RESIDENTIAL SUBSTANCE ABUSE TREATMENT (RSAT)

Training and Technical Assistance

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

Advocates for Human Potential, Inc.

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Module I: Introduction

Audience

This training tool is designed for:

- Residential Substance Abuse Treatment (RSAT) administrators and staff and other correctional clinical care providers;
- Correctional case managers;
- Other administrative, security, and program staff;
- Community corrections, parole, and probation staff;
- Community-based substance use disorder (SUD) and mental health service providers;
- Reentry courts and other jail diversion programs;
- Early release and reentry programs and interagency reentry councils;
- Employment, housing, and faith- and community-based agencies; and
- Volunteers and peer recovery support service providers.

Purpose

The purpose of this document is to provide useful tools and information to assist with pre-release planning for RSAT clients, including continuing care for SUDs and linkages to community-based transitional and recovery supports that pave the way for reentry success.

Fulfilling RSAT's Legislative Mandate

To qualify for RSAT funding, state agencies administering RSAT programs must, by federal law (34 U.S.C. § 10422 [c][1]), "ensure that individuals who participate in the substance abuse treatment program…will be provided with aftercare services…. State aftercare services must involve the coordination of the correctional treatment program with other human service and rehabilitation programs, such as education and job training programs, parole supervision programs, half-way house programs, and participation in self-help and peer group programs."

The legislative mandate to provide continuing care is based on research that has demonstrated better outcomes for justice-involved individuals who receive drug treatment in custody followed by community-based treatment and recovery services upon release (Taxman, Perdoni, & Harrison, 2007). Continuing care and transitional support can involve coordination with probation/parole, work release facilities, or halfway houses and partnership with community-based treatment providers and other allied agencies that offer employment services, housing, peer support, and an array of other reentry resources.

Providing structured aftercare, treatment, and recovery support activities helps RSAT clients adopt a recovery-oriented lifestyle upon reentry. Research has shown this

maximizes investments into rehabilitation programming delivered in custody settings (Welsh, 2007). A step-down approach from more intensive levels of RSAT programming to less intensive levels of clinical care—along with an appropriate level of community supervision—is ideal. However, not every RSAT graduate is released under ideal circumstances.

Pre-release planning and care transitions are highly individualized and can be complex. Effective reentry planning begins at intake, when risk and needs assessments identify priority programming needs to prevent the likelihood of a return to criminal behavior (Andrews & Bonta, 1998). Some priorities are addressed by programs available in custody settings (e.g., RSAT, cognitive behavioral interventions to target criminal thinking, mental health services). But risks and needs must be reassessed prior to reentry to determine the degree of structured programming required upon release and to reassess priority needs, such as housing and employment, as clients approach their release date (Gendreau, French, & Taylor, 2002; National Institute of Corrections, 2004). Planning for reentry success requires addressing at least three different categories of risks and needs.

- **Practical needs**—Clients may have immediate needs, including, but not limited to, any or all of the following:
    - Housing
    - Employment
    - Health care
    - Transportation
    - Family reunification
- **Criminogenic risks**—Levels of supervision and structured pro-social activities for clients who are:
    - Stepping down to pre- or work-release facilities and halfway houses;
    - Released to the community under correctional supervision; and
    - Completing their sentences to be released without supervision.
- **Clinical care**—Continuing care for SUDs and related conditions. This may include:
    - Varying levels of ongoing treatment and recovery support services;
    - Linkage or referral to medication-assisted treatment (MAT) providers;
    - Continuing care for co-occurring mental health disorders;
    - Care for chronic health conditions such as HIV/AIDS or viral hepatis; and
    - Linkages to overdose prevention/risk reduction resources upon reentry.

This manual is designed to help RSAT programs engage clients in preparing for reentry during the core phases of treatment and in structured planning activities during the pre-release phase. It also offers information on coordination with community corrections,

treatment providers, and allied social service agencies. Resources for further learning on subgroups of reentering clients, such as women offenders and clients with co-occurring mental health or opioid use disorder (OUD), are also included.

Learning Objectives

Participants will be able to:

1. Explain the benefits of continuing community-based care for SUDs, aftercare, and ongoing recovery support for RSAT clients;
2. Name a tool or strategy RSAT staff use to integrate transitional planning into core treatment programming;
3. Discuss procedures, practices, and policies for enrolling reentering clients in benefits or programs that allow access to continuing care upon release;
4. List steps correctional staff and administrators can take to reduce the risks of post-release opioid and other drug overdose; and
5. Discuss examples of referral/warm handoff procedures RSAT programs employ with collaborating community agencies.

Approach

The following materials primarily focus on elements of reentry relevant to RSAT programs. While it is important for RSAT staff to be informed about a variety of reentry resources and practices, once a client leaves the facility, RSAT staff who deliver programming in custody settings have a limited role. Therefore, this manual focuses on the aspects of transitional planning for which most RSAT programs are responsible.

1. **Collaborating with other justice professionals** such as case managers, probation/parole staff, medical and mental health services, work release programs, reentry courts, and other early release programs
2. **Transitioning RSAT clients to continuing care**—facilitating pre-release planning and linkages to continuing care, peer support, and other recovery support services in the community
3. **Partnering with community agencies** to promote in-reach opportunities, dedicated contacts for RSAT referrals, and warm handoff procedures that help reentering clients make a connection to community-based services

Although reentering RSAT clients are vulnerable to multiple levels of stigma, anticipating barriers during pre-release planning helps to overcome them. RSAT programs can pave the way by building relationships with community providers and helping them understand the value of their contributions to reentry success.

The Effectiveness of Aftercare for RSAT Program Graduates

Research confirms that those who complete RSAT treatment reoffend at lower rates; however, ***significantly lower rates of recidivism*** are achieved when RSAT graduates access continuing care upon release in the form of community-based treatment and

recovery support and services (Taxman et al., 2007). Evaluation research suggests when RSAT staff take steps to ensure reentering clients receive follow-up care in the community, it increases the impact of RSAT programs. Effective linkages to continuing care involve more than simple referrals to SUD treatment providers or recommendations that clients attend meetings (Marlowe, 2002).

The treatment provided by RSAT programs should be considered the first phase of ongoing treatment that begins in prison or jail but continues after release.

—*Promising Practices Guidelines for RSAT*, p. 12

A 2003 study concluded only about half of RSAT programs offered an aftercare component (Harrison & Martin, 2003). However, since that time, national and regional attention on reducing recidivism through continuing community-based care for SUDs has increased.

