve as role models, demonstrating boundary-setting, prosocial behavior, empathy, and compassion.

VI. Staffing and Training

A. In group activities, the ratio of RSAT participants to staff should be no more than 20 to 1.⁷⁹

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

B. Both treatment and security staff should receive training about substance use disorders (SUDs), mental health disorders, and trauma, as well as specific training about the RSAT program, including its mission, operations, policies, and practices.

Both treatment staff and correctional officers should receive training in and understand RSAT standards, philosophy, benchmarks, and objectives. Both groups of staff should be expected to attend and participate in relevant program activities, including daily or weekly meetings as well as community meetings with RSAT participants. Both should be involved in discipline and performance reviews—including decisions about whether participants should advance to the next phase of treatment—along with assessments and clinical supervision.

Treatment staff and correctional staff should be involved in cross-training. Treatment staff should attend correctional officer training and security-related training, and correctional officers should be exposed to treatment training, including training on symptoms of SUDs and mental health disorders and on trauma-informed care. In addition to initial training, all staff should be required to complete a regimen of in-service training to keep up with latest evidence-based practices and treatment. Whether the primary modality of treatment is a modified therapeutic community (TC) or not, counselors and correctional officers should be trained appropriately and work as a team to ensure accountability.

Correctional officers must understand RSAT programming and be as committed to treatment as RSAT counselors and administrators. To be effective, SUD treatment programming should take up 40–70 percent of an individual’s time.⁸⁰ This requires a collaborative effort between correctional officers and treatment staff so that RSAT participants are involved in the program beyond the limited hours counselors are available in the institution. Officers can help with homework, facilitate or co-facilitate an evening group, or make themselves available for residents’ questions and interaction.

C. RSAT staff should be trained in cognitive behavioral therapy (CBT), Motivational Interviewing (MI), and other evidence based and promising practices and interventions that are implemented in the unit, including screenings, assessments, curricula, and other specific programming offered. Correctional officers should also be involved in these trainings.

All RSAT staff and officers should understand how to teach participants to become aware of their own thinking patterns, verbalize thoughts and feelings, modify behaviors, and stop reacting to automatic thinking. In doing so, all staff can provide skills and knowledge to help participants understand their own thoughts that put them at risk for criminal and addictive behavior. They can also provide opportunities for modeling and practicing prosocial healthy behaviors. Cognitive behavioral interventions (CBIs) are designed to directly address criminogenic risk factors and other at-risk thinking of RSAT participants.

It is important that groups and sessions using CBT be assessed on a regular basis to ensure fidelity to the basic approach and techniques, and to ensure that principles and skills are being reinforced within the program outside CBT groups, including participants being held accountable for their behaviors.

All RSAT staff, including officers, should be trained in at least the basics in MI, and they should integrate it into RSAT programming groups and daily interactions with participants to help move them toward desired prosocial change. MI is a person-centered way of interaction with people that helps move a person toward change by listening with empathy, using reflection, and allowing them to explore and resolve ambivalence. The practice helps a person address the common problem of ambivalence about change. Although there are specific MI counseling strategies, MI is not a counseling technique. It is a style of being with people that uses specific skills to foster motivation to change.⁸¹

MI is considered a practice, thus all staff should either attend ongoing training, receive feedback on their MI skills from a clinical supervisor or MI trainer, or develop an MI learning circle or circle of practice. An MI learning circle is a group of staff that meet regularly to sustain learning and strengthen MI skills. There are many exercises to practice specific MI skills; staff can also use real-life scenarios and provide feedback for one another.⁸²

Because of the highly organized structure of a TC, all staff need to be trained in their specific model of TC, know the rules and regulations, and be expected to hold residents and other staff accountable. RSAT programs that are TCs or modified TCs are different than other residential treatment programs. They present an alternative and more positive concept of incarcerated individuals. People in TCs are usually called “residents” and may address officers and other staff as “sir,” or “ma’am.” All TC staff are expected to be role models and examples of “right authority,” and there is usually a strong recovering presence within a TC, whether among staff or peer mentors. A TC has rituals, daily and weekly community meetings, and responsibilities and jobs within the Unit based on a hierarchy of progression throughout treatment. Residents are expected to call each other out when they are not living up to the expectations of the Unit and also to express encouragement when observing another doing well.

