

Bureau of Justice Assistance (BJA)  
Residential Substance Abuse Treatment (RSAT) Program for State Prisoners  
Training and Technical Assistance Resource

# Promising Practices Guidelines for Residential Substance Use Disorder Treatment



# Promising Practices Guidelines for Residential Substance Use Disorder Treatment

Updated February 2023



This guide was written by Advocates for Human Potential, Inc., and its RSAT TTA team, advised by a roundtable of experts (listed in Appendix A) with editing assistance provided by David D'Amora, Director of Special Projects, and his team at the Council of State Governments.

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

## Table of Contents

---

Table of Contents.....	1
Introduction .....	2
Available Research on RSAT Programs.....	3
Goal of These Guidelines.....	5
Promising Practices Guidelines for Residential SUD Treatment Programs .....	6
I. Diversity, Equity, and Inclusion .....	6
II. Intake, Screening, and Assessment.....	7
III. Core Program Components.....	11
RECOVERY SUPPORT: STATE EXAMPLE .....	16
IV. Core (Non-Medical) Treatment Modalities .....	17
V. Core Treatment Principles.....	24
VI. Provision of Medications, Health Care, and Harm Reduction Education.....	34
VII. Continuing Care and Reintegration .....	38
VIII. Staffing and Training .....	43
IX. Measuring Results .....	46
Conclusion .....	49
Postscript and Additional Resources.....	50
APPENDIX A: RSAT Promising Practices Guidelines Roundtable Attendees .....	52
APPENDIX B: Description of Evidence-Based Programs and Interventions.....	55
Appendix C: Pharmacotherapies.....	60
Endnotes.....	62

## 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 and tribal governments 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 adults and juveniles 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 certify to BJA that they are providing, and will continue to provide, an adequate level of residential substance use disorder (SUD) treatment aftercare services may use funds awarded under this subchapter for nonresidential SUD treatment aftercare services.

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 and science-based.

Congress has set limited basic requirements for all residential SUD treatment programs in prisons, juvenile detention facilities, or jails that are supported through RSAT grant funds (§ 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).

Residential SUD treatment programs must provide a course of comprehensive individual and group SUD treatment services, lasting a period of at least 6 months, in residential treatment facilities set apart from the general population of a prison or juvenile detention facility. Treatment services may include the use of pharmacological treatment, where appropriate, that may extend beyond such period. Residential SUD treatment programs in jails must meet the same requirements as prison-based programs; however, these programs must last for a period of at least 3 months.

As noted above, states may also make grants to local correctional and detention facilities in the State, for the purpose of assisting jail-based SUD treatment programs that are “effective and science-based.” As such, jail-based SUD treatment programs may initiate or continue evidence-based SUD treatment programs, including medication-assisted treatment, in pretrial populations and/or foster connections to SUD treatment in the community upon pretrial release.

As of May 2021 (FY 2021), 54 RSAT grants were awarded to all but 1 state, the District of Columbia (DC) and 1 U.S. territory. The RSAT funding is being used to provide substance use disorder and ancillary services in jail, state prison, and aftercare programs, for both juveniles and adults, in total serving about 21,000 individuals.

## 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.”<sup>1</sup>

The four residential SUD treatment programs supported through RSAT funds recognized as “promising” are:

- **Minnesota Department of Corrections prison-based chemical dependency treatment**, based on the therapeutic community (TC) model.<sup>2</sup>
- **The Forever Free program at the California Institute for Women**, which follows a cognitive-behavioral curriculum that stresses relapse prevention.<sup>3</sup>

- **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.<sup>4</sup>
- **The Delaware Department of Correction KEY/Crest programs**, which begin with a prison-based TC and continues with post-release treatment in the community.<sup>5</sup>

These four programs vary considerably, reflecting the diversity of residential SUD treatment programs around the country and across U.S. territories. The Minnesota 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 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 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 residential SUD treatment programs supported through RSAT funds vary in terms of gender served, geographical locations, treatment modalities, length, structure, and aftercare. As a result of the limited study of RSAT-funded programs and the diversity of the few evidence-based RSAT-funded 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 residential SUD treatment programs.

## Goal of These Guidelines

*Promising Practice Guidelines for Residential Substance Use Disorder Treatment* is intended to assist correctional administrators and practitioners at the state and county levels to establish and maintain RSAT-funded residential SUD treatment programs in prisons, juvenile detention facilities, and jails that adhere to the program requirements, as well as the promising practices suggested by existing research and related standards developed for substance use disorder treatment and criminal justice programming. Jail-based SUD treatment programs are not subject to the same requirements as residential SUD treatment programs; therefore *Promising Practices Guidelines* are being developed that reflect their standards and reinforce practices that are particular to the services they provide. In 2019, the Bureau of Justice Assistance (BJA) launched a national program to assess residential SUD treatment 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 nine 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 SUD Treatment Programs

## I. Diversity, Equity, and Inclusion

Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities states that “the Federal Government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.”<sup>6</sup>

In recognition of this wide-ranging and significant policy, the principles of diversity, equity, and inclusion (DEI) have been integrated throughout the *Promising Practices Guidelines for Residential SUD Treatment Programs*. Within each guideline, there are program and treatment practices, training topics, and accountability measures that reflect the need to provide inclusive and equitable treatment and services for the diverse populations eligible for and that participate in residential SUD treatment programs. DEI principles should be integrated throughout residential SUD treatment program operations, from assessment to treatment throughout reentry and continuing aftercare services, in practice as they are within these guidelines.

**A. Residential SUD treatment programs should have clearly written nondiscrimination policies included in their mission that are shared with participants.**

**Nondiscrimination policies should include the equitable treatment of all individuals regardless of race, ethnicity, nationality, gender, sexual orientation, age, religion, disability, rurality and other categories of people who have been historically underserved. These policies should be included within the residential SUD treatment program’s Mission Statement and shared with individuals upon entry into the program as part of the Participant’s Manual, Orientation paperwork, or similar documentation.**

**Nondiscrimination policies should be written in simple and clear language so that all RSAT participants are able to understand their meaning.** As with all materials used in RSAT programming, policies should be made available in languages other than English for ESL participants. American Sign Language (ASL) translators should be available for people who are deaf and hard of hearing.



## II. Intake, Screening, and Assessment

A. Residential SUD Treatment 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 a residential SUD treatment program should be the existence of a moderate to severe substance use disorder (SUD), with or without co-occurring mental health disorders and who have medium to high criminogenic risk/needs (i.e., having multiple factors in their life correlated with an increased risk of engaging in criminal activities). These determinations should be based on evidence-based or validated 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.<sup>7</sup> The results of these screenings and assessments should guide decision-making about eligibility criteria for RSAT programs. Approximately 75% of individuals incarcerated in state prisons and jails who have mental health problems also have substance misuse and/or substance use disorders.<sup>8</sup> Screening and assessments for mental health disorders should be administered to identify and provide appropriate treatment and services to eligible participants with co-occurring disorders.

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.<sup>9</sup>
- People with SUDs, despite even long periods of abstinence while incarcerated, still are at risk for relapse and reoffending.<sup>10</sup>
- Addressing criminogenic needs encompasses SUD treatment and other dynamic predictors of criminal behavior, including antisocial cognition, antisocial associates, family and marital relations, employment, and leisure and recreational activities.<sup>11</sup>

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.<sup>12</sup> Individuals showing a medium to high criminogenic risk would thus benefit most from cognitive and skill-building interventions designed to address their criminogenic needs.

**Gender specific screenings and assessment should be used when possible and as needed.**

The majority of risk/need screenings and assessments were developed and tested on men within the criminal justice system. However, there are gender-responsive and gender-specific instruments that have been developed and tested for women within the criminal justice system. These include the Women’s Risk Need Assessment (WRNA), the Northpointe Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) for Women, and Service Planning Instrument for Women (SPIn-W).<sup>13</sup> The Level of Service / Case Management Inventory (LS/CMI) also provides a gender-responsive scale as well.<sup>14</sup>

Culturally responsive screening and assessment tools should be used when possible. There are a number of instruments used to screen and assess SUD and mental health disorders and symptoms that have researched various racial/ethnic populations.<sup>15</sup> However, criminal justice professionals and researchers have found that there are issues with risk instrument validity when it comes to specific racial and ethnic populations. Many of these instruments have been validated for white participants, notwithstanding that correctional populations are disproportionately non-white. These instruments invariably show higher risk for non-white compared to white persons.<sup>16</sup>

**B. All individuals upon entry in jails and prisons should be screened for alcohol and substance use disorders upon entry using a validated assessment tool. Those on prescribed medications should be continued on those medications; those experiencing symptoms of withdrawal should be assessed for withdrawal management overseen by medical staff.**

Individuals who have opioid use disorder (OUD) or alcohol use disorder (AUD) who are experiencing opioid withdrawal should be continued on prescribed medication for OUD or offered a combination of medication and counseling and behavioral therapies, based on an assessment of individual needs. An individual’s decision to decline counseling and behavioral therapies or the absence of available psychosocial treatment should not preclude or delay the induction, or continuation, of medication for OUD.<sup>17</sup>

Those exhibiting symptoms of withdrawal should be assessed to determine the need for withdrawal management to mitigate adverse symptoms, reduce craving and encourage participation in SUD treatment offered by the prison or jail. The BJA and the National Institute of Corrections have developed protocols for correctional withdrawal management that should be followed.<sup>18</sup>

Intake and medical staff should know that while the prevalence of OUD is similar by race and ethnicity, because people of color are over-represented in jails and prisons, they more often have their medication for OUD interrupted by incarceration thus exposing them to higher death rates.<sup>19, 20</sup>

**All individuals upon entry should also be assessed for suicide risk as part of their mental health screening and reassessed at various points throughout their time in custody.**

Suicide is the leading cause of death in U.S. jails. Studies have found that half of those who died by suicide had been in jail for nine days or less.<sup>21</sup> One of the reasons for this is the large number of persons who enter jail under the influence of alcohol or drugs in need of clinical withdrawal management. For persons in withdrawal, the first few days in jail are the deadliest if medically managed withdrawal has not been provided. The risk for suicide also increases for persons who have co-occurring mental health disorders who experience an abrupt cessation or change in psychiatric medications. Intake staff should also be aware that studies have found that women in rural areas are statistically at higher risk than others for suicide.<sup>22</sup>

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

**Once screened for admission into residential SUD treatment, 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 a participant's ability to participate and progress in treatment and reduce their chances of recidivism.** Program staff should have access to any prior assessments from prior sentences or admissions to correctional facilities.

**More comprehensive individualized assessment will allow residential SUD treatment programs to identify participants with specific needs which can be addressed through specialized programming, treatment, and reentry planning.** Specialized programming can include parenting classes, grief and loss therapy and/or support groups, historical trauma counseling, GED and parenting classes, and more.

**Programs should have or 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.<sup>23</sup> The American Society of Addiction Medicine (ASAM) has provided guidance on what constitutes a comprehensive assessment. It includes 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.<sup>24</sup>

D. Participation in Residential SUD treatment should not depend on an individual's readiness for change.

**Residential SUD treatment staff should assess potential participants' readiness to change and adapt programming to match their stage of readiness and level of motivation.** Multiple validated and reliable readiness-to-change screening and assessment tools are available in the public domain.<sup>25</sup> Several risk/need/responsivity and substance use disorder screenings and assessments contain readiness to change scales within the instrument. After admission, the residential SUD treatment program should provide motivational strategies that help participants address their SUDs, other need areas, and commit to treatment.

Many studies have attempted to use a "stage-based" approach to multiple areas of need but have yielded limited efficacy. A comprehensive literature review of studies attempting to implement change on multiple adverse behaviors showed that only 1 out of 39 studies were able to achieve significant results on each of three or more adverse behaviors.<sup>26</sup> Residential SUD treatment programs should assume that most participants will be in different stages of readiness regarding their multiple needs. For instance, some participants may seem more motivated than others to work on issues of substance use, whereas other participants may be more motivated to work on anger management skills, reducing mental health symptoms or furthering their education. Regardless of a participant's readiness to change, participation in treatment can be effective.<sup>27</sup>

Research suggests that SUD treatment does not need to be voluntary to be effective.<sup>28</sup> Individuals should not be referred to residential SUD treatment based on rewards or consequences for institutional behavior or plea/sentencing agreements that are antithetical to eligibility for residential SUD treatment programming.

### III. Core Program Components

A. Program Length and Location: Residential SUD treatment programs must provide SUD and ancillary services in residential treatment facilities and juvenile detention facilities lasting a period of at least six months, and lasting a period of three months within jails. Residential SUD treatment programs must be set apart from the general population of the facility.

Prior to the latest amendments to the RSAT statute, only state residential SUD treatment programs in adult prisons and juvenile correctional facilities had to be at least 6 months. Residential SUD treatment programs in jails were required to be at least 90 days, given the much shorter sentences of persons sentenced to jail. However, the amended RSAT statute now allows states to make grants to local correctional and detention facilities in the State (provided such facilities exist therein), for the purpose of establishing “jail-based substance abuse treatment programs” that are “effective and science-based.” These jail-based substance abuse treatment programs are not required to be a set length, nor are participants required to be housed separately from the general population.

**Residential SUD treatment 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 residential SUD treatment participants from the general population.** The point is to keep persons in the program away from the potential negative influence of peers who are not engaged in treatment, may not be periodically drug tested, and may not reinforce the treatment goals of the RSAT program. While not all residential SUD treatment programs function as modified therapeutic communities (MTCs), 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. Residential SUD treatment programming should be offered in phases based on participants having reached specified behavioral and recovery milestones. Residential SUD treatment programming should be considered the first phase of ongoing treatment that continues upon release.

**Residential SUD treatment programming and services should be considered the initial phase of ongoing treatment that begins in prisons or jails and continues into the community upon release.** Institutional administrators, paroling authorities, and judges should

be advised to allow participants to remain in residential SUD treatment programs at least for program minimum lengths. Potential residential SUD treatment participants should be advised in advance that residential SUD treatment program completion may impact their eligibility to be considered for early release. (See “Related Research,” below.)

### **RELATED RESEARCH**

Two studies of a jail residential SUD treatment program found that those who did not complete their residential SUD treatment 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.<sup>29</sup>

**Residential SUD treatment 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/reentry phase prior to program completion. There are various models that residential SUD treatment programs may follow when identifying treatment targets for each phase. In all models, transition from one phase of the program to the next should be based on the achievement of individualized treatment and behavioral goals, not on time elapsed.

**There are differences in the lengths of time it takes for participants to successfully complete a residential SUD treatment program due to the individualized process of progress towards recovery and wellness.** The assessment and screening process should result in an individualized treatment plan for each residential SUD treatment participant. Since people may go back and forth among stages of change during treatment and the recovery process, participants may need more intensive services at some point in the program. Phases should be flexible and based upon the individual participant’s areas of need. Although all participants must meet the minimum length of time within the residential SUD treatment program, some may stay longer to achieve treatment goals.

### **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.

**Residential SUD treatment participants should be involved in positive, prosocial programming beyond treatment and clinical groups so that negative influences can be minimized,** even though many residential SUD treatment participants are housed apart 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) positively reinforce pro-social behaviors, interactions, and activities promoted by residential SUD treatment program standards and treatment staff.<sup>30</sup> Cross-training officers and residential SUD treatment staff will encourage consistent positive reinforcement for treatment.