Over the last decade, additional resources have become available that can help RSAT programs facilitate linkages to continuing care. Since the Second Chance Act (P.L. 110–199) was signed into law in 2008, federal grant programs have increased vital reentry supports. State and local initiatives aimed at reducing recidivism have improved the reentry process and expanded supports for individuals returning to the community. In many states, health reform and expanded Medicaid eligibility has made it possible for greater numbers of reentering individuals to access community-based addiction and mental health treatment and other vital health services. More recently, federal funding for states to support responses to the opioid crisis has increased access to MAT, overdose prevention, and continuing care for reentering individuals with OUD.

Nevertheless, barriers still exist, and resources may be scarce in many communities. This manual does not promise a quick fix, but it does offer examples of how jurisdictions are overcoming some of these barriers. It can help RSAT programs locate resources and information for clients transitioning from institutional to community-based care and incorporate aspects of reentry preparation into all phases of RSAT programming.

For many years, research on SUDs focused mainly on treatment. Treatment was defined by an admission and a discharge, and recovery was measured by abstinence alone (White, Kurtz, & Sanders, 2006). Very little research looked at the years and decades that followed treatment, the mechanisms that sustain long-term addiction recovery, and how recovering individuals manage to rebuild their lives. The field has begun to recognize the importance of ongoing recovery management. Developing the skills required to successfully manage long-term recovery is a lifelong process that demands active participation in one's own care.

Recovery-oriented approaches encourage reentering individuals to assume responsibility for their recovery, expand their network of support, and apply the skills that RSAT programs impart. When community-based treatment, peer recovery support, and important social services are in place upon release, it affords RSAT graduates a foundation upon which to build a better life in the community without drugs and alcohol.

Module II: Reentry Success through Pre-Release Planning

A. Context of Continuing Care and Reentry in Residential Substance Abuse Treatment (RSAT) Programs

B. Integrating Reentry Across the RSAT Continuum of Care

C. Transitional, Reentry, and Release Conditions

D. The Role of Community Corrections in Release Planning

Learning Objectives

After completing this module, participants will be able to:

1. Identify approaches to addiction recovery and offender rehabilitation that influence RSAT pre-release planning;
2. Discuss examples of how RSAT programs integrate reentry planning through each phase of treatment; and
3. List components of strong working partnerships RSAT programs establish between the community and corrections to improve continuing care for reentering individuals with substance use disorders (SUDs).

A. Context of Continuing Care and Reentry in RSAT Programs

Criminal justice, like any other public service, is subject to the changing winds of public opinion. When it comes to public safety, people understandably have strong opinions. They may have equally strong opinions about public spending. It is not unusual for there to be a call to get tough on crime one year and a push for drastic spending cuts that impact corrections the next. The challenge for criminal justice professionals is to put public safety first, but have the awareness that public funds are limited.

Criminal justice systems have applied data-driven approaches to reduce crime and increase the cost-effectiveness of rehabilitation programming. The high costs of incarceration have prompted policymakers to look at ways to reduce high recidivism rates, improve the reentry process, and maximize rehabilitative gains made in custody. Continuing care for behavioral health issues, employment programs, interventions that address criminal thinking, and other reentry supports can reduce recidivism and the high costs of repeat incarceration without compromising public safety.

RSAT and Data-Driven Approaches to Reducing Recidivism

The RSAT model is based on evidence of the effectiveness of intensive, long-term SUD treatment programs in custody settings where program participants are removed from the general population (Welsh, 2007). While the extent of resulting recidivism reductions varies from study to study, the research clearly demonstrates RSAT programs are effective. (See the library section of the RSAT website for examples of studies at http://www.rsat-tta.com/Library.) However, greater reductions in recidivism among RSAT graduates are achieved when they *also* receive continuing community-based treatment upon release (Taxman et al., 2007).

Generally, RSAT programs have the greatest impact when they use the following practices (Advocates for Human Potential, Inc., 2017):

- Employ data-driven approaches to behavioral change, such as motivational interviewing and cognitive behavioral interventions (CBI).
- Offer medication-assisted treatment (MAT) for clients with opioid and alcohol use disorders.
- Have clear incentives and pathways to rewards and privileges, as well as a system of swift and certain graduated sanctions.
- Employ risk and needs assessments and individualized treatment plans that address identified criminogenic risks and needs.
- Afford clients opportunities to observe staff, officers, and other clients modeling pro-social interactions and behaviors.
- Encourage participants to practice pro-social behaviors and alternative coping skills and take on valued roles within the therapeutic setting.
- Build reentry preparation into the fabric of each phase of programming and include a distinct pre-release phase of treatment.

The Purpose of RSAT Programs

RSAT programs are designed to break the cycle of drug use and crime. To best accomplish this, RSAT programs incorporate preparation for a crime-free and substance-free life in the community into all phases of treatment.

RSAT goals and objectives are to:

- Enhance the capacity of states and units of local government to provide residential substance abuse treatment in custody;
- Prepare RSAT clients for reintegration through linkages to community-based treatment, social services, and recovery supports;
- Assist both reentering clients and community-based providers to coordinate continuing care for SUDs and other supportive services; and
- Reduce recidivism by promoting a drug-free post-release lifestyle, structured pro-social activities, and expanded networks of recovery support.

Although it is possible to obtain drugs and alcohol in custody, access is greatly reduced. Separate housing units and random drug screens are additional steps RSAT programs can take to ensure a substance-free environment. This protected environment allows clients to focus on developing the skills they need to maintain abstinence when they return to the community, where access to alcohol and drugs is inevitable.

Core elements—Minimally, RSAT programs must meet the following criteria:

- Prison-based treatment programs are at least 6 and no more than 12 months; jail-based programs are at least 3 months.
- Programs are set apart from the general population—in separate facilities, dedicated housing units, or “treatment pods” in jails.
- Treatment develops cognitive, behavioral, and vocational skills that support recovery from addiction and promote rehabilitation.
- Program participants and graduates undergo periodic, random drug testing while they remain in treatment, in custody, or under correctional supervision.

Priority admission is given to clients who are no more than 6–12 months from release, since it is preferable to release RSAT graduates directly to the community, rather than return them to the general population. RSAT programs function as a bridge from incarceration to community reintegration. This makes “in-reach” and transitional elements vital to the core phases of treatment, as well as the pre-release phase.

Collaborating with treatment providers and community agencies offering broad-based recovery supports is critical to all phases of RSAT. When community partners contribute to programming, it can afford staff more time to focus on core treatment components and target criminal risk factors. Incorporating in-reach also offers clients contact with community agencies and services they may need upon release, making it

more likely clients will access them.