All RSAT staff should be trained on screenings/assessments (depending on the classification system within the facility), curricula, and other specific programming used within the Unit. It is not uncommon, especially in TCs, for RSAT officers to facilitate groups and administer screenings, thus it is advisable for officers to be trained in these instruments and curricula.

VII. Measuring Results

To measure the effectiveness of RSAT programs at the individual and program levels, RSAT program administrators should establish strong data collection standards and time frames for analyzing data. The performance measures required by the Bureau of Justice Assistance are helpful in providing measures of RSAT outcomes, but programs often include additional measures in their data collection processes. Although no program can be implemented with the exact same population of participants or under the same circumstances as the model, it is crucial that the key components of the model are implemented without compromising their integrity. As part of data collection standards, it is important to include key measures of implementation to test whether the program was implemented with fidelity to the original model.

A. Performance measures during an RSAT program should include a person’s participation, completion rates, urine test results, the percentage of slots in therapeutic communities (TCs) that were utilized for medium- to high-criminogenic-risk individuals, and other relevant activities. Measured outcomes should include rearrests, reincarcerations, initiation and retention in treatment, abstinence or length of time to relapse, drug overdoses, emergency room visits, and drug overdose deaths.

To determine effectiveness, RSAT programs should follow “program outcomes”—how program graduates do after they are released. The most easily obtained outcome measures fall under the category of recidivism, including new arrests and reincarcerations. Other important outcomes are measures of substance use disorder (SUD) relapse, generally associated with length of time in treatment. The most critical relapse outcomes that should be measured are deaths from overdoses and emergency room treatments for overdoses.

There should be periodic staff performance evaluations to achieve greater fidelity to the evidence-based program design, service delivery principles, and outcomes. Staff monitoring, measuring, and reinforcing promotes overall cohesiveness and greater support to the program mission.⁸³ Feedback is essential for RSAT participants and staff alike.⁸⁴

PERFORMANCE MEASURES: COUNTY EXAMPLE

The Yavapai County Jail in Arizona has partnered with Wellington Consulting Group to develop a method for calculating and tracking recidivism in the community with a cross-system recidivism database. This unique system can collect multiple data points, such as intake screening results, criminal offenses, court and release dates, and referrals. Post-release, they can track ongoing progress with each participant's request for service and behavioral health engagement. They have also partnered with Northern Arizona University's Center for Health Equity Research as a third-party data validator. With this partnership, they can understand their program in-depth. Data analyzed includes:

- The number of individuals identified with behavioral risk factors.
- The number of "other demographic risk factors" identified through screening.
- The number and type of service connections by behavioral risk level.
- Recidivism rates for the whole population versus those with behavioral risk factors.
- Recidivism rates by service connection + those with behavioral risk factors + post-release treatment engagement⁸⁵.

B. RSAT programs should encourage independent evaluations to determine outcome measures and review all aspects of their operations for fidelity to *Promising Practices Guidelines*.

For monitoring fidelity of service implementation, the program evaluation should include key measures based in implementation science.⁸⁶ The *Promising Practices Guidelines* for RSAT programs is intended to assist correctional administrators and practitioners at the state and county levels to establish and maintain RSAT programs that adhere to evidence-based and promising practices suggested by existing research and related standards developed for SUD and mental health disorder treatment and criminal justice programming.

Research on a program's effectiveness requires an equivalent comparison group of like individuals. Generally, sophisticated evaluative research requires an independent research effort. It is important, however, that the researcher has a full understanding of the program, the population studied, and the criminal justice context, and allows program officials to comment on the findings to ensure that the research has adequately interpreted the data found. For example, given the subjects involved, some RSAT program graduates may be reincarcerated following their release, but for charges that arose prior to their RSAT participation. Researchers must know how to read criminal records to decipher such circumstances.

To ensure that the RSAT program works as well for members of historically disadvantaged groups as for non-disadvantaged groups, for example, the outputs and outcomes of the former should be compared against those of the latter. Differences may reveal a programmatic bias that is not obvious or may require more investigation to diagnose. Independent evaluations should include all individuals initially referred to the RSAT program, including those who may drop out or be terminated before completing the program. Although an RSAT program might boast a perfect record among those who successfully complete the program, it might be because the vast majority of individuals who entered the program never completed it. Furthermore, an analysis of non-

completers might reveal that the completers are only those with the lowest risk/need scores of those admitted into the program, or are disproportionately represented by one racial or ethnic background over another, suggesting that the program lacks the cultural competence to respond to diverse populations. An intention-to-treat analysis will inform the program on which participants it serves best or that it must change its program to serve a specific group of participants.