Some programs offer meditation, mindfulness, yoga, and exercise classes. Community-based volunteers offer faith-specific gatherings, AA/NA and other self-help meetings, and culturally specific support and advocacy groups. Programs have collaborated with community-based agencies to become part of fundraising activities, holiday awareness and celebration events. Other residential SUD treatment programs provide participants with electronic tablets that can be monitored to measure time spent on specific activities and treatment exercises.

The need to keep residential SUD treatment participants positively engaged is one of the reasons why many programs employ MTCs to address participants' substance use and co-occurring disorders. In an MTC, 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 all examples of prosocial activities that take place outside of regular treatment or clinical group time.

### D. Residential SUD treatment programs should involve pro-social peers that will support participant efforts to reduce and discontinue substance use, promote wellness, and continue treatment upon release.

**Residential SUD treatment programs should help participants connect to community resources, mobilize family and prosocial peers, and develop a prosocial peer network by providing opportunities for:**

- 12-Step meetings, peer-led self-help meetings, and faith-based meetings
- Peer reentry support specialists
- Mental health peer support specialists
- Peer-to-Peer learning

Increasing residential SUD treatment participants' connections to a prosocial peer support network that will strengthen 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 MTC approach. Connections to safe and supportive peers, people in recovery from both substance use and mental health communities, and additional prosocial networks of support are important components of

successful residential SUD treatment programs. Often individuals reentering the community who have long histories of substance use have very few contacts who are not connected with substance 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.

Research finds a significant correlation between strong family bonds and decreased recidivism.<sup>31, 32</sup> Family counseling can improve family cohesion and support,<sup>33</sup> improve the family's understanding of both individual and family dysfunction, increase awareness of the contribution of family dynamics in each loved ones' behavior, improve abilities to cope with stressors, and enhance communication and trust within the family.<sup>34</sup> Residential SUD treatment participants that do have supportive family members and loved ones should have opportunities to stay connected as part of their treatment program. Where available, programs should facilitate no cost video communication with family members. Residential RSAT programs should also provide information for families to understand the reentry needs of their loved ones once released including continued use of any medications prescribed while incarcerated.

Peer reentry specialists can be correctional staff, contractual staff, or community-based providers in jails/prisons who leverage and apply their experiences to support and engage participants through the reentry process. They assist in seeking continued treatment for substance use and mental health disorders, community support resources, housing and employment. Peer reentry specialists can also facilitate groups for participants within residential SUD treatment programs in relapse prevention, recovery support, and harm reduction.<sup>35, 36</sup>

**Residential SUD treatment programs should consider race, ethnicity, nationality, gender, sexual orientation, age, religion, disability, justice involvement, and other relevant categories when providing participants with peer support services.** Residential SUD treatment programs should consider language and cultural considerations in providing peer support, offer gender-responsive peer support, and leverage the healing value of traditional cultural support and the power of peers from similar communities and backgrounds.

#### **EXAMPLES OF CULTURALLY RESPONSIVE PEER SUPPORT SERVICES IN RSAT**

- Wellbriety meetings
- Elder-led ceremonial sweat lodges
- Peer support specialists who have lived experience of mental health issues and substance use disorder(s)
- Providing the opportunity to participants for Recovery Coaches with same sexual orientation and/or gender identity
- Having peer support services provided by formerly incarcerated peer support specialists



It's important for peer support specialists, recovery coaches and other peer support workers to be trained in how historical and generational trauma, poverty, violence, discrimination, and stigmatization affects a person's efforts to maintain abstinence and recovery as well as cope with mental health issues upon release from custody.<sup>37</sup>

Peer support specialists have the potential to expand access to care, prevent hospitalizations, and lower health care costs.<sup>38</sup> Due to shared experiences, people who are having difficulties managing co-occurring mental health symptoms 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.

**Incarcerated peers have a role in treatment settings distinct from that of staff.** In many residential SUD treatment programs, participants who have progressed further in the program have the opportunity to take on a role of mentor. Residential SUD treatment mentors' responsibilities differ from program to program, but usually include helping to orient and support newcomers to the program, helping other participants through difficulties, and being an active role model for all within the program. Some residential SUD treatment mentors may stay within the program after successful completion or remain available for mentoring even after being moved to a lower level of security within the facility.

In those states and facilities where available, residential RSAT mentors may begin the process of becoming a certified peer support specialist or recovery coach while still incarcerated and complete the process within the community upon release. Certified peer support specialists and recovery coaches with histories of justice-involvement are a robust source of support for participants within residential SUD treatment programs, and people in custody in general. These individuals may be recruited from within the facility or outside the facility. Although some facilities bar volunteers with criminal records, many rightfully make exceptions for certified peer support specialists.

Peer mentors and peer support specialists who are justice-involved or have a history of justice-involvement can:

- Promote hope through positive self-disclosure, assuring others that recovery and healing is possible.
- Model prosocial 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 residential SUD treatment 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.<sup>39</sup>

### 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.

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

**Participants should be carefully monitored for alcohol and substance use during treatment in the correctional facility.** Those trying to recover from SUDs 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 residential SUD treatment 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. Core (Non-Medical) Treatment Modalities**

**The Residential Substance Abuse Treatment for State Prisoners Program (42 U.S.C §10421) states that 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.**<sup>40</sup> 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 evidence-based SUD treatment modalities initially implemented in the community are also used in-correctional settings. However, there is a 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.<sup>41, 42, 43</sup>

In the last two decades, research has consistently found that involvement in SUD treatment reduces recidivism for people in the criminal justice system who have SUDs.<sup>44</sup> Research has also shown that SUD treatment can be effective even when an individual enters it under legal mandate.<sup>45</sup>

In general, AUD 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 interventions for AUD 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.

There are multiple evidence-based treatment modalities for the successful treatment of SUD for people within the community and for people in the criminal justice system. Most residential SUD treatment programs include cognitive-behavioral based therapies (CBTs) to help individuals modify their attitudes and behaviors related to substance use and increase healthy life skills. CBTs can also be utilized in conjunction with other forms of evidence-based practices, such as motivational interviewing (MI) and medication-assisted treatment (MAT). CBT and other modalities utilized are discussed in this section. Most residential SUD treatment programs use a combination of all of these treatment modalities to increase participants' likelihood of long-lasting changes in substance use and prosocial behavior. The National Institute on Drug Abuse (NIDA), the National Institute of Corrections (NIC), the Substance Abuse Mental Health Services Administration (SAMHSA) and Crime Solutions have noted treatment modalities as evidence-based for people involved within the justice system.<sup>46</sup> See appendix B for descriptions of these approaches, along with a list of other evidence-based programs.

A. 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 that provide specific cognitive skills training should be implemented to help participants recognize patterns of thinking that lead to alcohol/substance use and other risky behaviors.** Interventions should target factors associated with criminal behavior in addition to SUDs because, for most incarcerated people, the two are intrinsically linked. For instance, “distorted cognitions” and “risky thinking” are processes very often found in people who commit criminal offenses as well as in people with SUDs. This can include a combination of thought patterns, feelings, 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.<sup>47</sup>

Residential SUD treatment programs should provide participants 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 CBIs for people involved in the justice system is based on the idea that an individual’s risky thinking and criminal-thinking patterns are learned, not inherited behavior. Therefore, CBIs typically use a set of structured techniques that attempt to build new pro-social and healthy cognitive skills. CBIs can also help “reframe” 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, and Anger Management for Substance Abuse and Mental health Clients: A Cognitive-Behavioral Approach.

**CBT should be available and provided by a clinical professional to help individuals identify and change unhealthy beliefs, thought, and patterns of behavior that contribute to criminal and other problematic behaviors.** CBT emphasizes individual accountability and attempts to help residential SUD treatment participants understand their thinking processes and

the choices they make.<sup>48</sup> Other examples of CBT-based therapy modalities include rational emotive behavior therapy (REBT), moral reconnection therapy (MRT), and dialectical behavioral therapy (DBT).

**All residential SUD treatment staff should understand the basic cognitive-behavioral approach, key terms, and CBIs.** Residential SUD treatment staff, officers, and clinical staff should teach participants to become aware of their thinking, verbalize their thoughts, help them stop reacting to automatic thoughts, and understand how their thoughts and beliefs can trigger criminal and addictive behaviors. Staff can provide skills training and opportunities for modeling and behavior rehearsal outside groups during community meetings and everyday interactions.

**CBT sessions should be monitored on a regular basis and feedback provided to facilitators to ensure fidelity to principles and technique.** Observation of groups and during individual interactions is the best way to confirm proper cognitive-behavioral techniques are employed, and that principles and skills are being applied throughout the residential SUD treatment program. This allows both staff and participants to be held accountable.<sup>49</sup> Clinical supervisors, mental health clinicians, or other licensed mental health professionals proficient in CBT are appropriate staff to observe and provide feedback to others on their use of CBIs and use of CBT.

#### RELATED RESEARCH

A review of 50 individual program and eight meta-analysis results that incorporate CBT as a central part of the intervention within the National Institute of Justice Crime Solutions database showed evidence that was clear and consistent. CBT programs that have been rigorously evaluated are effective at deterring crime, assisting victims, and preventing recidivism.<sup>50</sup>

**B. Motivational Interviewing (MI) skills should be used to help strengthen participants' motivation to engage and participate in treatment, and make prosocial changes concerning substance and alcohol use, mental health issues, and other need areas.**

**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.<sup>51</sup>

**MI should be used in groups, assessment and screening interviews, case management sessions, individual meetings, and daily interactions between all staff and participants to support them in their efforts to change.** Although there are specific MI skills and techniques, MI is not a counseling method. It is a style of communicating with people that uses specific methods to foster motivation to change.<sup>52</sup> The four interconnected foundational elements of MI

underscore the necessary beliefs and behaviors that facilitate treatment and reentry success for participants.<sup>53</sup> These elements form the acronym PACE and are described as:

- Partnership – collaboration and working together with participant(s) towards shared goals; shared decision-making.
- Acceptance – empathy, looking for participant(s) strengths, and having a nonjudgmental respect and honoring of their autonomy; right to choose.
- Compassion – an intentional commitment to the client(s)' well-being as the prime directive
- Evocation, Empowerment, Encouragement – Acknowledging that the participant has their own wisdom and strength to change that the MI practitioner can help to identify and draw out.<sup>54</sup>

**All residential SUD treatment staff should be trained in MI skills on an ongoing basis, and receive feedback on MI skills from qualified trainers, clinical supervisors trained in MI, and/or in peer coaching circles.** MI is referred to as a practice since it requires booster trainings after initial training, and feedback from observed or recorded sessions on how to improve skills. MI trainers or clinicians who utilize and practice MI themselves may also provide feedback to residential SUD treatment staff. Peer coaching or circles of practice are other options where staff trained in MI spend time at least once a month to meet, present MI case studies, and role-play MI scenarios using various MI techniques they would like to improve. An excellent Communities of Practice Manual created by Justice System Assessment & Training can be found on the Minnesota Department of Corrections website, along with other related resources.<sup>55</sup>

#### 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.<sup>56</sup>

C. Therapeutic communities (TCs) should be modified to operate within a correctional setting that includes treatment and services for those with co-occurring disorders without sacrificing essential components.

**Modified TCs (MTCs) provide a comprehensive, structured, non-confrontational, individualized residential treatment program model for participants with co-occurring SUDs and mental health issues that help foster changes in attitudes, perceptions, and behaviors that are harmful and risky.** Most of the key elements, structure, and processes of the standard TC are maintained in the MTC model but have been revised to accommodate the

individual needs of people with COD who are incarcerated. Compared to the standard TC approach, the MTC maximizes social learning opportunities in the following ways:

- Incorporates increased flexibility.
- Reduces the duration of various activities (i.e., groups, community meetings).
- Less confrontation during interactions to decrease the likelihood of triggering trauma responses and mental health crises.
- Increased emphasis on orientation and instruction.
- Fewer sanctions and more explicit affirmations for achievements.
- Greater sensitivity to individual differences and greater responsiveness to the special developmental needs of the participant.<sup>57</sup>

Incarceration-based MTCs 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.<sup>58, 59</sup> MTCs for individuals with co-occurring mental health issues and substance use disorders have also been found to be “promising” in the CrimeSolutions registry.<sup>60</sup>

**The defining features of MTCs are their emphasis on the power of the community and participants / peers as agents of change and having a community or unit separate from the rest of the general population.** The MTC model proposes that recovery from substance use and co-occurring disorders involves rehabilitation to learn healthy behaviors and “habilitation” to integrate those healthy behaviors into a routine.<sup>61</sup> MTCs 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.<sup>62</sup> 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 housed separately from the rest of the correctional population to help participants adjust to the idea of a community working together toward a common goal.<sup>63</sup> All treatment, education, other psychosocial and medical services, as well as meals and recreation should occur within the separate unit to reinforce the idea of community among participants. Treatment includes aftercare and reentry services as means of providing continued support and relapse prevention after leaving the TC.<sup>64</sup>

**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.** Since MTCs are based on the standard TC model, the following factors also apply for MTCs.

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 potential negative attitude 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 behavioral expectations with known 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.<sup>65</sup>

#### **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.

**D. Contingency Management (CM) is an effective evidence-based intervention that can increase achievement of specific behavioral goals and should be considered for use within residential RSAT programs.**

CM has been researched for treating substance use and other problematic behaviors for over 45 years. It involves providing tangible and concrete reinforcers or incentives to people for evidence of objective behavior change. The reinforcers most often consist of vouchers or tokens that can be exchanged for gift cards, candy bars, and usually a large prize such as a radio or CD player.<sup>66</sup> CM has been extensively researched with people who have substance use disorders and with co-occurring mental health issues to remain abstinent, to stay in treatment, and to comply with medication. A meta-analysis from 2018 searched 50 random control studies involving over



6,900 clients with cocaine and/or amphetamine use disorder to compare various psychosocial interventions. CM plus community reinforcement approach had the highest number of statistically significant results when it came to abstinence and treatment retention both short and long-term as compared to cognitive-behavioral therapy, 12-step programs, and non-contingent rewards (rewards for non-specific behaviors).<sup>67</sup>

Since CM has been researched and used in community settings, including drug courts and probation, tangible reinforcers such as gift cards and bus tokens are feasible. However, they are not within jail and prison settings. It is important to note that residential SUD treatment funds cannot be used for tangible rewards that the majority of CM programs utilize. However, CM has been successfully implemented in residential SUD treatment programs using non-monetary incentives.

#### **TREATMENT AND SERVICES INTERVENTIONS: STATE EXAMPLE**

The Florence McClure Women’s Correctional Center in Las Vegas, NV has two RSAT funded programs called STARS (Sisters Together Achieving Recovery and Sobriety) and New Light. Both utilize a modified contingency management program that was first piloted in 2017 to increase community members’ motivation in programming. Rather than one target behavior, the programs target prompt attendance at counselor-led groups, utilization of pro-social skills, completion of additional duties beyond regular assignment within the community, addressing a problem using specific problem-solving steps, and encouragement of another community member using pro-social and motivational language. Members will receive tokens immediately after a target behavior has been observed along with verbal reinforcement. Once a member has received 14 tokens within one week, they earn the privilege to draw from the “fishbowl” in a drawing held at the same time on the same day every week; for those who receive 20 tokens, they earn the privilege to draw two time during the drawing. Reinforcers that can be drawn include small items such as highlighters, toothpaste or shower caps, medium items such as a pack of crayons or body lotion, or large reinforcers such make-up, shampoo, or a sewing kit.