Some RSAT programs contract with community-based SUD treatment providers to come into the facility and deliver core components of programming, and some clients may continue to receive ongoing care from these providers upon release. However, such arrangements do not preclude additional in-reach from a variety of other community agencies.

For example, community public health and HIV/AIDS service providers are not only well-equipped to deliver educational sessions on preventing the spread of HIV and viral hepatitis, but they also consider justice-involved individuals to be a high-risk, priority population. Pre-release offenders have from 5 to 11 times the rate of HIV/AIDS as the general population (Centers for Disease Control and Prevention [CDC], 2006; Solomon et al., 2014). The prevalence of hepatitis C in 2015 was 1 percent in the general U.S. population but estimated at more than 17 percent among U.S. prisoners (Varan, Mercer, Stein, & Spaulding, 2014).

Public health and nonprofit partners can also introduce clients to important services available upon reentry, such as confidential testing, risk reduction counseling, overdose prevention, viral hepatitis testing and treatment, and resources for people living with HIV/AIDS. The same holds true for community-based recovery and peer support centers, syringe exchanges, overdose prevention programs, faith-based initiatives, 12-step fellowships, employment services, and many other agencies. Involving the community enriches RSAT programming.

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

(a) REQUIREMENT FOR AFTERCARE COMPONENT.—Section 1902(c) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796ff–1(c)), is amended—

__(1) To be eligible for funding under this part, a State shall ensure that individuals who participate in the substance abuse treatment program established or implemented with assistance provided under this part will be provided with aftercare services, which may include case management services and a full continuum of support services that ensure providers furnishing services under that program are approved by the appropriate State or local agency, and licensed, if necessary, to provide medical treatment or other health services.

(b) DEFINITION.—Section 1904(d) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796ff–3(d)) is amended to read as follows:

__(d) RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAM DEFINED.—In this part, the term "residential substance abuse treatment program" means a course of comprehensive individual and group substance abuse treatment services, lasting a period of at least 6 months, in residential treatment facilities set apart from the general population of a prison or jail (which may include the use of pharmacological treatment, where appropriate, that may extend beyond such period).

Legislative Aftercare Mandate

Section 102 of the continuing authorization legislation for RSAT programs (Second Chance Act, 2008) specifically addresses coordination of aftercare for reentering

clients. Notably, it highlights the inclusion of MAT in programming and continuing care.

Single State Agency (SSA) Collaboration

RSAT programs are required to work with the state governmental agency responsible for alcohol and drug services, or SSA, to coordinate continuing care for reentering clients. This agency receives federal block grant dollars earmarked for treatment services, has extensive knowledge of the capacities of all contracted providers, and knows which agencies have experience with justice populations. Established RSAT programs are most likely already in contact with these agencies.

Alcohol and Drug Services SSA Directory, December 2018:
https://www.samhsa.gov/sites/default/files/ssa_directory_12-03-2018_final_508.pdf

State Opioid Treatment Authorities: https://dpt2.samhsa.gov/regulations/smalist.aspx

Each SSA also has a designated opioid treatment authority who can help connect reentering individuals with opioid use disorder (OUD) to MAT and other resources. RSAT program managers who are not already in contact with these individuals can take advantage of this opportune time to connect with them. Recent federal funding awarded to the states to respond to the opioid crisis may be earmarked for new initiatives, including some paying for MAT for people in need of treatment without any other source of payment. The state opioid treatment authority will be familiar with any new programs for which reentering clients with OUDs may qualify. This office also certifies and monitors all opioid treatment programs (OTPs) authorized to dispense methadone and may also have information about newly waivered physicians qualified to offer office-based OUD treatment with buprenorphine.

RSAT programs may be working with state and local reentry taskforces that meet regularly to coordinate services and supports. Such groups may have been formed as the result of grant-funded programs or initiatives aimed at reducing recidivism. There may be a statewide forum, as well as one or more community-level groups. If there is no forum for collaboration on reentry, it may be worth the consideration of program or facility administrators and other interested stakeholders.

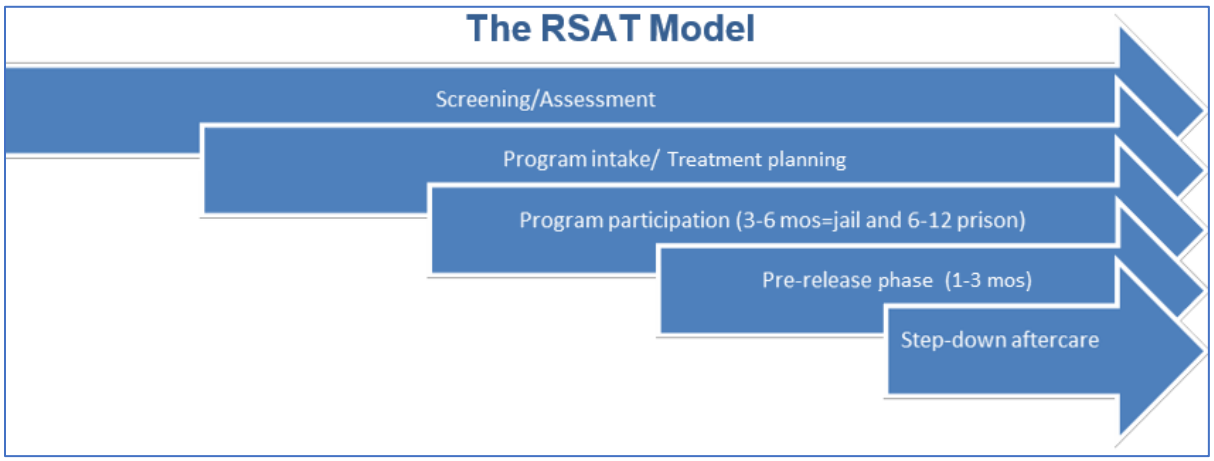
Reentering RSAT clients rely on community-based treatment providers, but working with RSAT programs offers providers a lot in return.

Most people in long-term recovery and almost half of clients in publicly funded treatment have been involved with the justice system (Engel, 2008; Marlowe, 2003). Community providers that serve RSAT graduates are working with a small segment of justice-involved clients who have successfully completed long-term treatment based on best practices specific to this population. RSAT clients have a working knowledge of recovery principles, may be highly motivated, and have the ability to succeed. Moreover, community providers benefit from working with RSAT staff who have

specialized knowledge of best practices that address the intersection of rehabilitation and recovery.

B. Integrating Reentry Across the RSAT Continuum of Care

The ***continuum of care*** for RSAT clients is a sequential progression through specific phases of treatment and recovery tasks. Reentry, continuing care, and ongoing recovery are considered at each phase.