Many criminal justice interventions appear to be successful in terms of recidivism at 6 months. If the time period is lengthened, however, the success rates may decline dramatically. Generally speaking, follow-up measures should be taken at least a year out.

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

Although in-depth independent evaluations are recommended, RSAT programs should review performance data periodically to measure progress and make incremental adjustments as indicated. There should be a system in place to capture data in a timely manner with as much accuracy as possible. This could be part of a jail or prison database or, for some programs, might be a shared Excel or Access database. Although the Bureau of Justice Assistance aggregates data by state grantee, the specific RSAT programs receiving these RSAT grants can maintain and track the data submitted annually to monitor performance measure changes for better or worse.

If programs are to learn from their results, the results should continually be as current as possible. RSAT programs evolve and change over time as staff, correctional officers, prison and jail policies, and participant populations change.

Conclusion

The RSAT for State Prisoners Program enables state and local governments to provide residential substance use treatment for participants in prison and jails and arrange for continuity of care in the community post-release. The goal of RSAT is to provide at least initial treatment to respond to participants' substance use and mental health disorders and prepare them for their return to the community and continued care to ensure long-term recovery, well-being, and law-abiding citizenship. This document outlines the first promising practices guidelines for RSAT programs based upon available research as well as information on current and past programs that have demonstrated success.

Postscript and Additional Resources

This collection of promising practices guidelines is designed to be a living document. As more research is completed and as more feedback is received from RSAT programs across the nation and U.S. territories, these guidelines will be updated and revised. They are, of course, intended to assist frontline staff, as research confirms, in the final analysis, the quality of the interpersonal relationships between staff and program participants, along with the skills of the staff, are essential for the success of RSAT and related treatment programs.⁸⁷ In short, there will never be a substitute for the work of dedicated and committed counselors, correctional officers, and other program staff who make up prison and jail RSAT programs.

To learn more about the latest research establishing evidence-based substance use disorder (SUD) and correctional treatment programming, a few resources of particular value include:

The CrimeSolutions registry

National Institute of Justice, U.S. Department of Justice
www.crimesolutions.gov

Evidence-Based Practices Resource Center

The Substance Abuse and Mental Health Services Administration
www.samhsa.gov/ebp-web-guide

Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)

National Institute on Drug Abuse
www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment

Adult Drug Court Best Practice Standards

National Association of Drug Court Professionals
<https://www.nadcp.org/standards/adult-drug-court-best-practice-standards/>

Some of the best research that specifically focuses on in-prison SUD treatment—which was relied upon in the development of these guidelines, in addition to the many studies cited in the footnotes and endnotes—includes the following:

- Taxman, F. S., & Belenko, S. (2012). *Implementing evidence-based practices in community corrections and addiction treatment*. Springer.
<https://doi.org/10.1007/978-1-4614-0412-5>
- Taxman, F. S., & Bouffard, J. A. (2000). *Residential Substance Abuse Treatment (RSAT) in jail: Comparison of six sites in Virginia*. University of Maryland, U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.
<https://www.ncjrs.gov/pdffiles1/nij/grants/182858.pdf>

- Taxman, F. S., Silverman, R. S., & Bouffard, J. A. (2000). *Residential Substance Abuse Treatment (RSAT) in prison: Evaluation of the Maryland RSAT program*. University of Maryland, U.S. Department of Justice, Office of Justice Programs, National Institute of Justice. <https://www.ncjrs.gov/pdffiles1/nij/grants/184953.pdf>

To learn of updates to *Promising Practices Guidelines for Residential Substance Abuse Treatment*, including trainings and technical assistance around implementation and continued discussion, please follow the RSAT Training and Technical Assistance Project, www.rsat-tta.com.