Many CM programs will describe the program to participants prior to implementation and ask input from them on what they would find rewarding. In residential RSAT programs where material reinforcers are not allowed, ideas such as “being first in line for coffee in the morning,” “having an extra 30 minutes for sleep,” “additional 30 minutes of rec time,” and “being first in line for telephones for the week” have been used as rewards. Continued treatment within the community or aftercare is a setting where CM can be utilized to increase attendance, retention, and negative drug test results. Depending on other sources of funding, there may be monies available to provide material reinforcers should the facility allow.

CM does not adversely impact motivation to change, even though people initially change behaviors due to an external reward. As time goes on, people become more invested in the behavioral change(s) and the tangible reinforcers become less important as internal motivation becomes the driving force of change.<sup>68</sup>

## V. Core Treatment Principles

A. Residential SUD treatment programs should be trauma responsive. Trauma-specific services should be provided for those who have experienced trauma either within the residential SUD treatment program or, if unavailable, referrals made to services outside of the program.

While many residential SUD treatment programs are trauma-informed, becoming trauma-responsive means looking at all aspects of the program's, and the larger organization's activities, environment, language, and values and involving all staff to better serve participants who have experienced trauma. Trauma-informed includes education about trauma, adverse childhood events and its effects into adulthood, generational and historical trauma, and related topics. Trauma-responsive services include what correctional staff need to do when working with individuals within the justice system including making changes in policies, practices and the environment. Trauma-specific services include the utilization of evidence-based programs, treatment modalities, and interventions for those who have experienced trauma.<sup>69</sup>

**Residential SUD treatment programs should integrate trauma responsive practices to increase the accessibility of substance use and mental health treatment for individuals who have experienced trauma.** At least one third of males and two thirds of females in residential SUD treatment programs may be experiencing lasting effects of trauma exposure that play a role in their continued use of drugs and alcohol.<sup>70</sup> 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 may be difficult for staff to manage.<sup>71</sup> 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.<sup>72</sup>

Trauma-informed residential SUD treatment 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 residential SUD treatment participants due to the inherent power differential, resident councils can be formed to give participants some input into how the residential SUD treatment programs operate (in such a way that does not compromise the security and safety of the institution).

**Cognitive-behavioral trauma-specific interventions that include emotional regulation and resiliency training should be available for residential SUD treatment program participants to help them learn skills that will increase their engagement in effective recovery programming starting within jail/prison and continuing upon reentry into the community.** There are curricula that address trauma and resiliency skills using cognitive-behavioral approaches for diverse populations that both clinicians and non-clinical staff can facilitate. They include:

- [Healing Trauma+: A Brief Intervention for Women and Gender-Diverse People \(3<sup>rd</sup> Edition\)](#)
- [Exploring Trauma+: Brief Intervention for Men and Gender-Diverse people \(2<sup>nd</sup> Edition\)](#)
- [Beyond Trauma: A Healing Journey for Women \(2<sup>nd</sup> Edition\)](#)
- [Helping Women Recover: A Program for Treating Addiction \(Criminal Justice\)](#)
- [Helping Men Recover: A Program for Treating Addiction, 2<sup>nd</sup> Edition \(Criminal Justice\)](#)
- [Seeking Safety: A Treatment Manual for PTSD and Substance Abuse](#)
- [Trauma Recovery and Empowerment for Women \(TREM\)](#)
- [Men's Trauma Recover and Empowerment Model \(M-TREM\)](#)
- [Traumatic Stress & Resilience - Men](#)
- [Trauma in Life - Women](#)

### **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 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.

**Residential SUD treatment programs should recognize and offer specialized treatment for participants with intergenerational and/or historical trauma.** Historical trauma is the cumulative, multigenerational, collective experience of emotional and psychological injury experienced by a specific cultural, racial, or ethnic group, or a community. It is related to major events that oppressed a particular group of people such as slavery, the Holocaust, forced migration, and the violent colonization of Native Americans.<sup>73, 74</sup> Intergenerational trauma occurs when trauma is not resolved and passed from one generation to the next. It is important to remember that not everyone within a group or community or family has been impacted by historical or intergenerational trauma.

Historical and intergenerational trauma can span across generations. Descendants who have not directly experienced a traumatic event can still exhibit the sign and symptoms of trauma, such as depression, fixation on trauma, low self-esteem, anger, substance misuse, and mental health issues. Other communities who have been marginalized, faced discrimination and violence, and stigmatized have also experienced historical trauma. LGBTQIA+ have had a long history of violence perpetrated against them, as have women, people with mental health disorders, and those with certain physical and intellectual disabilities.

Such historical and intergenerational traumatic stressors can be exacerbated by individual trauma, and both can be triggered for residential SUD treatment participants since incarceration itself can be a traumatizing experience.<sup>75</sup> SAMHSA outlines core competencies for treatment staff to become more effective when working with individuals from diverse backgrounds and histories. All staff should examine their stereotypes, prejudices, and emotional reactions toward others, including individuals from their own races or cultural backgrounds and individuals from other groups. They should examine how these attitudes and biases may be detrimental to participants in treatment for substance use and co-occurring mental health issues. Residential SUD treatment staff should understand how participants' individual differences affect their substance use, mental health and health beliefs, help-seeking behavior, and perceptions of treatment.<sup>76</sup> Skills of culturally responsive staff include:

- Trust and power: Staff need to understand the impact of their role and status within the program and the client-staff relationship from diverse perspectives.

- Knowledge of other cultural and diverse groups: Residential RSAT staff should have an understanding of how participants' diverse cultural and other groups' values can affect the treatment process. Staff should learn how various cultures and other groups interact with health beliefs, substance use and other behavioral issues.
- Frame issues in culturally relevant ways: Staff should frame treatment issues with culturally appropriate references. For example, in groups that value the community or family as much as the individual, it is helpful to bring community members and family into the treatment and reentry process.
- Allow for complexity of issues based on cultural context: Staff must take care with suggesting simple solutions to complex problems. It is often better to acknowledge the intricacies of the participant's cultural or group context and circumstances.
- Explore culturally based experiences of power and powerlessness: What constitutes power and powerlessness varies from culture to culture according to a participant's gender, age, occupations, ancestry, religious or spiritual affiliation, history of trauma, and other factors.
- Expand roles and practices: Staff need to become more flexible with roles and practices when working with diverse cultures and groups. What may be effective for one culture may not be the most effective with another group.<sup>77</sup>

**B. Residential SUD treatment programs should offer integrated treatment for participants with co-occurring SUD and mental health disorders.**

**Groups and counseling that address both mental health and co-occurring SUDs should be provided within residential SUD treatment programs for those who would benefit, or referrals made to such outside the program.**

**According to the National Institutes of Health and SAMHSA, SUD and mental health disorders are both brain disorders that respond better to integrated approaches that combine elements of both mental health and SUDs into a comprehensive treatment program.** Integrated treatment for co-occurring disorders begins by assessing and screening for both mental health issues and substance use. Staff in these programs develop integrated treatment plans to address both substance use and mental health needs and/or collaborate with mental health staff to do so. Participants receive one consistent, integrated message about treatment, and all staff working with residential SUD treatment participants understand the complexity of interactions between the disorders and communicate more effectively.<sup>78</sup>

## 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.<sup>79</sup>

**There should be standard procedures for collaboration between residential SUD treatment program staff and 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.<sup>80</sup> 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.

Communication between mental health and residential SUD treatment program staff is critical in order to provide the best care and treatment for participants, most of whom may be diagnosed with a mental health disorder and/or have histories of trauma. Residential SUD treatment programs emphasize self-change which can be emotionally difficult for some participants. For these participants, it is important that all staff, including security, treatment, medical, and support staff, should be alert to participant behaviors that may indicate an individual is having extra difficulty coping with the stress of residential SUD treatment participation. Mental health staff should also inform residential SUD treatment staff if they believe a participant may be having difficulties so that temporary revisions can be made as necessary to lower stress. Collaboration and communication are key to keeping all residential SUD treatment participants safe and able to actively and effectively participate in treatment within the program.

**All residential SUD treatment staff should receive training on the signs and symptoms of co-occurring 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 residential SUD treatment staff should know how to identify those who may require further screening and assessment by a qualified mental health professional.

Since incarcerated people are at elevated risk of suicide, especially those with co-occurring mental health disorders, all staff should participate in suicide prevention training. Two basic, simple to utilize trainings include the QPR (Question. Persuade. Refer.) Institute<sup>81</sup> that offers a specialized course for correctional professionals and Mental Health First Aid for Public Safety from the National Council for Mental Wellbeing.<sup>82</sup>

The challenge for residential SUD treatment staff is to understand how SUDs and mental health disorders interact, so they can provide participants with tools to manage recovery from both and ensure that reentry 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.<sup>83</sup>

## 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.

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.<sup>84, 85</sup>

C. Treatment plans must be assessed and modified periodically to meet changing needs of participants and must incorporate a plan for reentry into the community. They should be developed in collaboration with participants.

**Treatment plans should be based upon screening and assessment results and incorporate collaboratively developed goals with residential SUD treatment participants.** Treatment plans should be based upon results of assessments and screenings administered upon entry into an intake and assessment facility, and/or upon entry into the current facility. Just as important, participants should be actively involved in the development of their treatment plan. When participants are more actively engaged, they are more likely to feel a sense of ownership over their programming and more invested in their recovery.<sup>86</sup>

**Treatment plans should include specific, measurable goals that will allow for determination of a participant’s progress throughout the residential SUD treatment program.** Attainable, realistic, and time-based goals and objectives are essential to the development of treatment planning to assess participants’ accomplishments and program



effectiveness. Residential SUD treatment staff, security staff, and participant should work together to assess progress and change in treatment plan goals and objectives on a regular basis throughout the program. Other goals agreed upon in a collaborative manner between the participant and staff should also be evaluated in the same manner.

**Reentry planning should be incorporated into treatment planning to ensure continuing treatment and services within the community.** Treatment planning must also include reentry needs to ensure continuing SUD, mental health disorder treatment, and referrals to other necessary services within the community to support a prosocial lifestyle. Ongoing coordination between courts, parole and probation officers, and community providers is another important factor in addressing the complex and changing needs of residential SUD treatment participants.

**D. Evidence-based manualized treatment interventions (those that are implemented according to instruction manuals and/or specialized training) are effective, offer structure, and consistency, and should be utilized within residential SUD treatment programs.**

Manualized treatment interventions 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.<sup>87</sup> It is important to note, that 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.<sup>88</sup>

Residential SUD treatment programs should utilize curricula that is responsive to race, ethnicity, nationality, gender, sexual orientation, age, religion, disability, and other areas relevant to inclusion and access to treatment. There are curricula currently in use within residential SUD treatment programs that are age and gender specific that have been developed for people who are incarcerated and have SUD and co-occurring mental health disorders. See Appendix B for the names and links to these resources. There are fewer manualized treatment interventions that are responsive to race, ethnicity, national origin, gender identity, sexual orientation, religion or spirituality, and disability. The Habilitation Empowerment Accountability Therapy (HEAT) curriculum has been utilized within drug courts and incorporates Black participants' cultural heritage and life experiences with racism and discrimination as core elements of the intervention. HEAT is a culturally proficient, strength-based, and trauma-informed group counseling intervention specifically designed for Black men between 18 and 29 years old who engaged in problematic substance use and are involved in the criminal justice system. Findings from two pilot studies provide support for HEAT in improving success rates in drug courts for young Black men.<sup>89</sup>

### **CULTURALLY RESPONSIVE MANUALIZED TREATMENT: 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.<sup>90</sup> 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. 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 treatment for SUD and mental health issues.** 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 a residential SUD treatment program, especially if it is a MTC, rewards for prosocial behaviors and interactions, program and treatment progress, and achieving other accomplishments are built into the program. Participants will get called out for “being caught” doing something exceptional such as helping another residential SUD treatment participant 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) participants and staff recognize the accomplishment during a community meeting. Many times, a sincere recognition of an individual’s efforts and/or behavioral improvement by an officer or by 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 residential SUD treatment program so there is no misunderstanding of program expectations. Consequences should be clinically driven.** Generally, less intense responses are used for early and less serious non-compliances, with increasingly sanction-based responses issued for continued inappropriate behaviors. 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.

It is important to remember that since it is likely that the majority of residential SUD treatment participants have co-occurring mental health issues as well as histories of trauma, consequences should always be addressed with a treatment or clinical response whenever possible. Suspending or discharging people from the program should be considered the last resort.

## RELATED RESEARCH

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.<sup>91</sup> 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.<sup>92</sup>

### F. Other needs should be addressed, along with SUD and co-occurring mental health issues, during residential SUD treatment to prepare participants for successful reentry.

Examples of compatible treatment and services include the following, also identified by drug court researchers:<sup>93</sup>

- Clinical case management.
- Housing assistance (sober/drug-free).
- Criminal thinking interventions.
- Family and social support and interpersonal counseling.
- Recovery community support.
- 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/>

## VI. Provision of Medications, Health Care, and Harm Reduction Education

A. Medications for substance and alcohol use disorder and mental health disorders should be provided in conformity with contemporary standards of care and in accordance with the American Disability Act.

**Persons entering prison or jail with valid prescriptions for medication to treat opioid or alcohol use disorders or mental health disorders should be continued until and unless subsequent medical and/or psychiatric assessments find the medications are no longer medically indicated.** This is not only consistent with contemporary standards of care, but also specifically mandated for jails and prisons under the American with Disabilities Act (ADA). The U.S. Department of Justice Civil Right Division published a guidance document in April 2022 providing information on how the ADA protects people from discrimination when entering correctional facilities with prescribed medication to treat their OUD.<sup>94</sup> Discontinuation of OUD medication forcing withdrawal discourages engagement in community treatment, increases the risk for substance use during incarceration, and increases the risk of death upon release.<sup>95, 96</sup> Similarly, 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.<sup>97</sup>

**Individuals diagnosed with OUD, AUD, and mental health disorders should be prescribed FDA approved medically appropriate medications that conform to contemporary standards of care for those conditions.** A robust body of evidence has demonstrated the benefits of providing medications for OUD in correctional settings. Medications to treat OUD such as buprenorphine, naltrexone, and methadone significantly reduce post-release overdose deaths. People leaving custody without such medications are at high risk for dying from overdoses immediately following their discharge than people in the general population. State studies of released prisoners have found during the first two weeks after release from prison, untreated persons with opioid use disorders are from 40 to 142 times more likely than people in the general population to die of an opioid overdose.<sup>98, 99</sup>

Both the U.S. Justice Department Civil Rights Division and federal District Courts have come to recognize that medication-assisted treatment is an essential element of contemporary standards of care for persons with OUD and AUD. Similarly, medication for various mental disorders constitute standard of care for these disorders. For this reason, both the Justice Department's Civil Rights Division, U.S. Attorneys, and federal courts have found that failure to provide medications can violate individual's 8<sup>th</sup> and 14<sup>th</sup> Amendment Rights guaranteed by the US Constitution.<sup>100</sup>

**The provision of medications for OUD, AUD, and mental health disorders requires continuation beyond the length of the residential SUD treatment program.** Programs must arrange for medication to be provided as needed upon a participant's completion or discharge and are returned to general population, another correctional unit or released to the community with or without correctional supervision.

Effective reentry requires that residential SUD treatment participants or graduates have appointments and arrangements for continuing treatment and services scheduled prior to a participant's release date whenever possible. Medication-assisted therapy (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.<sup>101</sup> While there is no consensus for how long buprenorphine or naltrexone should be taken, the research indicates longer is generally better.