Screening/Assessment

An individual is usually assessed for criminal risks and needs, along with medical and behavioral health issues, at facility intake. Some forensic risk and needs assessments include substance use and mental health screening questions. Many facilities administer additional standardized SUD or mental health screens, such as the Brief Jail Mental Health Screen, the Texas Christian University Drug Screen, or the Clinical Opiate Withdrawal Scale (all available for public use at no cost). Multiple validated screening tools are used in correctional settings. They all answer a "yes or no" question: Should the individual be fully assessed to determine if they meet the criteria for an SUD, the level of severity, and other issues/conditions relevant to treatment planning?

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

—*Promising Practices Guidelines for RSAT*, p. 7

By the time candidates enter the intensive level of treatment RSAT programs offer, the presence and sufficient severity of an SUD has been established. Clients may also have been assessed for co-occurring mental health disorders, but re-assessment may be warranted during treatment if the emergence of symptoms is noted. Clinical and forensic assessments and the client's psychosocial, criminal, and medical history offer insight into the level of reentry planning and support required. Screening should also include benefit eligibility for potential enrollment or continuation of benefits such as Social Security, veterans' benefits, Medicaid and

Medicare, or any other help they may have been receiving in the community, including specialized supports for people with disabilities or those living with HIV/AIDS. Other "responsivity" factors, or factors that could interfere with the delivery of interventions, are also considered.

- Does the client have the level of literacy treatment requires?
- Are there cognitive, mental, or physical problems to be addressed first?
- Are there accommodations that will allow for full participation in treatment?

The listings below link to comprehensive screening and assessment resources for substance use, related behavioral health conditions, and forensic risks and needs. Prisons and jails make use of different forensic and clinical screening and assessment tools as RSAT program participants move from intake through assignment of security levels and housing units, program participation, and pre-release planning.

Risk Assessment Instruments Validated in U.S. Correctional Settings (Council of State Governments [CSG], 2013)

SAMHSA Listing of Substance Abuse Screening and Assessment Tools (with descriptions)

SAMHSA/HRSA Center for Integrated Health Solutions Clinical Practice Screening Tools

Substance Use Screening & Assessment Instruments Database (Alcohol & Drug Abuse Institute, University of Washington)

Screening and Assessment of CODs in the Criminal Justice System (Substance Abuse and Mental Health Services Agency [SAMHSA], 2015)

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

Intake and Treatment Planning

Individual treatment plans are informed by assessments, the role of substances in the crime, patterns of use, primary drug of choice, protective factors, and biopsychosocial histories. Level of motivation is also considered since treatment planning may require measures to strengthen motivation. Reentry issues to be addressed throughout the core treatment phases, as well as the pre-release phase, are noted and provide insight to the different reentry needs of RSAT clients.

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

—*Promising Practices Guidelines for RSAT*, p. 9

For example, consider a young client with a history of intravenous (IV) opioid use who was homeless prior to arrest, is completing a general educational development (GED) program, and sees a mental health clinician in custody. He or she may have no employment history, may require housing upon reentry, and referrals to mental health services and possibly to an MAT provider. Treatment planning may involve ongoing coordination with facility mental health services and/or other correctional programs, as well as with community-based providers prior to release. In contrast, a married electrician with a history of alcohol and cocaine use who has job skills, ,a home, and family to return to upon release will not require the same level of reentry planning.

Reentry Checklist #1: Assessment and Treatment Planning

- ☐ **Assessment:** Highlights the degree of reentry planning clients are likely to require. A pre-release risk and needs reassessment is administered as clients approach release dates. The client and staff review progress to determine release planning priorities and reentry risks and needs.
- ☐ **Case Management:** Clients are assigned to other correctional programs that will prepare them for release, such as educational programs, career and technical training, and job readiness and placement.
- ☐ **SMART Goals:** Treatment plans are developed *with the client* and comprise **S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**ime-limited objectives. Complex goals are broken down into a series of action steps, and responsibility for completion is assigned to the client, with appropriate staff support. The timeframes for completion become critical prior to reentry.
- ☐ **Intensity:** Criminal risk factors and addiction severity are reviewed with the client to inform required levels of post-release supervision and continuing SUD care. Intensive residential treatment upon release may be duplicative and is reserved for high-risk offenders with severe SUDs, especially if they are reentering after a long period in custody without community supervision and have low levels of recovery support.
- ☐ **Managing Critical Information:** Arrangements are in place for sharing with Medicaid or other benefit programs to suspend enrollment when possible. Release dates and status are tracked, with sentence reductions factored in (unsupervised releases are flagged). Clients sign releases to allow confidential SUD treatment information to be shared for purposes of release planning and supervision assignments.

Primary Treatment

The focus in the core phases of the program is on achieving initial goals, such as maintaining abstinence from drug and alcohol use, developing conflict resolution and life skills, identifying triggers, addressing criminal thinking and family/relationship issues, and adopting alternative leisure activities. Clients develop and practice new coping skills. To make skill rehearsal effective, scenarios and role playing are relevant to real-life situations clients will face upon release. It is sometimes helpful for clients to deconstruct failed attempts at recovery or relapses to identify what they can do differently. Recovery self-management, relapse prevention, and expansion of recovery support networks are all core treatment topics that pertain to reentry.

Utah Department of Corrections (DOC): Engaging Incarcerated People in Reentry Planning Through Tablet Technology

Inmates in the Utah prison system use electronic tablets to work on release planning up to 1 year prior to reentry. The tablet platform is secure and allows inmates to create their own release plan and manage goals and tasks. The electronic tablet follows them into the community upon release to help them implement the plan, track completion of tasks, and modify their goals.

- Individuals can share pre-release plans with the supervising agent the offender will report to upon release.
- They can search housing, employment, and other reentry resources.
- Plans can be shared with community treatment providers as well as social service agencies and agents.
- Case workers and providers can access attached messages and files.
- A calendar allows post-release appointments to be scheduled and tracked with reminder notices.
- Offenders can check in and out of counseling sessions, work, community service, and curfew.

The tablet technology has simplified and increased parole/probation in-reach to decrease recidivism. It has also motivated inmates to invest time and effort into their release planning. Upon release, it helps offenders organize and structure their time and allows agents to monitor and reinforce progress and intervene early if compliance diminishes.

Distinct Reentry Phase

The pre-release phase differs from core clinical treatment. It focuses on the specifics of release planning, building a recovery support network, and coordinating clinical care transitions. Commitments are publicly announced, and clients are positively reinforced for completing milestones to increase self-efficacy prior to release.