APPENDIX A: RSAT Promising Practices Guidelines Roundtable Attendees

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APPENDIX B: Description of Evidence-Based Programs

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) emphasizes the importance of learning processes in the development of maladaptive behaviors. Participants identify and work to correct these behaviors by applying different skills to deal with substance use and other co-occurring health problems. In particular, CBT focuses on the enhancement of a participant's self-control through a variety of coping strategies.

For more information, see www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral.

Contingency Management Interventions/Motivational Incentives

Contingency management principles aim to reinforce positive behaviors (e.g., abstinence for people with substance use disorders [SUDs]) with tangible rewards. Incentive-based treatments have proven to be highly effective in promoting abstinence from drugs. They typically are done using either voucher-based reinforcement, in which patients receive vouchers with monetary value that increase with every drug-negative urine sample, or through prize incentives in which patients are given the chance to win prizes such as gift cards, gas cards, or food for every drug-negative test.

For more information, see www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-0.

Community Reinforcement Approach Plus Vouchers

The community reinforcement approach (CRA) is an “intensive 24-week outpatient therapy for treating people addicted to cocaine and alcohol.” Its two main goals are to (1) maintain short-term abstinence among patients so they can develop new life skills that serve to sustain abstinence in the long term, and (2) reduce alcohol consumption in patients whose cocaine use is associated with their drinking. To do this, CRA uses a range of social reinforcers and material incentives to make a drug-free lifestyle more rewarding than substance use.

For more information, see <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies/community-reinforcement-approach-vouchers>.

Motivational Enhancement Therapy

Motivational Enhancement Therapy (MET) promotes rapid and internally motivated change among patients through a counseling approach that helps individuals resolve their uncertainty about taking part in treatment and stopping their drug use. In general, MET is most effective with adults

who are addicted to or dependent on alcohol and marijuana. It is seen as an effective method for engaging individuals in treatment, rather than as a way to produce changes in their drug use.

For more information, see www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-2.

The Matrix Model

The Matrix Model provides a framework for patients to reach abstinence. With this approach, patients are instructed and supported by a therapist who acts as both a teacher and a coach. Patients learn about critical issues regarding their addictions and are familiarized with self-help programs. The Matrix Model uses a wide variety of treatment materials drawn from other tested treatment approaches (e.g., family and group therapy, 12-step programs).

For more information, see www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-3.

Twelve-Step Facilitation Therapy

This therapy uses the principles of “acceptance,” “surrender,” and “active involvement” to increase the likelihood of an individual with an SUD becoming affiliated with a 12-step self-help group. It involves the individual *accepting* that drug addiction is a disease over which they have no control and for which abstinence is the only alternative, *surrendering* to the fellowship and support of other recovering addicts and to the activities of the 12-step program, and being *actively involved* in 12-step meetings and associated activities.

For more information, see www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-4.

Family Behavior Therapy

Family Behavior Therapy focuses on addressing SUD problems as well as co-occurring physical and mental health issues such as conduct disorders, child mistreatment, depression, family conflict, and unemployment. Therapy includes both the patient and at least one family member or significant other. Skills taught in this therapy are aimed at improving the home environment of patients.

For more information, see www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-5.

Behavioral Therapies for Adolescents/Multisystemic Therapy

One adaptation of behavioral therapy for drug-using adolescents is multisystemic therapy (MST). MST examines the factors associated with antisocial behavior in children and adolescents and

typically provides its treatment in natural environments—such as home or school—addressing factors such as the child’s characteristics, family, peers, school, and neighborhood, in an effort to reduce drug use and incarceration.

For more information, see www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-6.

Creating Lasting Family Connections Fatherhood Program

This program provides services to reduce substance misuse, support recovery, and reduce repeat offenses among fathers and father-like figures who experience dissonance due to incarceration, substance misuse, or military service.

For more information, see the following resources provided by SAMHSA: <https://crimesolutions.ojp.gov/programdetails?id=689>, <https://youth.gov/content/creating-lasting-family-connections-fatherhood-program-family-reintegration-clfcfp>, <http://copes.org/overview-clfc-fatherhood-program-modules/>

Forever Free

This program provides individualized SUD treatment with case planning for incarcerated women, influenced by a 12-step model. The program teaches clients life skills to cope with stress while helping them gain self-respect and a sense of empowerment. It provides in-prison counseling, group services, educational workshops, 12-step programs, relapse prevention training, and community aftercare.