- **If a residential SUD treatment participant has continued on or been inducted on medications for OUD, AUD, 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 residential SUD treatment 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, reentry workers 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.

**Residential SUD treatment 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 any of the medications to treat OUD, or choose not to use it, or request detoxification so that they can receive naltrexone to treat wither AUD or OUD, the program should adhere to science-based withdrawal management protocols to minimize risk for death and mitigate discomfort.** To gain the trust and confidence of participants, programs must ensure that participants do not suffer unnecessary, gratuitous, and potentially lethal detoxification. The Bureau of Justice Assistance and the National Institute of Corrections has promulgated withdrawal management protocols specifically for correctional institutions which are forthcoming. These should be adopted. Until then, there are alternative sources that provide protocols that should be followed.<sup>102, 103, 104</sup>

## 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%).<sup>105</sup>

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.<sup>106</sup>

**B. Hospitalization: If residential SUD treatment participants require hospitalization, 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 residential SUD treatment 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.

**C. Residential SUD treatment programs should provide and encourage harm reduction education including the provision of health literacy education.**

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with substance use. It incorporates a spectrum of practices that includes safer use, managed use, abstinence, as well as meeting people who use substances “where they’re at,” including mitigation strategies for people who continue to abuse drugs. Harm Reduction is an important part of the federal government’s comprehensive approach to addressing substance use disorders through prevention, treatment, and recovery allowing individuals who use substances set their own goals.<sup>107</sup>

**Residential SUD treatment participants should be provided information about reducing negative consequences associated with substance use.** Participants should be provided information about harm reduction organizations within the community of release and what they offer. In some areas, harm reduction information and services can be accessed through peer recovery centers, AIDS service organizations and similar community-based programs. Collaborating with agencies that provide harm reduction education to facilitate classes to participants is one way to offer specialized information and expand community-based connections.

**Residential SUD treatment participants and their families / loved ones should be provided education on overdose prevention and be provided naloxone upon release to prevent overdose deaths.** There are different options to implement an overdose education and naloxone distribution program for residential SUD treatment programs. There are community-based organizations that already distribute naloxone and are often eager to become partners and will work with local and regional correctional facilities to offer overdose training. Some states distribute naloxone directly through state departments or local or regional governments. Reaching out to the government entity that is responsible for naloxone distribution may also be an option to form a partnership to provide naloxone access.

Efforts should be made to ensure that as many residential SUD treatment participants as possible are provided with naloxone upon release. Individuals with a history of OUD should be prioritized in cases where there is not a large enough supply of naloxone for all individuals leaving the facility. Naloxone can be placed in each individual's personal property so that they will have it upon release from the facility. In reviewing its provision of naloxone to persons leaving state prisons, researchers noted several cases where formerly incarcerated participants were able to use their prison supplied naloxone to save an associate overdosing on opioids.<sup>108</sup>

Naloxone distribution is most effective when paired with training on how to use naloxone and general overdose education. This should ideally be taught on a regular basis and made available to both sentenced and pre-trial individuals, as appropriate. Again, remember that partnering with a community organization for overdose education may be the most effective route in many cases.<sup>109</sup>

**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 people, and those under community supervision than in the general population.<sup>110, 111, 112</sup> 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 residential SUD treatment 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.

**All residential SUD treatment participants should be taught how to obtain, process, and understand basic health information needed to make appropriate health decisions and access health care services.** The U.S. Department of Health and Human Services defines personal health literacy as “the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.”<sup>113</sup> People with SUDs and co-occurring mental health issues tend to have low levels of health literacy and do not have adequate understanding of disease symptoms and management.<sup>114, 115</sup> This lack of knowledge is associated with not understanding the health risks associated with substance

use, increased likelihood of risky behavior related to substance use, and not knowing when to seek medical help appropriately.<sup>116, 117</sup>

Equipping residential SUD treatment participants with the information to make good decisions about their health will help them be successful as they reenter the community. Many residential RSAT participants have complex medical concerns or will face a higher risk of health issues in the future related to their alcohol and substance use. Ideally, residential SUD treatment participants will also be continuing treatment and services for substance use and mental health disorders upon release. Navigating behavioral health and healthcare systems is often complex and confusing. Teaching participants the skills to help them understand what healthcare they need, how to find healthcare providers, and understand the information given to them by healthcare professionals will assist them to become more successful within their communities.

### **HEALTH LITERACY SERVICES: COUNTY EXAMPLE**

The Adams County Adult Correctional Complex in Pennsylvania provides information on HIV/AIDS, Hepatitis B and C, TB, sexually transmitted diseases, and Covid-19 through their medical department. A Resource Guide provided to all individuals within the facility with written guidance on how to navigate community systems of behavioral health, pregnancy related needs, food, clothing, housing, VA services, and how to apply for medical assistance with the help of staff while incarcerated. In addition, a Life Skills program is offered which covers topics such as the importance of taking care of one's physical and mental health and hygiene.

## **VII. Continuing Care and Reintegration**

**A. Continuity of care is essential for people with SUDs and mental health disorders who are reentering the community. Residential SUD treatment programs should assist participants with post-release services, which can include case management services and a full continuum of support services, including medical treatment and other health services.**

**Residential SUD treatment programs should assist participants with accessing continuing care within the community through various means including the following:**

- Continuing medication(s) for OUD, AUD, and mental health disorders immediately upon release.
- Providing specialized case management services and support services.
- Attending behavioral health and treatment programs.
- Peer recovery support and self-help groups.
- Coordinating linkages to medical providers and medical case management prior to release.
- Housing assistance.



- Educational and job training programs.
- Obtaining personal identification documents.
- Parole/probation supervision programs.

**Effective reentry planning and aftercare requires collaboration with various departments within a correctional facility and providers within the community of release, including probation/parole and treatment courts.** 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.<sup>118</sup> Research shows how providing continuing care can improve outcomes.<sup>119</sup> 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.

- **Residential SUD treatment staff should collaborate and meet regularly with medical, mental health, MAT, and reentry staff to coordinate reentry planning.** Best practices indicate that initiation with community-based SUD and mental health disorder treatment should occur within one week after release from correctional custody. Prior to release, it is important to accomplish as much as possible regarding recommended services. This includes ongoing communication with treatment staff, medical and MAT providers and reentry staff within the correctional facility to ensure that barriers to access for continued treatment and services within the community have been addressed.

Important tasks for residential SUD treatment and reentry staff include making continuing care appointments prior to release, having multidisciplinary meetings at regular intervals during and after residential SUD treatment, reassessing criminogenic needs at regular intervals, and collaborating with community corrections, treatment courts, and community-based services to ensure continuity of care, including the transfer of treatment records.

- **Residential SUD treatment staff should collaborate with parole and probation departments, and treatment courts to coordinate reentry and continuing care planning.** If participants will be under correctional supervision upon release, residential SUD treatment 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.

- **Residential SUD treatment staff should collaborate and meet regularly with state, regional, and community-based agencies to increase continuing care opportunities and coordinate reentry planning and referral.** Efforts by various correctional departments have demonstrated that improving the process of reentry planning and referral can result in most participants entering aftercare.<sup>120</sup> 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.<sup>121</sup>
- **Residential SUD treatment staff should support participants by expanding continuing care that is responsive to race, culture, ethnicity, national origin, sex, gender identity, sexual orientation, disability, age, and other needs.**

#### **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.

**Residential SUD treatment programs should make every effort to incentivize graduates’ participation in aftercare upon release, or refer to providers that do, to improve participant outcomes. It is especially important to motivate those graduates who will not be under correctional supervision upon release to continue treatment on their own.** All graduates can benefit from developing a reentry plan that outlines the supports they will need to assist them in maintaining a healthier pro-social lifestyle within the community. Whenever possible, allowing representatives from community-based providers, treatment facilities, the Department of Veterans Affairs, state health insurance providers, and other support services 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 issues that must be treated and managed. 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, reduce use, manage symptoms, and access appropriate support. 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 and assisting with access to wraparound support services.

**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.**

**Residential SUD treatment 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 SUDs, many participants are likely to have other significant physical and behavioral health care needs that require regular access to care after release.<sup>122, 123</sup> 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, people 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).<sup>124</sup> 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.<sup>125</sup> In addition, continuous access to health care immediately after release may reduce the risk of rearrest and reincarceration.<sup>126</sup>

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.<sup>127</sup>

## HEALTH COVERAGE UPON RELEASE: COUNTY EXAMPLE

The Hampshire County Sheriff's Office RSAT funded Lifeskills Program in Massachusetts ensures that all participants have their public or private health insurance reinstated prior to release. Otherwise, staff assist participants in enrolling in public health insurance prior to release to ensure continued medical and behavioral health care coverage within the community. Reentry staff schedule first outpatient MOUD and mental health / psychiatric appointments after release for participants. Bridge doses are provided upon release for medications including MOUD, with the exception of methadone, and a last dose letter is provided. Transportation is provided by staff and peer support specialists to sober homes, probation, parole, medical and behavioral health appointments, and home as needed upon release.<sup>128</sup>

**In Medicaid expansion states, eligible residential SUD treatment participants should be enrolled in their state's Medicaid program (as should all eligible incarcerated populations). Correctional staff should identify participants 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 2021, the Kaiser Family Foundation published [State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care](#), which reviews steps that states have taken to leverage Medicaid to improve continuity of care for justice-involved individuals. These include Medicaid enrollment prior to release, Section 1115 waivers, connecting high-need individuals to wraparound services prior to release and provide “in-reach” activities to connect individuals with Medicaid prior to release. Section 1115 waivers target eligibility expansions, benefit expansions (particularly in the area of behavioral health) and provisions related to social determinants of health.

The Centers for Medicare & Medicaid Services (CMS), a part of the Department of Health and Human Services (HHS) published a fact sheet in March 2022 that provides information and guidance for application counselors when help people who are incarcerated or recently

incarcerated to understand their health coverage options. “[Incarcerated and Recently Released Consumers](#)” reviews Medicaid, Medicare, and Marketplace Coverage and provides additional resources to assist both correctional staff and residential SUD treatment participants during reentry.

Another comprehensive website, [Reentry Resources](#), is funded by the U.S. Department of HHS Office of Minority Health. It contains a wealth of information regarding health insurance, continuing behavioral health treatment upon release, information about Covid-19, employment, financial, and housing resources, as well as information on supporting children of parent(s) who are incarcerated.

## VIII. Staffing and Training

A. In group activities, the ratio of residential SUD treatment participants to staff should be no more than 20 to 1.<sup>129</sup>

**The ratio of treatment staff to participants and correctional officers to participants should be sufficient to provide an environment conducive to achieving residential SUD treatment program goals and objectives regardless of treatment modalities employed.** The residential SUD treatment program 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), signs and symptoms of withdrawal, mental health disorders, suicide prevention, trauma, and specific training about the residential SUD treatment program including Promising Practices Guidelines for RSUDT, the program’s philosophy, mission, and objectives.

**Both treatment staff and correctional officers should receive training in and understand residential SUD treatment standards, philosophy, benchmarks, and objectives.**

**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 symptoms of SUDs and mental health disorders, signs and symptoms of withdrawal, suicide prevention education, and trauma-responsive 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. All staff should be aware of the Promising Practices Guidelines (PPGs) for residential SUD treatment programs to ensure that their program is aligned with evidence-based and promising practices for best outcomes. All residential SUD treatment staff and correctional officers should be trained appropriately and work as a team to ensure accountability.

**Correctional officers must understand residential SUD treatment programming and be as committed to treatment as residential SUD treatment staff and administrators.** To be effective, SUD treatment programming should take up 40–70 percent of an individual’s time.<sup>130</sup> This requires a collaborative effort between correctional officers and treatment staff so that residential SUD treatment 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 classes, oversee peer led groups, or make themselves available for residents’ questions and interaction.

C. Both treatment and security staff should receive, at minimum, annual training in the principles of diversity, equity, and inclusion and related topics.

**Residential SUD treatment staff should learn and understand how race, ethnicity, nationality, gender, sexual orientation, age, religion, disability influences each client’s worldview, beliefs and traditions surrounding initiation of substance use, healing, and treatment.**<sup>131</sup> **Staff should also have an understanding of their own core beliefs and values and how they affect interactions with clients from other and similar backgrounds and experiences.**<sup>132</sup> 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.”<sup>133</sup> 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.<sup>134</sup>

All staff should participate in trainings on the impact of implicit biases and microaggressions that can negatively impact interactions with participants by reducing trust and increasing symptoms in people with mental health issues and those who have experienced trauma.<sup>135</sup> Staff should also learn how to change stigmatizing language since it has significant impacts on participants, their view of themselves, and their treatment outcomes.<sup>136</sup> Using person-first and neutral alternative language reduces negative thoughts about participants and shows respect for them not as a condition or as one aspect of their life, but as whole person.<sup>137</sup>

## Updating Our Language—Non-Stigmatizing Alternatives<sup>138</sup>

STIGMATIZING LANGUAGE	CONSIDER AN ALTERNATIVE
Substance abuse or misuse	Substance use, substance use disorder
Dope sick	A person in withdrawal
Addict, abuser, alcoholic, junkie, etc.	A person who uses alcohol, drugs, substances, or a person with substance use disorder
When referring to urinalysis results, clean or dirty	Negative or positive urinalysis results
Get clean	A person who is currently abstinent from drugs or alcohol, or in some cases, a person in recovery
Relapse, lapse, slip	Recurrence of substance use, resumed substance use

D. Residential SUD treatment staff should be trained in promising practices and evidence-based interventions that are implemented in the program, such as Dialectical Behavior Therapy (DBT), Rational Emotive Behavior Therapy (REBT), anger management, screenings, assessments, curricula, and other specific programming offered.

**Residential SUD treatment staff should be trained on screenings/assessments (depending on the classification system within the facility), curricula, and other specific programming used within the Unit.**

E. Correctional officers working within a residential SUD treatment program should be trained in the basics of MI and CBT and the implementation of CBIs. Whenever possible, correctional officers should attend multi-disciplinary meetings and case management meetings with residential SUD treatment staff, support staff, and community providers.

**Correctional officers working in residential SUD treatment programs should be trained in basic motivational interviewing skills.** Correctional settings inherently involve the use of power and authority. These are dynamics that tend to increase participant defensiveness which can lead to conflicts with corrections staff. Depending on staff response, potential for conflict can either increase or decrease. Successful MI utilization involves replacing authoritarian approaches with MI skills and techniques, which although initially challenging to many correctional officers, will usually reduce confrontations with participants.<sup>139</sup>

**Correctional officers working in residential SUD treatment program should be trained in CBT-based techniques and CBIs.** This practice will reinforce treatment staff efforts to address participants' underlying unhealthy and unproductive thoughts and thinking patterns. Security staff can use "thinking reports," emphasize participant choice, assist with problem-solving, and even use role-play to help model healthier pro-social behaviors.<sup>140</sup>

**For improved participant outcomes within a residential SUD treatment program, correctional officers should collaborate with treatment and support staff regarding participants’ progress, interactions, and other programmatic issues. Residential SUD treatment correctional officers should attend and participate in relevant program activities, including daily or weekly meetings as well as community meetings with residential SUD treatment participants. Security staff 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.**

## **IX. Measuring Results**

To measure the effectiveness of residential SUD treatment programs at the individual and program levels, residential SUD treatment program administrators should establish strong data collection standards and time frames for analyzing data. The performance measures required by the BJA are helpful in providing measures of RSAT outcomes, but programs often include additional measures in their data collection processes. 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 proposed.