Reentry Checklist #2: Core Programming and Structure

- ☐ **Active Roles for Clients:** Participants take on responsibilities and roles within the therapeutic community. Progress is rewarded by assigning leadership roles or mentorship responsibilities. Clients are introduced to ongoing recovery self-management tools.
- ☐ **Mentoring/Peer Assistance:** Programs engage clients to serve as mentors, navigators, or peer educators. Twelve-step and other recovery meetings with outside speakers are held at the facility. Mentor or coaching programs match reentering individuals with peers or volunteers in the community prior to release.
- ☐ **Dedicated Staff:** Specialized case managers, who are skilled in facilitating continuing community-based treatment, benefit enrollment, and reentry housing, serve as points of contact for providers, community corrections, and family members. They develop in-reach and referral contacts to serve the reentry population.
- ☐ **Mapping:** Programs use mapping templates to help clients produce visual representations of complex relationships, family and social support networks, reentry service plans, and goals (see resource section for specific examples).
- ☐ **Community partners:** Community partners are involved in the reentry phase. HIV and overdose prevention, parenting programs, and other community public and nonprofit agencies are included. Information sessions are held regularly, and partnerships with community SUD treatment providers are in place.

RSAT programs should be provided in flexible phases, based on participants having reached specified behavioral and recovery milestones.

—*Promising Practices Guidelines for RSAT*, p. 12

Pre-Release Phase

RSAT clients benefit from a distinct pre-release phase of treatment that allows enough time to focus on the specifics of transitioning from institutional to community-based care. Once clients have satisfactorily completed the core phases of treatment, practical reentry needs are addressed (e.g., housing, employment, healthcare), preliminary steps are executed, and progress is closely monitored as release dates approach. For jail programs where the duration of RSAT may be only 90 days, release planning is often integrated into treatment programming and higher levels of continuing care in the community, such as intensive outpatient treatment, may be required. Clients take primary responsibility for ensuring their release plans are sound with support from RSAT staff, peers, case managers, and other staff. Transitional

teams expand during this phase to include probation/parole, reentry navigators, peer recovery specialists, mentors, sponsors, employers, supportive family and friends, and faith and recovery community volunteers. Planning includes front-loading peer support and pro-social contacts to fill the critical initial days and weeks of reentry. Priority tasks scheduled for the day of release may include obtaining naloxone, getting identification, and enrolling in or reactivating benefits.

Reentry Checklist #3: Pre-release Phase

- ☐ **Identification of and Enrollment in Benefit Programs:** Clients eligible for benefit enrollment or reactivation undergo processes to ensure health care coverage upon release. In states without expanded Medicaid eligibility, other sources are identified, including publicly funded treatment, resources for treating OUD, programs for veterans or people with HIV/AIDS, and so on.
- ☐ **Behavioral Health Services:** Intake for community SUD and/or mental health treatment is arranged by phone or video conferencing when possible. Appointments are set and prescribers are in place for important medications. Medical homes, community case management, transportation, and other resources are coordinated.
- ☐ **Contact with Assigned Agent or Officer:** Processes are in place for planning and information sharing, client introductions, and pre-release two-way communication with community corrections staff who will be supervising the offender upon release. RSAT staff confer with post-release supervisors on release planning. (See below for more information on the role of community corrections staff.)
- ☐ **Child Welfare and Family Services:** Clients in need of pre-release family conflict resolution, child reunification planning, and parenting support are linked to child welfare services, visitation centers, domestic violence services, and child support offices. Supportive family members are involved, and clients may be linked to cultural or community groups that offer support in communities of release.
- ☐ **Linkages to Faith Community and Leisure Activities:** Chaplains are actively involved in cultivating welcoming congregations that offer faith-based supports such as family activities, fellowship, and general assistance. Drug- and alcohol-free pro-social recreational activities, recovery centers, and fitness or sports should not be overlooked.
- ☐ **Overdose/Relapse Prevention and Risk Reduction:** If overdose prevention and risk reduction education is not offered to RSAT clients in treatment, they are linked to community-based agencies that offer these services and access to naloxone for reentering clients with OUD. All clients require an overdose/ relapse risk-reduction plan.

- ☐ **72-Hour Plan**: Clients develop a detailed plan for the initial post-release period, which may include a pick-up and drop-off schedule, first contact with supervision and recovery contacts, initial aftercare sessions, attending to identification, benefit enrollment, or reactivation, and so forth. Transitional housing arrangements are finalized. Clients seek feedback from peers on release plans, and RSAT staff closely monitor progress.

> **Tool: The San Francisco Reentry Council 72 Hour Checklist** is a printable, one-page sheet, available online as part of ***Getting Out & Staying Out,*** the council's reentry resource website for people reentering San Francisco County from jails and prisons.

C. Transitional, Reentry, and Release **Conditions**

RSAT clients may be released to a variety of destinations and under different conditions, which has an impact on pre-release planning. They may be:

1. Transferred to a correctional halfway house, transitional housing/reentry unit, or minimum security work release facility;
2. Released to low-intensity, long-term residential treatment, a reentry program, or supportive housing (usually also under community supervision, but not when the following bullet is the case);
3. Released without criminal justice supervision when they have completed their entire sentence (maxed out); or
4. Released to the community under correctional supervision (probation, parole, or court supervision).

Transfer to Correctional Step-Down Facilities

Work release/minimum security reentry facilities or correctional halfway houses for low-risk offenders nearing release are typically part of state prison systems. Transitional housing offering less-intensive levels of supervision, opportunities to work at a job during business hours, and access to community-based treatment are ideal conditions for most reentering RSAT clients.

Some halfway houses or transitional housing programs (including federal reentry centers) are managed by contractors engaged by correctional systems. They usually provide guidelines for resident behavior, some (minimal) programming, case management, and collaboration with community or parole supervision while offenders reside there.

When reentry housing, supervision, and a degree of structure are provided, pre-release planning can focus on coordinating continuing clinical care needs, continuity, linkages to MAT providers as indicated, and engaging clients in planning for other priority needs. These can include employment, job training, expanding recovery support networks, and developing a solid relapse prevention and overdose risk

reduction plan. The reality is step-down programs and transitional housing slots are limited, and transfers may be contingent on timing and a host of other factors.

Note: Health care services for individuals living in minimum security/work release facilities or correctional halfway houses are not generally covered by Medicaid. As long as they involuntarily reside in a correctional facility, Medicaid cannot reimburse for most health care expenses. However, some state correctional systems and the federal system place reentering individuals on early release status or furlough them to correctional step-down facilities and halfway houses, which makes it possible for eligible individuals enrolled in Medicaid to obtain covered services in the community. Medicaid coverage is also available to reentering individuals released to home confinement or electronic home monitoring with an ankle device and anyone released under community supervision.