For more information, see www.crimesolutions.gov/ProgramDetails.aspx?ID=40.

Helping Women Recover & Beyond Trauma

These two combined programs serve women with SUDs who have co-occurring trauma histories. They aim to reduce substance use, encourage involvement in voluntary aftercare treatment upon parole, and reduce the likelihood of reincarceration, with a series of trauma-informed treatment sessions in group settings with female counselors.

For more information, see <https://www.cebc4cw.org/program/helping-women-recover-beyond-trauma/>.

Interactive Journaling

This program aims to provide a “structured and experimental writing process that motivates and guides participants toward positive life changes.”

For more information, see <https://pubmed.ncbi.nlm.nih.gov/21362642/>

Living in Balance

A program for adults in correctional facilities who have issues related to SUDs, crime, treatment, and violence. It consists of a series of psychoeducational training sessions, both on an individual basis and in groups. These sessions involve a large amount of roleplay to improve the client's level of functioning in a variety of life areas.

For more information, see <https://www.hazelden.org/web/public/livinginbalance.page>, <https://dualdiagnosis.org/resource/approaches-to-drug-abuse-counseling/living-in-balance/>

Moral Reconciliation Therapy

Moral Reconciliation Therapy (MRT) is a treatment strategy aimed at reducing reincarceration among juvenile and adult offenders by increasing moral reasoning. Through group and individual counseling, MRT addresses ego, social, moral, and positive behavioral growth. It focuses on seven basic treatment issues: "(1) confrontation of beliefs, attitudes, and behaviors; (2) assessment of current relationships; (3) reinforcement of positive behavior and habits; (4) positive identity formation; (5) enhancement of self-concept; (6) decrease in hedonism and development of frustration tolerance; and (7) development of higher stages of moral reasoning."

For more information, see <https://ncjfcj-old.ncjfcj.org/moral-reconciliation-therapy-mrt>.

Mapping-Enhanced Counseling

These evidence-based guides are for adaptive treatment services. They are developed from cognitive-behavioral models designed for SUD treatment counselors. The manuals provide focused, time-limited strategies for engaging clients in important recovery discussions.

For more information, see <https://ibr.tcu.edu/manuals/description-mapping-enhanced-counseling/>.

Correctional Therapeutic Community

This program for clients with SUDs provides for an isolated community of participants to promote recovery and prevent relapse. The program separates participants from the general prison populace to enhance the effectiveness of the rehabilitative communities.

For more information, see [https://www.cdhs.udel.edu/publications/nrepp-correctional-therapeutic-community-\(ctc\)](https://www.cdhs.udel.edu/publications/nrepp-correctional-therapeutic-community-(ctc)).

Appendix C: Pharmacotherapies

Methadone

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

Buprenorphine

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

Buprenorphine treatment can be provided in office-based settings by qualified physicians who have received a waiver from the Drug Enforcement Administration.

Naltrexone

Naltrexone is a synthetic opioid antagonist—it blocks opioids from binding to their receptors and thereby prevents their euphoric and other effects and reduces cravings for opioids. It can be taken orally, either daily or three times a week, or injected for 28 days (Vivitrol). Patients must be opioid free 7 to 10 days before an injection. Naltrexone also blocks receptors that are involved in the rewarding effects of drinking alcohol and the craving for alcohol.

Acamprosate

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

Disulfiram

Disulfiram (Antabuse) interferes with degradation of alcohol, resulting in the accumulation of acetaldehyde, which, in turn, produces a very unpleasant reaction that includes flushing, nausea, and palpitations if a person drinks alcohol. The utility and effectiveness of disulfiram is considered

limited because compliance is generally poor. However, among patients who are highly motivated, disulfiram can be effective, and some patients use it episodically for high-risk situations, such as social occasions where alcohol is present. It can also be administered in a monitored fashion, such as in a clinic or by a spouse, improving its efficacy.

Topiramate

Topiramate is thought to work by increasing inhibitory (GABA) neurotransmission and reducing stimulatory (glutamate) neurotransmission, although its precise mechanism of action is not known. Although topiramate has not yet received FDA approval for treating alcohol addiction, it is sometimes used off-label for this purpose. Topiramate has been shown in studies to significantly improve multiple drinking outcomes, compared with a placebo.

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