A. Performance measures during a residential SUD treatment 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, residential SUD treatment 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.<sup>141</sup> Feedback is essential for residential SUD treatment participants and staff alike.<sup>142</sup>



**It is also recommended that residential SUD treatment programs review other metrics on a periodic basis.** When possible, reviewing data on who was found eligible for residential SUD treatment program participation and who actually entered the program can help management explore issues related to screening, eligibility determination, and other factors. Analyzing the demographics, risk factors, and co-occurring issues of residential SUD treatment participants who successfully completed programming vs. those who didn't may show patterns that can revise programming and service implementation.

#### **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 engagement.<sup>143</sup>

**B. Residential SUD treatment programs should encourage independent evaluations to determine outcome measures and review all aspects of their operations for fidelity to *Promising Practices Guidelines*. Programs should participate in fidelity assessments supported by BJA.**

**For monitoring fidelity of service implementation, the program evaluation should include key measures based in implementation science.**<sup>144</sup> The *Promising Practices Guidelines for Residential SUD Treatment* programs is intended to assist correctional administrators and practitioners at the state and county levels to establish and maintain residential SUD treatment 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. Residential SUD treatment fidelity assessments supported by the BJA are based upon the *Promising Practices Guidelines (PPGs) for Residential SUD Treatment* and are intended to determine program alignment with the PPGs and provide recommendations for improvement across all areas of need.

**Research on a program’s effectiveness requires an equivalent comparison group of like individuals.** Generally, sophisticated evaluative research requires 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 residential SUD treatment program graduates may be reincarcerated following their release, but for charges that arose prior to their residential SUD treatment participation. Researchers must know how to read criminal records to decipher such circumstances.

To ensure that the residential SUD treatment 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 residential SUD treatment program, including those who may drop out or be terminated before completing the program. Although a residential SUD treatment 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 residential SUD treatment programs to make course adjustments to improve participant outcomes.**

**Although in-depth independent evaluations are recommended, residential SUD treatment 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 BJA aggregates data by state grantee, the specific 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. Residential SUD treatment 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 residential SUD treatment 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.<sup>145</sup> 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

[Evidence-based Practices \(EPB\)](#)

[National Institute of Corrections](#)

[Evidence-Based Practices Resource Center](#)

The Substance Abuse and Mental Health Services Administration

[Principles of Drug Addiction Treatment: A Research-Based Guide \(Third Edition\)](#)

National Institute on Drug Abuse

[Adult Drug Court Best Practice Standards](#)

National Association of Drug Court Professionals

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](http://www.rsat-tta.com).

## APPENDIX A: RSAT Promising Practices Guidelines Roundtable Attendees

May 19, 2016

Roger Allen  
Massachusetts RSAT  
Director of Inmate Services  
Barnstable County Correctional Facility  
[rallen@bsheriff.net](mailto:rallen@bsheriff.net)

Stephanie Arnold  
Virginia RSAT  
Criminal Justice Program Coordinator  
Virginia Department of Criminal Justice  
Services  
[stephanie.arnold@dcjs.virginia.gov](mailto:stephanie.arnold@dcjs.virginia.gov)

Daryl Atkinson  
Second Chance Fellow  
Reentry Council  
U.S. Department of Justice  
[Daryl.Atkinson@ojp.usdoj.gov](mailto:Daryl.Atkinson@ojp.usdoj.gov)

Edward Banks  
Senior Policy Advisor  
Office of Justice Programs  
U.S. Department of Justice  
[Edward.Banks@usdoj.gov](mailto:Edward.Banks@usdoj.gov)

LaShawn Benton  
State Policy Advisor  
Bureau of Justice Assistance  
U.S. Department of Justice  
[LaShawn.Benton@usdoj.gov](mailto:LaShawn.Benton@usdoj.gov)

Jon Berg  
Public Health Advisor  
Center for Substance Abuse Treatment  
Substance Abuse and Mental Health  
Services Administration  
[Jon.Berg@samhsa.hhs.gov](mailto:Jon.Berg@samhsa.hhs.gov)

Danica Binkley  
Senior Policy Advisor  
Office of Justice Programs  
U.S. Department of Justice  
[Danica.Binkley@ojp.usdoj.gov](mailto:Danica.Binkley@ojp.usdoj.gov)

Jac Charlier  
RSAT Faculty (Probation)  
Director of Consulting and Training  
Treatment Alternatives for Safe Communities  
[JCharlier@tasc-il.org](mailto:JCharlier@tasc-il.org)

Gregory Crawford  
Correctional Program Specialist  
Community Services Division  
Federal Bureau of Prisons  
[gscrawford@bop.gov](mailto:gscrawford@bop.gov)

Fredia Dunn  
Louisiana RSAT  
Policy Planning Administrator  
Louisiana Commission on Law Enforcement  
[Fredia.dunn@lcle.la.gov](mailto:Fredia.dunn@lcle.la.gov)

Carson Fox  
Chief Executive Officer  
National Association of Drug Court  
Professionals  
[cfox@nadcp.org](mailto:cfox@nadcp.org)

Rob Gaskill  
Indiana RSAT  
Director of Residential Services  
Bartholomew County Court Services  
[rgaskill@bartholomew.in.gov](mailto:rgaskill@bartholomew.in.gov)

Jon Grand  
RSAT T/TA Coordinator  
Advocates for Human Potential, Inc.  
[jgrand@ahpnet.com](mailto:jgrand@ahpnet.com)

Elizabeth Griffith  
Associate Deputy Director for  
Strategic Initiatives  
Bureau of Justice Assistance  
U.S. Department of Justice  
[Elizabeth.Griffith@ojp.usdoj.gov](mailto:Elizabeth.Griffith@ojp.usdoj.gov)

Beth Haynes  
Manager, Quality and Science  
American Society of Addiction Medicine  
[bhaynes@asam.org](mailto:bhaynes@asam.org)

Rebecca R. Hogamier  
Director, Division of Behavioral Health  
Services  
Washington County Health Department  
[rebecca.hogamier@maryland.gov](mailto:rebecca.hogamier@maryland.gov)

Elaine Humphrey  
New York RSAT  
Chief of Corrections  
Research and Grants Management  
Department of Corrections and Community  
Supervision  
[Elaine.Humphrey@doccs.ny.gov](mailto:Elaine.Humphrey@doccs.ny.gov)

Timothy Jeffries  
Policy Advisor  
Bureau of Justice Assistance  
U.S. Department of Justice  
[Timothy.Jeffries@usdoj.gov](mailto:Timothy.Jeffries@usdoj.gov)

Kimberly Johnson  
Director  
Center for Substance Abuse Treatment  
Substance Abuse and Mental Health Services  
Administration  
[Kimberly.Johnson@samhsa.hhs.gov](mailto:Kimberly.Johnson@samhsa.hhs.gov)

Andrew Klein  
RSAT T/TA Director  
Advocates for Human Potential, Inc.  
[aklein@ahpnet.com](mailto:aklein@ahpnet.com)

Tara Kunkel  
BJA Visiting Fellow  
Prescription Drug Abuse  
Office of Justice Programs  
U.S. Department of Justice  
[Tara.Kunkel@ojp.usdoj.gov](mailto:Tara.Kunkel@ojp.usdoj.gov)

Mary Lou Leary  
Deputy Director  
Office of National Drug Control Policy  
[Mary.L.Leary@ondcp.eop.gov](mailto:Mary.L.Leary@ondcp.eop.gov)

Lisa Talbot Lundrigan  
RSAT Faculty (ACA)  
Vice President  
AdCare Criminal Justice Services  
[ltalbotlundrigan@gmail.com](mailto:ltalbotlundrigan@gmail.com)

Denise O'Donnell  
Director  
Bureau of Justice Assistance  
U.S. Department of Justice  
[Denise.O'Donnell@usdoj.gov](mailto:Denise.O'Donnell@usdoj.gov)

Ruby Qazilbash  
Associate Deputy Director  
Bureau of Justice Assistance  
U.S. Department of Justice  
[Ruby.Qazilbash@usdoj.gov](mailto:Ruby.Qazilbash@usdoj.gov)

Neal Shifman  
President and Chief Executive Officer  
Advocates for Human Potential, Inc.  
[nshifman@ahpnet.com](mailto:nshifman@ahpnet.com)

Kristin Stainbrook  
Deputy Director of Research  
Advocates for Human Potential, Inc.  
[kstainbrook@ahpnet.com](mailto:kstainbrook@ahpnet.com)

Colleen Stoner  
California RSAT  
Field Representative  
Corrections Planning and Programs Division  
Board of State and Community Corrections  
[Colleen.Stoner@bscc.ca.gov](mailto:Colleen.Stoner@bscc.ca.gov)

Faye S. Taxman, Ph.D.  
Director  
Center for Advancing Correctional Excellence  
George Mason University  
[ftaxman@gmu.edu](mailto:ftaxman@gmu.edu)

Linda Truitt  
Senior Social Science Analyst  
National Institute of Justice  
U.S. Department of Justice  
[Linda.Truitt@ojp.usdoj.gov](mailto:Linda.Truitt@ojp.usdoj.gov)

Steve Valle  
RSAT Faculty (ACA)  
President  
AdCare Criminal Justice Services  
[svalle@comcast.net](mailto:svalle@comcast.net)

Tisha Wiley  
Health Scientist Administrator  
National Institute on Drug Abuse  
[tisha.wiley@nih.gov](mailto:tisha.wiley@nih.gov)



## **APPENDIX B: Description of Evidence-Based Programs and Interventions**

### **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](http://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](http://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](http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-2).

### **Motivational Interviewing (MI)**

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

**For more information,** see [Crime Solutions – Rated Practices](#), [SAMHSA's Empowering Change: Motivational Interviewing](#), and [NIC – Evidence-based practice](#).

### **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](http://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](http://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](http://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](http://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](http://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. Although older, 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)).

### **Modified Therapeutic Community**

This program is an adaptation of the therapeutic community models used with individuals who have co-occurring substance use problems and mental health issues within the Colorado Department of Corrections' San Carlos Correctional Facility. It offers a more flexible, more personalized, and less intense approach to achieve greater reductions in substance use and recidivism.

For more information, see <https://crimesolutions.ojp.gov/ratedprograms/90#em>

## 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 the following formulations:

- Buprenorphine and naloxone in sublingual film or tablet usually taken daily.
- Buprenorphine only in sublingual tablets usually taken daily.
- Extended release buprenorphine only, which is injected subcutaneously approximately once a month.

Naloxone has no effect when buprenorphine is taken as prescribed. However, if an individual attempts to inject the medication, the naloxone will produce immediate 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.

## Endnotes

---

- <sup>1</sup> CrimeSolutions, n.d., *About CrimeSolutions*, Washington, DC: National Institute of Justice, U.S. Department of Justice Office of Justice Programs, retrieved January 24, 2023 from <http://www.crimesolutions.gov/about.aspx>.
- <sup>2</sup> CrimeSolutions, 2011, *Program Profile: Minnesota Prison-Based Chemical Dependency Treatment*, Washington, DC: National Institute of Justice, U.S. Department of Justice Office of Justice Programs, retrieved January 24, 2023 from <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=150>.
- <sup>3</sup> CrimeSolutions, 2011, *Program Profile: Forever Free*, Washington, DC: National Institute of Justice, U.S. Department of Justice Office of Justice Programs, retrieved January 24, 2023 from <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=40>.
- <sup>4</sup> CrimeSolutions, 2011, *Program Profile: Delaware KEY/Crest Substance Abuse Programs*, Washington, DC: National Institute of Justice, U.S. Department of Justice Office of Justice Programs, retrieved January 24, 2023 from <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=55>.
- <sup>5</sup> Ibid.
- <sup>6</sup> The White House, 2021, *Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, Washington, DC: Executive Office of the President, retrieved January 24, 2023 from <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>.
- <sup>7</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2019, *Enhancing Motivation for Change in Substance Use Disorder Treatment*, Treatment Improvement Protocol (TIP) Series No. 35, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, PEP19-02-01-003, retrieved January 25, 2023 from <https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003>.
- <sup>8</sup> James, Doris J., & Lauren E. Glaze, September 2006, *Mental Health Problems of Prison and Jail Inmates*, Special Report, Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, NCJ 213600, retrieved January 25, 2023 from <https://bjs.ojp.gov/library/publications/mental-health-problems-prison-and-jail-inmates>.
- <sup>9</sup> National Institute on Drug Abuse, 2020, *Common Comorbidities with Substance Use Disorders Research Report*, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, retrieved January 24, 2023 from <https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders>.
- <sup>10</sup> Fletcher, Bennett W., & Redonna K. Chandler, 2014, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, NIH Publication No. 11-5316, p. 15, retrieved January 24, 2023 from [https://www.drugabuse.gov/sites/default/files/txcriminaljustice\\_0.pdf](https://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf).
- <sup>11</sup> Andrews, D. A., & J. Bonta, 2010, *The Psychology of Criminal Conduct*, Anderson Publishing.
- <sup>12</sup> Binswanger, Ingrid, Marc Stern, Richard Deyo, Patrick Heagerty, Allen Cheadle, Joann Elmore, & Thomas Koepsell, 2010, "Release from Prison — A High Risk of Death for Former Inmates," *New England Journal of Medicine* 356(2): 157–165, retrieved January 24, 2023 from <https://doi.org/10.1056/NEJMsa064115>.
- <sup>13</sup> Council of State Governments Justice Center, August 2021, "Gender-Responsive Criminogenic Risk and Needs Assessment," in *Adopting a Gender-Responsive Approach for Women in the Justice System: A Resource Guide*, retrieved January 24, 2023 from [https://csjjusticecenter.org/wp-content/uploads/2021/08/Adopting-GR-Approach\\_Gender-Responsive-Criminogenic-Risk-and-Needs-Assessment.pdf](https://csjjusticecenter.org/wp-content/uploads/2021/08/Adopting-GR-Approach_Gender-Responsive-Criminogenic-Risk-and-Needs-Assessment.pdf).
- <sup>14</sup> Serin, Ralph C., & Christopher T. Lowenkamp, December 2015, *Selecting and Using Risk and Need Assessments*, Drug Court Practitioner Fact Sheet, X(1), Alexandria, VA: National Drug Court Institute, retrieved January 25, 2023 from [https://ndcrc.org/wp-content/uploads/2022/01/Selecting\\_and\\_Using\\_Risk\\_and\\_Need\\_Assessments.pdf](https://ndcrc.org/wp-content/uploads/2022/01/Selecting_and_Using_Risk_and_Need_Assessments.pdf).
- <sup>15</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2014, *Improving Cultural Competence*, Treatment Improvement Protocol (TIP) Series No. 59, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, HHS Publication No. (SMA) 14-4849, retrieved January 25, 2023 from <https://www.samhsa.gov/resource/ebp/tip-59-improving-cultural-competence>.
- <sup>16</sup> Shepherd, Stephanie M., & Roberto Lewis-Fernandez, 2016, "Forensic Risk Assessment and Cultural Diversity: Contemporary Challenges and Future Directions," *Psychology, Public Policy, and Law* 22(4): 427–438.
- <sup>17</sup> Unknown, 2020, "The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update," *Journal of Addiction Medicine* 14(2S): 1–91, retrieved January 25, 2023 from <https://doi.org/10.1097/adm.0000000000000633>.
- <sup>18</sup> Guidelines for Managing Substance Withdrawal in Jails forthcoming
- <sup>19</sup> National Commission on Correctional Health Care, 2021, *Opioid Use Disorder Treatment in Correctional Settings*, retrieved January 24, 2023 from <https://www.ncchc.org/opioid-use-disorder-treatment-in-correctional-settings-2021/>.