Release to Low-Intensity Residential Treatment, Supportive Housing, or Recovery Housing

Some RSAT clients can benefit greatly from low-intensity, long-term residential treatment programs upon release. These types of programs may be especially helpful to clients with long histories of heavy alcohol and drug use, IV drug use, and few or no periods of successful abstinence, with family and social networks primarily composed of people who use drugs. Publicly funded treatment systems generally offer halfway houses with stays ranging from 3 to 18 months. Most require residents to find employment within a certain timeframe, attend house meetings and groups, attend recovery meetings, and engage in appropriate levels of outpatient treatment.

Another option is “sober” or recovery housing, the oldest form of which is Oxford Houses. (See text box on next page.) Substance-free shared housing options that maintain a reliable recovery environment are increasing. These types of supportive housing environments offer vast advantages to RSAT clients whose only option in the past was renting a place at a local rooming house, usually in neighborhoods where drugs were rampant and they were exposed to other residents using drugs and alcohol daily.

New legislation signed into law in the fall of 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act for Patients and Communities, may increase the availability of sober living resources for reentering RSAT clients.

The law includes a provision supporting the creation of recovery housing standards. Several states have already developed recovery housing standards, and the Substance Abuse and Mental Health Services Administration (SAMHSA) recently posted draft National Recovery Housing Standards for public comment (White, 2019). These developments are likely to increase options for RSAT clients who do not have a stable, drug-free living situation awaiting them upon release.

Other types of transitional supportive housing programs may be available to RSAT clients who were homeless prior to incarceration or who are at high risk for homelessness, veterans, or people with mental or physical disabilities. (See housing section in Module IV for screening tools and additional resources.)

Increased Recovery Housing Options

Recovery Housing: This option offers low-cost, drug- and alcohol-free shared housing as a recovery support service and is distinct from residential treatment. Most recovery houses require an application process to ensure residents are working toward common recovery goals, such as abstinence. Generally, attendance is required at regular house meetings, as is compliance with resident rules and responsibilities. Recovery houses that function with a high degree of integrity offer advantages to reentering RSAT clients regardless of whether they are released under community supervision.

Guidelines and Certification: In 2019, SAMHSA posted draft proposed national recovery housing guidelines for public comment. Part of the SAMHSA definition of recovery housing reads: *"Recovery houses are safe, healthy, family-like substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long-term recovery"* (White, 2019). Some states have adopted certification processes that make recovery houses eligible to enter into contracts with criminal justice and addiction treatment divisions of state or local government.

Oxford Houses: In 1987, guidelines for self-managing, completely self-sustaining, and self-governing shared homes for recovering individuals according to the Oxford House model were codified, and the Oxford World Services Office was established. Since that time, groups of recovering individuals have secured charters for new Oxford Houses, which are shared rented houses in decent neighborhoods. An online national directory lists Oxford Houses in every state, the date each house was founded, its address, a picture of the property, and its capacity and current vacancy information. Link to Oxford House directory: https://oxfordhouse.org/userfiles/file/house-directory.php

Reentry Checklist #4: Transfer to Step-down Facilities—Preliminary Planning

- ☐ **Arrangements for sharing client information,** including medical records covered by the Health Insurance Portability and Accountability Act (HIPAA), are in place, and releases in accordance with 42 C.F.R. Part 2 are signed by the client, with copies provided to receiving facilities.
- ☐ **Conferral with the receiving facility** includes communication with RSAT program staff and the receiving facility's case management staff, at minimum.
- ☐ **Contact with community corrections** has been made if clients released or transferred are under supervision and the assigned agent or officer is involved.

- ☐ **Additional family/community/recovery supports** and the steps clients will take to expand them are emphasized in release plans to discourage dependence on solely what the step-down facility provides. Family and children's services are available for visitation and/or preparation for reunification.
- ☐ **Structured activities,** such as job training and readiness programs or education, are part of the client's plans.
- ☐ **Permanent housing** and options for where clients plan to live once they leave transitional housing are included in the clients' plans.
- ☐ **Clinical care** providers for SUDs and mental health and medical services are in place. Prescribers are identified so clients can continue all medications without interruption, including those for substance use and mental disorders. Community health care is arranged if receiving facilities do not rely on correctional healthcare.
- ☐ **Enrollment in benefits** for which reentering clients qualify, reactivation of benefits, or application for any programs subsidizing clinical care has been planned or completed.
- ☐ **Transportation** to work, community corrections reporting, treatment-related activities, appointments, visitation, and support groups is discussed with the receiving facility.

The Shea Farm minimum-security work release facility serves women reentering from the New Hampshire State Prison for Women. It is in a rural area with one road leading to the nearest bus stop, a two-mile walk that is quite dark and fairly deserted at night. Women returning from work in the evening reported incidents of harassment and being followed. The facility collaborated with the local domestic violence coalition to provide donated cell phones that only connect to 911 for emergency calls for women working in the community to carry with them in the evening when they returned to the facility.

Release Directly to the Community Without Correctional Supervision

Although a majority of RSAT clients are released under community supervision, most programs report that some proportion of clients reenter after completing their entire sentence. This segment of clients may include offenders returned due to parole violations (often related to drug use) or others serving their entire sentence for various reasons. Pre-release planning for these clients can be more challenging, although nearly all items on checklist #3 (pre-release phase) still apply, as does much of the information that follows on coordinating community-based services. However, additional supports can benefit motivated RSAT clients reentering the community directly. In some cases, RSAT programs may decide that priority should be given to clients released without supervision when openings are available.

- Mentoring programs
- Recovery coaching
- Reentry programs
- Recovery housing
- Other supportive housing
- Faith-based reentry supports
- Education, job training, and placement programs

Examples of Mentoring Programs and Resources

The Second Chance Act supports state, local, and tribal government efforts to reduce recidivism and offers reentry mentoring programs for juvenile and adult offenders. Programs match participants with mentoring prior to release, arrange regular post-release meetings, incorporate evidence-based practices, and formalize agreements with correctional systems.

The Connection offers the award-winning Reentry Assisted Community Housing and Mentoring (REACH-M) program. It incorporates peer mentors who provide pre- and post-release support, as well as transitional housing and case management for offenders referred by the Connecticut Department of Corrections (DOC).

Colorado DOC Re-Entry Mentors are matched with offenders during incarceration and continue to mentor them upon release to promote community support and involvement, providing a continuum of care to help with successful reintegration into the community.

Career Solutions' Community Offender Reentry Program in Minnesota incorporates e-mentoring to offer one-on-one and group post-release mentoring to participants released to rural areas. Virtual mentoring allows participants to send emails, instant messages, or texts to mentors via an online platform and offers at least one phone or video conference mentor meeting for 16 weeks post-release.