- 
- <sup>20</sup> Pro, George, Ethan Sahker, & Julie Baldwin, 2020, "Incarceration as a Reason for US Alcohol and Drug Treatment Non-Completion: A Multilevel Analysis of Racial/Ethnic and Sex Disparities," *The Journal of Behavioral Health Services & Research* 47: 464–475, retrieved January 25, 2023 from <https://doi.org/10.1007/s11414-020-09703-7>.
- <sup>21</sup> Carson, E. Ann, December 2021, *Mortality in Local Jails, 2000 – 2019 – Statistical Tables*, Washington, DC: U.S. Department of Justice Office of Justice Programs, Bureau of Justice Statistics, NCJ 301368, retrieved January 25, 2023 from <https://bjs.ojp.gov/library/publications/mortality-local-jails-2000-2019-statistical-tables>.
- <sup>22</sup> Leah Wang, 2021, *Rise in Jail Deaths Is Especially Troubling as Jail Populations Become More Rural and More Female*, Northampton, MA: Prison Policy Initiative, retrieved January 24, 2023 from [https://www.prisonpolicy.org/blog/2021/06/23/jail\\_mortality/](https://www.prisonpolicy.org/blog/2021/06/23/jail_mortality/).
- <sup>23</sup> Fletcher, Bennett W., & Redonna K. Chandler, 2014, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, NIH Publication No. 11-5316, p. 15, retrieved January 24, 2023 from [https://www.drugabuse.gov/sites/default/files/txcriminaljustice\\_0.pdf](https://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf). [Program conducts screening and assessment with valid instrument.]
- <sup>24</sup> American Society of Addiction Medicine, n.d., *About the ASAM Criteria*, retrieved January 24, 2023 from <https://www.asam.org/asam-criteria/about>.
- <sup>25</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2019, *Enhancing Motivation for Change in Substance Use Disorder Treatment*, Treatment Improvement Protocol (TIP) Series No. 35, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, PEP19-02-01-003, retrieved January 24, 2023 from <https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003>.
- <sup>26</sup> Raihan, Nahrain, & Mark Cogburn, 2022, *Stages of Change Theory*, Treasure Island, FL: StatPearls Publishing, retrieved January 24, 2023 from <https://www.ncbi.nlm.nih.gov/books/NBK556005/>.
- <sup>27</sup> National Institute on Drug Abuse (NIDA), 2014, "Principles of Effective Treatment," in *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, NIDA, retrieved January 25, 2023 from <https://nida.nih.gov/sites/default/files/podat-3rdEd-508.pdf>.
- <sup>28</sup> See, e.g., Coviello, Donna M., James W. Cornish, Kevin G. Lynch et al., 2012, "A Multisite Pilot Study of Extended-Release Injectable Naltrexone Treatment for Previously Opioid-Dependent Parolees and Probationers," *Substance Abuse* 33(1): 48–59, retrieved January 25, 2023 from <https://doi.org/10.1080/08897077.2011.609438>.
- <sup>29</sup> Klein, Andrew, & Douglas Wilson, 2002, *An Outcome Evaluation of a Residential Substance Abuse Program: Barnstable House of Corrections*, Waltham, MA: BOTEC Analysis Corporation, retrieved January 24, 2023 from <https://www.ncjrs.gov/pdffiles1/nij/grants/196142.pdf>; Wilson, Dennis, & Andrew Klein, 2003, *A Study on the Habilitation of Chronic Offenders in a Massachusetts House of Correction*, Waltham, MA: BOTEC Analysis Corporation, retrieved January 24, 2023 from <https://www.rsat-tta.com/Files/Habilitation-of-Chronic-Offenders-in-a-Massachusetts-House-of-Correction>.
- <sup>30</sup> Ben Ekelund, 2017, *The Role of the Corrections Officer in RSAT Programs* [Webinar], retrieved January 25, 2023 from <https://www.rsat-tta.com/Training-Curricula/Archived-Webinars>; Thomson, M., & Churchill, R. C. (2011). *Partners in Crime Reduction: Building Stronger Relationships Among Correctional Officers and Treatment Staff to Ensure Program Effectiveness* [Webinar], retrieved January 25, 2023 from <https://www.rsat-tta.com/Training-Curricula/Archived-Webinars>.
- <sup>31</sup> Datchi, Corinne C., & Thomas L. Sexton, 2013, "Can Family Therapy Have an Effect on Adult Criminal Conduct? Initial Evaluation of Functional Family Therapy," *Couple and Family Psychology: Research and Practice* 2(4): 278–293, retrieved January 24, 2023 from <https://doi.org/10.1037/a0034166>.
- <sup>32</sup> Vera Institute of Justice, 2011, *Why Ask About Family?*, retrieved January 24, 2023 from <https://www.vera.org/downloads/publications/Why-ask-about-family-Final.pdf>.
- <sup>33</sup> Datchi, Corinne C., Louis M. Barretti, & Christopher M. Thompson, 2016, "Family Services in Adult Detention Centers: Systemic Principles for Prisoner Reentry," *Couple and Family Psychology: Research and Practice* 5(2): 89–104, retrieved January 24, 2023 from <https://doi.org/10.1037/cfp0000057>.
- <sup>34</sup> Swank, Jacqueline M., & Joseph C. Gagnon, 2016, "Mental Health Services in Juvenile Correctional Facilities: A National Survey of Clinical Staff," *Journal of Child and Family Studies* 25: 2862–2872, retrieved January 24, 2023 from <https://doi.org/10.1007/s10826-016-0436-3>.
- <sup>35</sup> Reingle Gonzalez, Jennifer M., Rachel E. Rana, Katelyn K. Jetelina, & Madeline H. Roberts, 2019, "The Value of Lived Experience with the Criminal Justice System: A Qualitative Study of Peer Re-Entry Specialists," *International Journal of Offender Therapy and Comparative Criminology* 63(10): 1861–1875, retrieved January 25, 2023 from <https://doi.org/10.1177/0306624X19830596>.
- <sup>36</sup> Foney, Dana, & Shannon Mace, 2019, *Factors That Influence Access to Medication-Assisted Treatment*, Ann Arbor, MI: University of Michigan Behavioral Health Workforce Research Center, & the National Council for Behavioral Health, University of Michigan School of Public Health, retrieved January 25, 2023 from [https://behavioralhealthworkforce.org/wp-content/uploads/2019/10/Factors-that-Influence-MAT\\_Full-Report.pdf](https://behavioralhealthworkforce.org/wp-content/uploads/2019/10/Factors-that-Influence-MAT_Full-Report.pdf).
-

- 
- <sup>37</sup> Blanch, Andrea, Beth Filson, & Darby Penney, 2012, *Engaging Women in Trauma-Informed Peer Support: A Guidebook*, Rockville, MD: Center for Mental Health Services, National Center for Trauma-Informed Care & National Association of State Mental Health Program Directors. [https://www.nasmhpd.org/sites/default/files/PeerEngagementGuide\\_Color\\_REVISED\\_10\\_2012.pdf](https://www.nasmhpd.org/sites/default/files/PeerEngagementGuide_Color_REVISED_10_2012.pdf)
- <sup>38</sup> Heller, E., National Conference of State Legislatures, 2016, "Using Peers to Improve Mental Health Treatment," *LegisBrief* 24(10).
- <sup>39</sup> Niki Miller, 2019, *RSAT Training Tool: Transitional Strategies to Reduce Recidivism and Sustain Recovery*, Sudbury, MA: Advocates for Human Potential, Inc., retrieved January 24, 2023 from [https://www.rsat-tta.com/Photos/Final-Re-entering-RSAT-Clients\\_9-27-19](https://www.rsat-tta.com/Photos/Final-Re-entering-RSAT-Clients_9-27-19); National Institute on Drug Abuse (NIDA), 2014, "Where Do 12-Step or Self-Help Programs Fit into Drug Addiction Treatment?" in *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, NIDA, retrieved January 25, 2023 from <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/where-do-12-step-programs-fit>; Substance Abuse and Mental Health Services Administration, n.d., *Recovery and Recovery Support*, retrieved January 24, 2023 from <http://www.samhsa.gov/recovery/peer-support-social-inclusion>; National Institute on Drug Abuse (NIDA), 2014, *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide*, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, NIDA, NIH Publication Number 14-7953, retrieved January 25, 2023 from <https://nida.nih.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/director>.
- <sup>40</sup> Taxman, Faye, & Steven Belenko, 2012, *Implementing Evidence-Based Practices in Community Corrections and Addiction Treatment*, Springer, retrieved January 24, 2023 from <https://doi.org/10.1007/978-1-4614-0412-5>; Crime and Justice Institute, 2004, *Implementing Evidence-Based Practice in Community Corrections: The Principles of Effective Intervention*, retrieved January 24, 2023 from [https://www.doc.ks.gov/community-corrections/resources/Implementing%20EBP%20in%20Community%20Corrections\\_%20The%20Principles%20of%20Effective%20Intervention.pdf](https://www.doc.ks.gov/community-corrections/resources/Implementing%20EBP%20in%20Community%20Corrections_%20The%20Principles%20of%20Effective%20Intervention.pdf).
- <sup>41</sup> Grant Duwe, June 2017, *The Use and Impact of Correctional Programming for Inmates on Pre- and Post-Release Outcomes*, Washington, DC: U.S. Department of Justice Office of Justice Programs, National Institute of Justice, NCJ 250476, retrieved January 24, 2023 from <https://nij.ojp.gov/library/publications/use-and-impact-correctional-programming-inmates-pre-and-post-release-outcomes>.
- <sup>42</sup> Milkman, Harvey, & Kenneth Wanberg, 2007, *Cognitive-Behavioral Treatment: A Review and Discussion for Correction Professionals*, Washington, DC: U.S. Department of Justice, National Institute of Corrections, NIC Accession Number 021657, retrieved January 24, 2023 from <https://nicic.gov/cognitive-behavioral-treatment-review-and-discussion-corrections-professionals>.
- <sup>43</sup> Mary McMurrin, 2009, "Motivational Interviewing with Offenders: A Systematic Review," *Legal and Criminological Psychology* 14(1): 83–100, retrieved January 24, 2023 from <https://doi.org/10.1348/135532508X278326>.
- <sup>44</sup> Substance Abuse and Mental Health Services Administration, 2005, *Substance Abuse Treatment for Adults in the Criminal Justice System*, Treatment Improvement Protocol (TIP) Series, No. 44, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, HHS Publication No. [SMA] 13-4056, retrieved January 25, 2023 from <https://www.samhsa.gov/resource/ebp/tip-44-substance-abuse-treatment-adults-criminal-justice-system>.
- <sup>45</sup> National Institute on Drug Abuse (NIDA), 2014, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide: Resources*, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, NIDA, retrieved January 25, 2023 from <https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations-research-based-guide/resources>.
- <sup>46</sup> National Institute on Drug Abuse (NIDA), 2014, *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, NIDA, NIH Publication No. 12–4180, retrieved January 25, 2023 from <https://nida.nih.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/preface>.
- <sup>47</sup> Wanberg, Kenneth W., & Harvey B. Milkman, 1998, *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change: The Provider's Guide*, Sage Publications, Inc.
- <sup>48</sup> Development Services Group, Inc., September 2010, *Cognitive-Behavioral Treatment*, Literature review, Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, retrieved January 24, 2023 from [http://www.ojjdp.gov/mpg/litreviews/Cognitive\\_Behavioral\\_Treatment.pdf](http://www.ojjdp.gov/mpg/litreviews/Cognitive_Behavioral_Treatment.pdf); Lipsey, M. W., Nana A. Landenberger, & Sandra J. Wilson, 2007, "Effects of Cognitive-Behavioral Programs for Criminal Offenders," *Campbell Systematic Reviews* 3(1): 1–27, retrieved January 24, 2023 from <https://doi.org/10.4073/csr.2007.6>.
- <sup>49</sup> Fred Zackon, 2011, *Key Elements of Effective Cognitive Behavioral Therapies* [Webinar], retrieved January 25, 2023 from <https://www.rsat-tta.com/Training-Curricula/Archived-Webinars>.
- <sup>50</sup> Feucht, Thomas, & Tammy Holt, 2016, "Does Cognitive Behavioral Therapy Work in Criminal Justice? A New Analysis from CrimeSolutions," *National Institute of Justice Journal*, retrieved January 24, 2023 from <https://nij.ojp.gov/topics/articles/does-cognitive-behavioral-therapy-work-criminal-justice-new-analysis-crimesolutions>
- <sup>51</sup> National Institute of Corrections, n.d., *Motivational Interviewing*, Washington, DC: U.S. Department of Justice, retrieved January 25, 2023 from <https://nicic.gov/projects/motivational-interviewing>.

---

<sup>52</sup> Ibid.

<sup>53</sup> Stinson, Jill D., & Michael D. Clark, 2017, *Motivational Interviewing with Offenders: Engagement, Rehabilitation, and Reentry*, New York, NY: The Guilford Press.

<sup>54</sup> Ibid.

<sup>55</sup> Minnesota Department of Corrections, n.d., *Communities of Practice Links*, retrieved January 24, 2023 from <https://mn.gov/doc/staff-partners/ebp/communities-of-practice/links/>.

<sup>56</sup> Frost, Helen, Pauline Campbell, Margaret Maxwell, Ronan O'Carroll, Stephan Dombrowski, Brian Williams, Helen Cheyne, Emma Coles, & Alex Pollock, 2018, "Effectiveness of Motivational Interviewing on Adult Behaviour Change in Health and Social Care Settings: A Systematic Review of Reviews," *PLOS ONE* 13(10): Article e0204890, retrieved January 24, 2023 from <https://doi.org/10.1371/journal.pone.0204890>.

<sup>57</sup> Sacks, Stanley, Steven Banks, Karen McKendrick, & Joann Sacks, 2008, "Modified Therapeutic Community for Co-Occurring Disorders: A Summary of Four Studies," *Journal of Substance Use and Addiction Treatment* 34(1): 112–22, retrieved January 24, 2023 from <https://doi.org/10.1016/j.jsat.2007.02.008>.

<sup>58</sup> CrimeSolutions, 2015, *Practice Profile: Incarceration-Based Therapeutic Communities for Adults*, Washington, DC: U.S. Department of Justice, National Institute of Justice, retrieved January 24, 2023 from <https://crimesolutions.ojp.gov/ratedpractices/52#eb>.

<sup>59</sup> National Institute on Drug Abuse (NIDA), July 2015, *Therapeutic Communities*, Research Report Series, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, NIDA, NIH Publication Number 15-4877, retrieved January 24, 2023 from [https://nida.nih.gov/sites/default/files/therapeuticcomm\\_rrs\\_0723.pdf](https://nida.nih.gov/sites/default/files/therapeuticcomm_rrs_0723.pdf).

<sup>60</sup> Sullivan, Christopher, Karen McKendrick, Stanely Sacks, & Steven Banks, 2007, "Modified Therapeutic Community Treatment for Offenders with MICA Disorders: Substance Use Outcomes," *The American Journal of Drug and Alcohol Abuse* 33(6): 823–832, retrieved January 24, 2023 from <https://doi.org/10.1080/00952990701653800>.

<sup>61</sup> National Institute on Drug Abuse (NIDA), July 2015, *Therapeutic Communities*, Research Report Series, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, NIDA, NIH Publication Number 15-4877, retrieved January 24, 2023 from [https://nida.nih.gov/sites/default/files/therapeuticcomm\\_rrs\\_0723.pdf](https://nida.nih.gov/sites/default/files/therapeuticcomm_rrs_0723.pdf).