It is even more critical to facilitate benefit enrollment; connect these RSAT clients to reentry resource centers in their community of release, harm reduction coalitions, and overdose prevention programs; and to ensure they have access to case management services. In some cases, Medicaid can provide certain case management or peer support services. RSAT staff can also determine if these clients qualify for reentry supports or programs provided for veterans, people with disabilities, people living with HIV/AIDS, people with serious mental illness, people with a severe SUD or OUD, or people at risk for homelessness.

The main component that will differ for many of these clients is the level of clinical SUD services that will benefit them, which is discussed in detail in the next module. Residential programs and halfway houses may be a good option for those with long histories of heavy drug use, especially if they have been incarcerated for long periods.

The duration of such programs is probably more important than the intensity.

Supports that can be put in place pre-release and offer these clients structure and connections with others in the community and help them navigate social and clinical service systems are beneficial, along with peer recovery support.

Treatment planning for people with substance use disorders who are reentering the community should include strategies to prevent and treat serious chronic medical conditions such as HIV/AIDS, hepatitis B and C, and tuberculosis, as well as overdose prevention.

—*Promising Practices Guidelines for RSAT*, p. 13

D. The Role of Community Corrections in Release Planning

*Release to the **C**ommunity **U**nder **C**orrectional **S**upervision*

Reentry planning for RSAT clients supervised upon release requires considering the differences between probation and parole. Working with probation and parole on pre-release planning is an essential element of reentry success. Programs employ a wide variety of strategies to accomplish this task.

Both probation and parole can contribute to rehabilitation and ensure public safety by providing appropriate levels of supervision and coordinating and monitoring participation in evidence-based interventions or programs that address identified criminogenic risks and needs. The needs of reentering RSAT clients on probation and parole are often similar. At minimum, they include continuing clinical care for SUD (at varying levels of intensity and duration), recovery supports, transitional housing, and employment. Subsets of RSAT clients will need additional community-based clinical care for co-occurring mental health disorders, medication management, MAT, and continuing care for chronic health conditions (discussed in detail in the next module).

Probationers are generally charged with or convicted of a criminal offense but released to the community under supervision in lieu of incarceration. Those who spend time in jail may be

- Awaiting trial, often due to financial inability to post bond. Unfortunately, in such cases, logistics can prevent them from accessing substance abuse treatment in custody or in the community.
- Sentenced to a short period in jail after they are convicted of an offense. Maximum sentences served in jails vary among jurisdictions.

In some cases, individuals with SUDs on probation for low-level offenses end up in jails due to technical violations of probation conditions (e.g., multiple positive drug screens). This is especially common among women offenders.

An Essex County, Massachusetts, pilot project with the jail and the Office of the Commissioner of Probation placed a probation officer inside the jail to work with reentry staff.

Illinois' Sheridan Correctional Center has contracted dedicated case managers and employment specialists who come into the prison to help staff and incarcerated individuals with pre-release and reentry planning.

Massachusetts DOC mandates "continuity of care" for individuals released from custody, with follow-up consistent with the recommendations of the treatment plan.

Shelby County, Tennessee, plans to screen individuals released to community supervision to determine if they can benefit from referral to a peer navigator to help them access services.

Erie County, New York, intends to pilot opioid-specialized probation caseloads of no more than 30 to closely monitor participation in treatment before participants transition to regular probation supervision.

The City of Longmont, Colorado, uses peer case managers and transportation assistance and has six dedicated Housing First units for justice-involved individuals at high overdose risk who are experiencing homelessness.

Probationers who complete RSAT programs have most likely spent more than 3 to 6 months in jail, as programs last a minimum of 90 days in jail settings. Detainees and sentenced offenders with SUDs are generally expected to continue to engage in treatment and aftercare services as a condition of release while under community supervision. The agency that ultimately oversees compliance with release conditions is the court that mandated a period on probation, and the court determines punitive sanctions—which may include time in jail—for technical violations.

While less time away from the community can benefit probationers, in some cases it also makes it easier to resume associating with peers who use drugs or are involved with drug-related criminal activities and influenced by the same antisocial conditions that led to arrest or prosecution. According to SAMHSA (Center for Substance Abuse Treatment [CSAT], 2005b), the challenge for probationers isn't necessarily reintegration, but rather behavioral changes and new ways of reacting to the same negative influences that confronted them in the past. Case management and planning

If individuals will be under correctional supervision upon release, the RSAT program should collaborate with probation/parole workers to incorporate aftercare treatment and services.

—Promising Practices Guidelines for RSAT, p. 26

should anticipate these challenges and offer alternative pro-social community supports to counter such influences.

Parolees released from state (or federal) prisons have usually spent significant time away from the community. They are generally more seasoned offenders who may present greater public safety risks. Reentering RSAT clients leaving state prisons on parole generally have spent a minimum of 6–12 months in treatment. The prison system is the agency that oversees their compliance with conditions of release and determines if technical violations while under community supervision will result in a return to prison or other punitive sanctions. The graphic below demonstrates that both justice supervision and participation in treatment have the greatest effect on reducing recidivism for adult offenders.

However, parolees' extended removal from society in comparison to probationers often requires more comprehensive pre-release planning and additional services to help with reintegration back into the community. A common challenge for parolees is the absence of pro-social contacts and activities.

Desistance is defined as ceasing to engage in criminal behavior, which implies lifestyle changes at a deeper level than what is required to simply avoid criminal justice involvement. Research consistently points to strong predictors of desistance such as:

- Informal networks of pro-social support
- Identity transformation: a sense of belonging distinct from a criminal history
- Involvement in gainful employment, job training, and/or educational pursuits (Uggen, Wakefield, & Western, 2005)

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

—*Promising Practices Guidelines for RSAT*, p. 9

This suggests critical thinking skills, exposure to new ideas, and social contacts outside of the networks common to offenders with extensive criminal histories help change how clients think of themselves. They adopt a new view of the world around them and other people. Identity transformation also appears extensively in recovery literature—abandoning the "addict" identity in favor of a recovering identity (Borrelli, Mantori, Kaar, Kelleher, & Bell, 2017).

Helping reentering individuals develop a vision of life in the community that is no longer centered around criminality and substance use is an important step in rehabilitation. It is especially important to establish connections to recovery activities, employment, and education for parolees who have been away for long periods (McDaniel, 2014). This provides opportunities to make new connections and develop aspects of an identity distinct from substance use and incarceration (Veysey, Christian, & Martinez, 2009).