<sup>62</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2005, *Substance Abuse Treatment for Adults in the Criminal Justice System*, Treatment Improvement Protocol (TIP) Series, No. 44, Rockville, MD: U.S. Department of Health and Human Services; National Institute on Drug Abuse (NIDA), July 2015, July, *Therapeutic Communities*, Research Report Series, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, NIDA, NIH Publication Number 15-4877, retrieved January 24, 2023 from [https://nida.nih.gov/sites/default/files/therapeuticcomm\\_rrs\\_0723.pdf](https://nida.nih.gov/sites/default/files/therapeuticcomm_rrs_0723.pdf).

<sup>63</sup> Ibid.

<sup>64</sup> National Institute on Drug Abuse (NIDA), July 2015, July, *Therapeutic Communities*, Research Report Series, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, NIDA, NIH Publication Number 15-4877, retrieved January 24, 2023 from [https://nida.nih.gov/sites/default/files/therapeuticcomm\\_rrs\\_0723.pdf](https://nida.nih.gov/sites/default/files/therapeuticcomm_rrs_0723.pdf).

<sup>65</sup> Downloaded from former website when Treatment Communities of America. Treatment Communities of America was named Therapeutic Communities of America.

<sup>66</sup> Nancy M. Petry, 2013, *Contingency Management for Substance Abuse Treatment: A Guide to Implementing This Evidence-Based Practice*, New York, NY: Routledge.

<sup>67</sup> De Crescenzo, Franco, Marco Ciabattini, Gian Loreto D'Alò, et al., 2018, "Comparative Efficacy and Acceptability of Psychosocial Interventions for Individuals with Cocaine and Amphetamine Addiction: A Systematic Review and Network Meta-Analysis," *PLOS Medicine* 15(12): Article e1002715, retrieved January 24, 2023 from <https://doi.org/10.1371/journal.pmed.1002715>.

<sup>68</sup> Ledgerwood, David M., & Nancy M. Petry, 2006, "Does Contingency Management Affect Motivation to Change Substance Use?" *Drug and Alcohol Dependence* 83(1): 65–72, retrieved January 24, 2023 from <https://doi.org/10.1016/j.drugalcdep.2005.10.012>.

<sup>69</sup> Covington, Stephanie S., & Sandra L. Bloom, 2018, *Moving from Trauma-Informed to Trauma-Responsive: A Training Program for Organizational Change*, Center City, MN: Hazelden Publishing.

<sup>70</sup> Niki Miller, 2011, *RSAT Training Tool: Trauma-Informed Approaches in Correctional Settings*, Sudbury, MA: Advocates for Human Potential, Inc., U.S. Department of Justice, Bureau of Justice Assistance, retrieved January 25, 2023 from [www.rsat-tta.com/Files/Trainings/Trauma\\_Informed\\_Manual](http://www.rsat-tta.com/Files/Trainings/Trauma_Informed_Manual).

<sup>71</sup> Owen, Barbara, James Wells, Joycelyn Pollock, Bernadette Muscat, & Stephanite Torres, 2008, *Gendered Violence and Safety: A Contextual Approach to Improving Security in Women's Facilities*, Washington, DC: U.S. Department of Justice Office of Justice Programs, National Institute of Justice, NCJ 225340, retrieved January 24, 2023 from <https://nij.ojp.gov/library/publications/gendered-violence-and-safety-contextual-approach-improving-security-womens-1>; Stephanie S. Covington, 2008, "Women and Addiction: A Trauma-Informed Approach," *Journal of Psychoactive Drugs* 40(sup5): 377–385, retrieved January 24, 2023 from <https://doi.org/10.1080/02791072.2008.10400665>.

- 
- <sup>72</sup>Ann Booker Loper, 2002, "Adjustment to Prison of Women Convicted of Possession, Trafficking, and Nondrug Offenses," *Journal of Drug Issues* 32(4): 1033–1050, retrieved January 24, 2023 from <https://doi.org/10.1177%2F002204260203200402>.
- <sup>73</sup> Substance Abuse and Mental Health Services Administration, 2022, *Tips for Disaster Responders: Understanding Historical Trauma When Responding to an Event in Indian Country* [Fact sheet], PEP22-01-01-005, retrieved January 25, 2-23 from <https://store.samhsa.gov/product/tips-disaster-responders/pep22-01-01-005>.
- <sup>74</sup> Michelle M. Sotero, 2006, "A Conceptual Model of Historical Trauma: Implications for Public Health Practice and Research," *Journal of Health Disparities Research and Practice* 1(1): 93–108.
- <sup>75</sup> Mika'il DeVeaux, 2013, "The Trauma of the Incarceration Experience," *Harvard Civil Rights-Civil Liberties Law Review* 48(1): 257–77, retrieved January 25, 2023 from [https://harvardcrcl.org/wp-content/uploads/sites/10/2013/04/DeVeaux\\_257-277.pdf](https://harvardcrcl.org/wp-content/uploads/sites/10/2013/04/DeVeaux_257-277.pdf).
- <sup>76</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2014, *Improving Cultural Competence*, Treatment Improvement Protocol (TIP) Series No. 59, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, HHS Publication No. (SMA) 14-4849, retrieved January 25, 2024 from <https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849>.
- <sup>77</sup> Ibid.
- <sup>78</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2009, *Integrated Treatment for Co-Occurring Disorders: Building Your Program*, HHS Publication No. (SMA) 08-4366, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA.
- <sup>79</sup> Mueser, Kim T., Douglas L. Noordsy, Robert E. Drake, & Lindy Fox Smith, 2003, *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*, New York, NY: Guilford Press.
- <sup>80</sup> James, Doris J., & Lauren E. Glaze, September 2006, *Mental Health Problems of Prison and Jail Inmates*, Special Report, Washington, DC: U.S. Department of Justice Office of Justice Programs, Bureau of Justice Statistics, NCJ 213600, retrieved January 24, 2023 from <http://www.bjs.gov/index.cfm?ty=pbdetail&iid=789>.
- <sup>81</sup> QPR Institute, n.d., *Professional Training*, retrieved January 24, 2023 from <https://qprinstitute.com/professional-training>.
- <sup>82</sup> Mental Health First Aid, n.d., *Mental Health First Aid for Public Safety*, Washington, DC: National Council for Mental Wellbeing, retrieved January 24, 2023 from <https://www.mentalhealthfirstaid.org/population-focused-modules/public-safety/>.
- <sup>83</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2020, *Substance Use Disorder Treatment for People With Co-Occurring Disorders*, Treatment Improvement Protocol (TIP) Series, No. 42, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, SAMHSA Publication No. PEP20-02-01-004, retrieved January 24, 2023 from <https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004>.
- <sup>84</sup> Drake, Robert, Susan Essock, Andrew Shaner, et al., 2001, "Implementing Dual Diagnosis Services for Clients with Severe Mental Illness," *Psychiatric Services* 52(4): 469–476, retrieved January 24, 2023 from <https://doi.org/10.1176/appi.ps.52.4.469>.
- <sup>85</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2009, *Integrated Treatment for Co-Occurring Disorders: Building Your Program*, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, HHS Pub. No. SMA-08-4366, retrieved January 24, 2023 from <https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-building-your-program-10112019.pdf>.
- <sup>86</sup> The Council of State Governments Justice Center, n.d., *Collaborative Comprehensive Case Plans*, retrieved June 13, 2002 from <https://csjusticecenter.org/publications/collaborative-comprehensive-case-plans/>.
- <sup>87</sup> Godley, Susan, William White, Guy Diamond, Lora Passetti, & Janet Titus, 2001, "Therapist Reactions to Manual-Guided Therapies for the Treatment of Adolescent Marijuana Users," *Clinical Psychology: Science and Practice* 8(4): 405–417, retrieved January 24, 2023 from <https://doi.org/10.1093/clipsy.8.4.405>.
- <sup>88</sup> Dowden, Craig, & D. A. Andrews, 2004, "The importance of Staff Practices in Delivering Effective Correctional Treatment: A Meta-Analysis of Core Correctional Practices," *International Journal of Offender Therapy and Comparative Criminology* 48(2): 203–214, retrieved January 24, 2023 from <https://doi.org/10.1177%2F0306624X03257765>.
- <sup>89</sup> Marlow, Douglas, Lisa Shannon, Bradley Ray, Darryl Turpin, Guy Wheeler, Jennifer Newell, & Spencer Lawson, 2018, "Developing a Culturally Proficient Intervention for Young African American Men in Drug Court: Examining Feasibility and Estimating an Effect Size for Habilitation Empowerment Accountability Therapy (HEAT)," *Journal for Advancing Justice*, 1: 109–130, retrieved January 26, 2023 from <https://www.ojp.gov/ncjrs/virtual-library/abstracts/developing-culturally-proficient-intervention-young-african>.
- <sup>90</sup> White Bison's Wellbriety Movement Advocacy Office, n.d., *Wellbriety Movement Products*, retrieved January 24, 2023 from <https://www.wellbriety.com/books.html>.
- <sup>91</sup> National Institute on Drug Abuse, 2012, *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, NIDA, NIH Publication No. 12–4180, retrieved January 24, 2023 from <https://codainc.org/wp-content/uploads/2018/10/NIDA-Principles-of-Drug-Addiction-Treatment.pdf>.
- <sup>92</sup> Wodahl, Eric, Brett Garland, Scott Culhane & William McCarty, 2011, "Utilizing Behavioral Interventions to Improve Supervision Outcomes in Community-Based Corrections," *Criminal Justice and Behavior* 38(4): 386–405, retrieved January 24, 2023 from <https://doi.org/10.1177%2F0093854810397866>.

- 
- <sup>93</sup> National Association of Drug Court Professionals, 2015, *Adult Drug Court Best Practice Standards, Vol. II*. (p. 5).
- <sup>94</sup> U.S. Department of Justice Civil Rights Division, 2022, *The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery*, retrieved January 24, 2023 from [https://archive.ada.gov/opioid\\_guidance.pdf](https://archive.ada.gov/opioid_guidance.pdf).
- <sup>95</sup> Brinkley-Rubinstein, Lauren, Michelle McKenzie, Alexandria Macmadu, et al., 2018, "A Randomized, Open Label Trial of Methadone Continuation Versus Forced Withdrawal in a Combined US Prison and Jail: Findings at 12 Months Post-Release," *Drug and Alcohol Dependence* 184: 57–63, retrieved January 26, 2023 from <https://doi.org/10.1016/j.drugalcdep.2017.11.023>.
- <sup>96</sup> Gordon, Michael S., Timothy W. Kinlock, Robert P. Schwartz, Terrence T. Fitzgerald, Kevin E. O'Grady, & Frank J. Vocci, 2014, A Randomized Controlled Trial of Prison-Initiated Buprenorphine: Prison Outcomes and Community Treatment Entry, *Drug and Alcohol Dependence* 142: 33–40, retrieved January 24, 2023 from <https://doi.org/10.1016/j.drugalcdep.2014.05.011>.
- <sup>97</sup> Reingle Gonzalez, Jennifer M., & Nadine M. Connell, 2014, "Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity," *American Journal of Public Health* 104(12): 2328–2333, retrieved January 24, 2023 from <https://doi.org/10.2105/AJPH.2014.302043>.
- <sup>98</sup> Ranapurwala, Shabbar, Meghan Shanahan, Apostolos Alexandridis, et al., 2018, "Opioid Overdose Mortality Among Former North Carolina Inmates: 2000-2015," *American Journal of Public Health* 108(9): 1207–1213, retrieved January 24, 2023 from <https://doi.org/10.2105/ajph.2018.304514>.
- <sup>99</sup> Binswanger, Ingrid, Marc Stern, Richard Deyo, et al., 2007, "Release from Prison—A High Risk of Death for Former Inmates," *New England Journal of Medicine* 356(2): 157–65.
- <sup>100</sup> See, e.g., United States Department of Justice Civil Rights Division & United States Attorney's Office, District of New Jersey, 2021, *Investigation of the Cumberland County Jail (Bridgeton, New Jersey)*, retrieved January 24, 2023 from <https://www.justice.gov/usao-nj/press-release/file/1354736/download>; *Pesce v. Coppinger*, 355 F. Supp. 3d 35 (2018).
- <sup>101</sup> National Sheriffs' Association & National Commission on Correctional Health Care, 2018, *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field*, retrieved January 24, 2023 from <https://www.rsat-tta.com/Files/Jail-Based-MAT-PPG-web>.
- <sup>102</sup> National Commission on Correctional Health Care, 2021, *Opioid Use Disorder Treatment in Correctional Settings (2021)*, retrieved January 24, 2023 from <https://www.ncchc.org/opioid-use-disorder-treatment-in-correctional-settings-2021/>.
- <sup>103</sup> Federal Bureau of Prisons, August 2021, *Opioid Use Disorder: Diagnosis, Evaluation, and Treatment: Federal Bureau of Prisons Clinical Guidance*, retrieved January 24, 2023 from [https://www.bop.gov/resources/pdfs/opioid\\_use\\_disorder\\_cg.pdf](https://www.bop.gov/resources/pdfs/opioid_use_disorder_cg.pdf).
- <sup>104</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2021, *Medications for Opioid Use Disorder, Treatment Improvement Protocol (TIP) 63*, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, Publication No. PEP21-02-01-002, retrieved January 24, 2023 from <https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf>.
- <sup>105</sup> Magura, Stephen, Joshua Lee, Jason Hershberger, et al., 2009, "Buprenorphine and Methadone Maintenance in Jail and Post-Release: A Randomized Clinical Trial," *Drug and Alcohol Dependence* 99(1–3): 222–230, retrieved January 24, 2023 from <https://doi.org/10.1016/j.drugalcdep.2008.08.006>.
- <sup>106</sup> Kinlock, Timothy W., Michael S. Gordon, Robert P. Schwartz, & Kevin E. O'Grady, 2008, "A Study of Methadone Maintenance for Male Prisoners: 3-Month Postrelease Outcomes," *Criminal Justice and Behavior* 35(1): 34–47, retrieved January 24, 2023 from <https://doi.org/10.1177%2F0093854807309111>.
- <sup>107</sup> Substance Abuse and Mental Health Services Administration, n.d., *Harm Reduction*, retrieved January 24, 2023 from <https://www.samhsa.gov/find-help/harm-reduction>.
- <sup>108</sup> Anthony-North, Vedan, Leah Pope, Stephanie Pottinger, & Izzy Sederbaum, March 2018, *Corrections-Based Responses to the Opioid Epidemic: Lessons from New York State's Overdose Education and Naloxone Distribution Program*, Brooklyn, NY: Vera Institute of Justice, retrieved January 26, 2023 from <https://www.vera.org/publications/corrections-responses-to-opioid-epidemic-new-york-state>.
- <sup>109</sup> Advocates for Human Potential, Inc., 2022, *Harm Reduction for Residential Substance Abuse Treatment in Jails and Prisons, Residential Substance Abuse Treatment Training and Technical Assistance*.
- <sup>110</sup> Mallik-Kane, Kamala, & Christy A. Visher, February 2008, *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration*, Washington, DC: Urban Institute Justice Policy Center, retrieved January 24, 2023 from <https://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF>
- <sup>111</sup> Saloner, Brendan, Kalind Parish, Julie A. Ward, Grace DiLaura, & Sharon Dolovich S, 2020, "COVID-19 Cases and Deaths in Federal and State Prisons," *JAMA* 324(6): 602–603, retrieved January 24, 2023 from <https://doi.org/10.1001/jama.2020.12528>.
- <sup>112</sup> Wang, Quan Qiu, David Kaelber, Rong Xu, & Nora Volkow, 2021, "COVID-19 Risk and Outcomes in Patients with Substance Use Disorders: Analyses from Electronic Health Records in the United States," *Molecular Psychiatry* 26: 30–39, retrieved January 24, 2023 from <https://doi.org/10.1038/s41380-020-00880-7>.
-

- 
- <sup>113</sup> Santana, Stephanie, Cindy Brach, Linda Harris, et al., 2021, "Updating Health Literacy for Healthy People 2030: Defining Its Importance for a New Decade in Public Health," *Journal of Public Health Management and Practice* 27(Suppl 6): S258–S264, retrieved January 26, 2023 from <https://doi.org/10.1097/phh.0000000000001324>.
- <sup>114</sup> Marshall, Alison, Jason Grebely, Gregory Dore, & Carla Treloar, 2017, "'I Didn't Want to Let It Go Too Far.' The Decisions and Experiences of People Who Inject Drugs Who Received a Liver Disease Assessment as Part of a Liver Health Promotion Campaign: The LiveRLife Study," *The International Journal on Drug Policy* 47: 153–60, retrieved January 26, 2023 from <https://doi.org/10.1016/j.drugpo.2017.06.001>.
- <sup>115</sup> Degan, Tayla J., Peter J. Kelly, Laura D. Robinson, & Frank P. Deane, 2019, "Health Literacy in Substance Use Disorder Treatment: A Latent Profile Analysis," *Journal of Substance Abuse Treatment*, 96: 46–52, retrieved January 26, 2023 from <https://doi.org/10.1016/j.jsat.2018.10.009>.
- <sup>116</sup> Ibid.
- <sup>117</sup> Dahlman, Disa, Malin Ekefäll, & Lars Garpenhag, 2020, "Health Literacy Among Swedish Patients in Opioid Substitution Treatment: A Mixed-Methods Study," *Drug and Alcohol Dependence*, 214: Article 108186, retrieved January 26, 2023 from <https://doi.org/10.1016/j.drugalcdep.2020.108186>.
- <sup>118</sup> Fletcher, Bennett W., & Redonna K. Chandler, 2014, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, NIH Publication No. 11-5316, p. 15, retrieved January 24, 2023 from [https://www.drugabuse.gov/sites/default/files/txcriminaljustice\\_0.pdf](https://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf).
- <sup>119</sup> Martin, Steven S., Clifford A. Butzin, Christine A. Saum, & James A. Inciardi, 1999, "Three-Year Outcomes of Therapeutic Community Treatment for Drug-Involved Offenders in Delaware: From Prison to Work Release to Aftercare," *The Prison Journal* 79(3): 294–320, retrieved January 24, 2023 from <https://doi.org/10.1177%2F0032885599079003002>.
- <sup>120</sup> NIATx & Council of State Governments Justice Center, n.d., *Bringing NIATx to Corrections: Lessons Learned from Three Pilot Studies*, Washington, DC: U.S. Department of Justice Assistance, Bureau of Justice Assistance, retrieved January 24, 2023 from <https://csgjusticecenter.org/wp-content/uploads/2020/01/BringingNIATxtoCorrectionsFullReport.pdf>.
- <sup>121</sup> Ibid.
- <sup>122</sup> David Cloud, 2014, *On Life Support: Public Health in the Age of Mass Incarceration*, Brooklyn, NY: Vera Institute of Justice, retrieved January 24, 2023 from <https://www.vera.org/publications/on-life-support-public-health-in-the-age-of-mass-incarceration>; Spaulding, Anne, Ryan Seals, Matthew Page, Amanda Brzozowski, William Rhodes, & Theodore Hammett, 2009, "HIV/AIDS Among Inmates of and Releasees from US Correctional Facilities, 2006: Declining Share of Epidemic but Persistent Public Health Opportunity," *PLOS ONE* Article e7558, retrieved January 24, 2023 from <https://doi.org/10.1371/journal.pone.0007558>.
- <sup>123</sup> Ibid. at 9. Citing Seth J. Prins, 2014, "Prevalence of Mental Illnesses in U.S. State Prisons: A Systematic Review," *Psychiatric Services* 65(7): 862–872, retrieved January 24, 2024 from <https://doi.org/10.1176/appi.ps.201300166>.
- <sup>124</sup> Binswanger, Ingrid, Marc Stern, Richard Deyo, et al., 2007, "Release from Prison — A High Risk of Death for Former Inmates," *New England Journal of Medicine* 356: 157–165, retrieved January 24, 2023 from <https://doi.org/10.1056/NEJMsa064115>.
- <sup>125</sup> Ibid. at 165.
- <sup>126</sup> Morrissey, Joseph P., Gary S. Cuddeback, Alison E. Cuellar, & Henry J. Steadman, 2007, "The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness," *Psychiatric Services* 58(6): 794–801, retrieved January 24, 2023 from <https://doi.org/10.1176/ps.2007.58.6.794>.
- <sup>127</sup> Howell, Embry, Cybele Kotonias, & Jesse Jannetta, 2017, *Case Management for Justice-Involved Populations: Colorado*, Washington, DC: Urban Institute, retrieved January 24, 2023 from [https://www.urban.org/sites/default/files/publication/88061/case\\_management\\_1.pdf](https://www.urban.org/sites/default/files/publication/88061/case_management_1.pdf).
- <sup>128</sup> Advocates for Human Potential, Inc., RSAT-TTA, 2021, RSAT Fidelity Assessment Instrument (FAI) Repot, Hampshire County Sheriff's Office – Life Skills Program; Hampshire County Sheriff's Office, Lifeskills Program <https://www.hampshiresheriffs.com/treatment-programming/lifeskills-program>
- <sup>129</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2015, *Substance Abuse Treatment: Group Therapy, Treatment Improvement Protocol (TIP) Series, No. 41*, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, HHS Publication No. (SMA) 15-3991), retrieved January 24, 2023 from <https://store.samhsa.gov/product/TIP-41-Substance-Abuse-Treatment-Group-Therapy/SMA15-3991>; Crime and Justice Institute, 2004, *Implementing Evidence-Based Practice in Community Corrections: The Principles of Effective Intervention*, Washington, DC: U.S. Department of Justice, National Institute of Corrections, retrieved January 24, 2023 from [https://www.doc.ks.gov/community-corrections/resources/Implementing%20EBP%20in%20Community%20Corrections\\_%20The%20Principles%20of%20Effective%20Intervention.pdf](https://www.doc.ks.gov/community-corrections/resources/Implementing%20EBP%20in%20Community%20Corrections_%20The%20Principles%20of%20Effective%20Intervention.pdf).
- <sup>130</sup> Crime and Justice Institute, 2004, *Implementing Evidence-Based Practice in Community Corrections: The Principles of Effective Intervention*, Washington, DC: U.S. Department of Justice, National Institute of Corrections, retrieved January 24, 2023 from [https://www.doc.ks.gov/community-corrections/resources/Implementing%20EBP%20in%20Community%20Corrections\\_%20The%20Principles%20of%20Effective%20Intervention.pdf](https://www.doc.ks.gov/community-corrections/resources/Implementing%20EBP%20in%20Community%20Corrections_%20The%20Principles%20of%20Effective%20Intervention.pdf).
-

- 
- <sup>131</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2014, *Improving Cultural Competence*, Treatment Improvement Protocol (TIP) Series No. 59, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, HHS Publication No. [SMA] 14-4849, retrieved January 23, 2024 from <http://store.samhsa.gov/shin/content/SMA14-4849/SMA14-4849.pdf>.
- <sup>132</sup> Hook, Joshua, Don Davis, Jesse Owen, Everett Worthington Jr., & Shawn Utsey, 2013, "Cultural Humility: Measuring Openness to Culturally Diverse Clients," *Journal of Counseling Psychology* 60(3): 353–366, retrieved January 24, 2023 from <https://doi.apa.org/doi/10.1037/a0032595>.
- <sup>133</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2003, *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations*, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, HHS Publication No. (SMA) 3828, retrieved January 26, 2023 from <https://www.samhsa.gov/resource/dbhis/developing-cultural-competence-disaster-mental-health-programs-guiding-principles>.
- <sup>134</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), 2014, *Improving Cultural Competence*, Treatment Improvement Protocol (TIP) Series No. 59, Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, HHS Publication No. (SMA) 14-4849, retrieved January 24, 2023 from <http://store.samhsa.gov/shin/content/SMA14-4849/SMA14-4849.pdf>.
- <sup>135</sup> FitzGerald, Chloë, & Samia Hurst, 2017, "Implicit Bias in Healthcare Professionals: A Systematic Review," *BMC Medical Ethics* 18(1): 19, retrieved January 24, 2023 from <https://www.ncbi.nlm.nih.gov/pubmed/28249596>.
- <sup>136</sup> van Boekel, Leonike, Evelien Brouwers, Jaap van Weeghel, & Henk Garretsen, 2013, "Stigma Among Health Professionals Towards Patients with Substance Use Disorders and Its Consequences for Healthcare Delivery: Systematic Review," *Drug and Alcohol Dependence* 131(1–2): 23–35, retrieved January 24, 2023 from <https://www.ncbi.nlm.nih.gov/pubmed/23490450>.
- <sup>137</sup> Kelly, John F., & Cassandra M. Westerhoff, 2010, "Does It Matter How We Refer to Individuals with Substance-Related Conditions? A Randomized Study of Two Commonly Used Terms," *The International Journal on Drug Policy* 21(3): 202–207, retrieved January 24, 2023 from <https://www.ncbi.nlm.nih.gov/pubmed/20005692>.
- <sup>138</sup> Ibid.
- <sup>139</sup> Bogue, Bradford, & Anjali Nandi, 2012, "Motivational Interviewing in Corrections: A Comprehensive Guide to Implementing MI in Corrections," Washington, DC: U.S. Department of Justice, National Institute of Corrections.
- <sup>140</sup> Advocates for Human Potential, Inc., 2016, *Role of Correctional Officers in Jail/Prison Substance Use Disorder Treatment Programs*, Residential Substance Abuse Treatment Training and Technical Assistance.
- <sup>141</sup> Henggeler, Scott W., Susan G. Pickrel, & Michael J. Brondino, 1999, "Multisystemic Treatment of Substance-Abusing and -Dependent Delinquents: Outcomes, Treatment Fidelity, and Transportability," *Mental Health Services Research* 1(3): 171–184, retrieved January 24, 2023 from <https://doi.org/10.1023/A:1022373813261>; Mihalic, Sharon, & Katherine Irwin, 2003, "Blueprints for Violence Prevention: From Research to Real-World Settings—Factors Influencing the Successful Replication of Model Programs," *Youth Violence and Juvenile Justice* 1(4): 307–329, retrieved January 24, 2023 from <https://doi.org/10.1177%2F1541204003255841>; Miller, William R., James L. Sorensen, Jeffrey A. Selzer, & Gregory S. Brigham, 2006, "Disseminating Evidence-Based Practices in Substance Abuse Treatment: A Review with Suggestions," *Journal of Substance and Addiction Treatment* 31(1): 25–39, retrieved January 24, 2023 from <https://doi.org/10.1016/j.jsat.2006.03.005>; Myers, Michael D., & D. E. Avison (Eds.), 2002, *Qualitative Research in Information Systems*, Sage; Miller, William R., & Kathy A. Mount, 2001, "A Small Study of Training in Motivational Interviewing: Does One Workshop Change Clinician and Client Behavior?" *Behavioural and Cognitive Psychotherapy* 29(4): 457–471, retrieved January 24, 2023 from <https://doi.org/10.1017/S1352465801004064>; Gendreau, Paul, Claire Goggin, & Paula Smith, 1999, "The Forgotten Issue in Effective Correctional Treatment: Program Implementation," *International Journal of Offender Therapy and Comparative Criminology* 43(2): 180–187, retrieved January 24, 2023 from <https://doi.org/10.1177%2F0306624X99432005>; Dilulio Jr., John, Geoffrey Alpert, Mark Moore, et al., October 1993, *Performance Measures for the Criminal Justice System*, Washington, DC: U.S. Department of Justice Office of Justice Programs, Bureau of Justice Statistics, NCJ 143505, retrieved January 6, 2023 from <https://bjs.ojp.gov/content/pub/pdf/pmcjs.pdf>.
- <sup>142</sup> W. Miller, 1988, *Project Match Research Group, 1997*; Agostinelli, Gina, Janice Brown, & William Miller, 1995, "Effects of Normative Feedback on Consumption Among Heavy Drinking College Students," *Journal of Drug Education* 25(1): 31–40, retrieved January 24, 2023 from <https://doi.org/10.2190%2FXD56-D6WR-7195-EAL3>; Alvero, Alicia, Barbar Bucklin, & John Austin, 2001, "An Objective Review of the Effectiveness and Essential Characteristics of Performance Feedback in Organizational Settings (1985-1998)," *Journal of Organizational Behavior Management* 21(1): 3–29, retrieved January 24, 2023 from [https://doi.org/10.1300/J075v21n01\\_02](https://doi.org/10.1300/J075v21n01_02); Baer, John, G. Marlatt, Daniel Kivlahan, Kim Fromme, Mary Larimer, & Ellen Williams, 1992, "An Experimental Test of Three Methods of Alcohol Risk Reduction with Young Adults," *Journal of Consulting and Clinical Psychology* 60(6): 974–979, retrieved January 24, 2023 from <https://doi.apa.org/doi/10.1037/0022-006X.60.6.974>; Phillip J. Decker, 1983, "The Effects of Rehearsal Group Size and Video Feedback in Behavior Modeling Training," *Personnel Psychology* 36(4): 763–773; Kate Ludeman, 1991, "Measuring Skills and Behavior," *Training and Development* 45(11): 61–66; Ron Zemke, 2001, "Systems Thinking: Looking at How Systems Really Work Can Be Enlightening – Or a Wake-Up Call," *Journal of Training* 39(2): 40–46; D. S. Elliott, 1980, "A Repertoire of Impact Measures," In Malcolm W. Klein & Katherine S. Teilmann Van Dusen (Eds.), *Handbook of Criminal Justice Evaluation* (pp. 507–515), Thousand Oaks, CA: Sage Publications.
- <sup>143</sup> Advocates for Human Potential, Inc., 2020, *RSAT Survey Summary Report of Yavapai County Jail*.
- <sup>144</sup> Fixsen, Dean, Sandra F. Naoom, Karen A. Blase, Robert M. Friedman, & Frances Wallace, 2005, *Implementation Research: A Synthesis of the Literature*, Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National

---

Implementation Research Network, FMHI Publication #231, retrieved January 24, 2023 from <http://nirn.fpg.unc.edu/sites/nirn.fpg.unc.edu/files/resources/NIRN-MonographFull-01-2005.pdf>.

<sup>145</sup> Crime and Justice Institute, 2004, *Implementing Evidence-Based Practice in Community Corrections: The Principles of Effective Intervention*, Washington, DC: U.S. Department of Justice, National Institute of Corrections, retrieved January 24, 2023 from <https://s3.amazonaws.com/static.nicic.gov/Library/019342.pdf>; Crime and Justice Institute & the Center for Effective Public Policy, 2010, *Implementing Evidence-Based Practices (Revised)*.