Selection and Training of Community Corrections Officers

Like their counterparts in jail or prison settings, community corrections officers have traditionally seen themselves primarily in a control or monitoring role (Clear & Dammer, 2003). The objectives of RSAT aftercare require community corrections officers to fully embrace their dual roles of supervision and rehabilitation in order to develop positive, consistent working relationships with offenders based on common goals (Vera Institute of Justice, 2013).

Correctional officers with specific training and interest in working with RSAT programs should be assigned to RSAT pods.

—*Promising Practices Guidelines for RSAT,* p. 15

This rehabilitative approach is only possible when officers fully embrace the fundamental premise that addiction is a disease that can be treated with evidence-based interventions (Marlowe, 2003). A high degree of motivation is required to motivate others, a skill the job continually entails. This allows probation and parole officers to act as strong recovery champions for the individuals they supervise, and in some cases, their only recovery champion during the early days and weeks post-release.

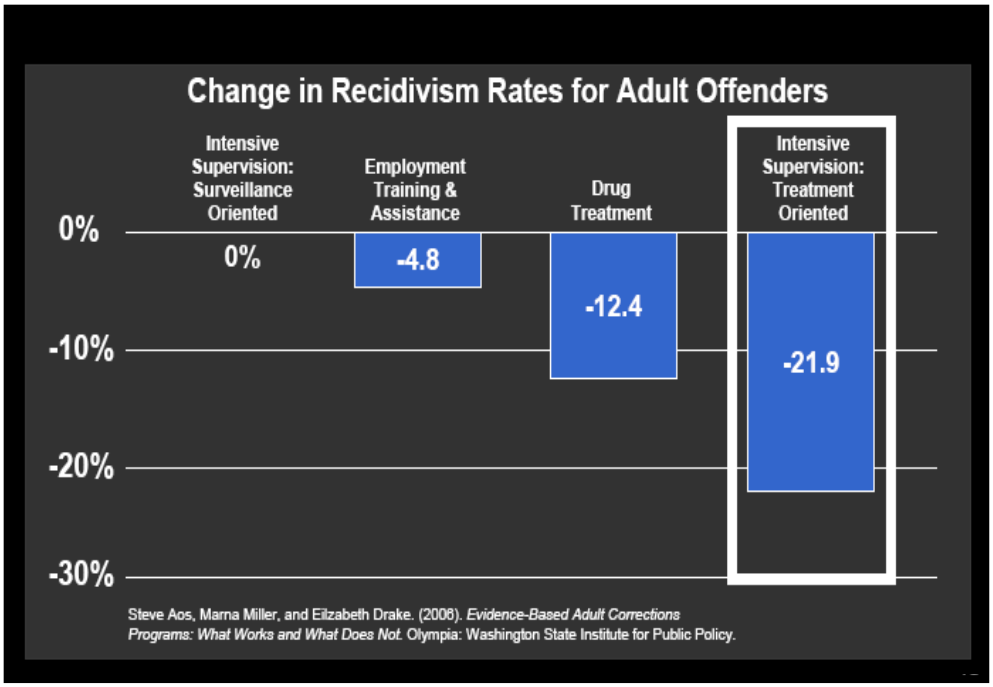
Illinois Department of Corrections (IDOC) created a team of parole agents who volunteer to supervise individuals released from Sheridan Correctional Center, the facility housing the RSAT program. They are trained in the science of addiction and reentry case management for RSAT graduates. The **Addiction Recovery Management Services Unit** (ARMSU) provides extensive training and clinical supervision to IDOC staff, vendors, and contractors and staff of collaborating local and state agencies relevant to addiction and recovery. ARMSU is also responsible for monitoring substance abuse programs within IDOC, providing oversight to enhance program development and serving as a liaison between corrections and other community and state agencies.

The Utah DOC Drug Offender Reform Act (DORA) Program offers specialized probation under DORA to qualifying offenders with SUDs who are within 90 days of probation. It provides funding for expedited access to treatment and supervision teams consisting of trained agents and addiction professionals. It provides funds to Utah DOC and other entities in Utah to "offer expedited treatment to qualified offenders."

Ideally, probation and parole officers supervising RSAT clients transitioning back to the community have an interest in working with this population. Just as correctional officers working in prisons and jails who volunteer for RSAT assignment act as role models and become a unique asset to the program, probation and parole officers are a primary, vital asset for reentering clients in recovery. Officers selected to supervise such caseloads place an emphasis on the "three-legged stool" that is foundational to

success in the community: recovery, rehabilitation, and reentry supervision.

In addition, to buy into a belief that treatment and supervision contribute to public safety, specialized training is required. Like their counterparts in jails and prisons, community corrections professionals benefit from training on the science of addiction, risk-need-responsivity theory, and effective SUD treatment practices for justice-involved individuals. These include, but are not limited to, MAT for alcohol and opioid use disorders, integrated treatment for post-traumatic stress disorder (PTSD) and other co-occurring mental health disorders, motivational interviewing techniques, and cognitive behavioral interventions (Gendreau, French, & Taylor, 2000). It is critical to brief community corrections staff and keep them up to date on the structure of RSAT programs and the interventions employed to facilitate continuity of care. Supervision staff require and quickly develop an ongoing deep knowledge of reentry support services in their communities, as well as any changes and additional resources that become available. They are familiar with community providers that can deliver appropriate, effective programming.



Most of the training topics mentioned above are important for all community corrections staff. Regardless of supervision approach or caseload composition, the proportion of the justice population dealing with substance abuse problems far exceeds the capacities of RSAT programs and other SUD interventions available in custody. Given the impact of the opioid crisis and its potentially fatal consequences, especially for the reentry population, many local and state justice systems are providing specific training on overdose response, naloxone administration, safe handling procedures of substances at found at the scene of an overdose, and collaboration with local emergency response initiatives.

Providing Naloxone Pre-release: North Carolina Harm Reduction Coalition

The North Carolina Harm Reduction Coalition (NCHRC) is a national leader in advocating for naloxone access, offering support and technical assistance (TA) to justice and law enforcement professionals implementing overdose prevention programs at national and state levels. They also offer in-reach overdose prevention education in North Carolina state prisons and local jails. Upon request from a reentering individual who has participated in overdose training in custody, NCHRC sends a volunteer to meet them at the gate on the day of release to provide them with a naloxone kit. Other examples of correctional overdose prevention in-reach providing naloxone kits pre-release to at-risk individuals include the New York State Prison System, San Francisco jails, the Rhode Island Correctional System, the New Hampshire Strafford County Jail, the Cook County jail in Chicago, and the entire Scottish correctional system, to name a few.

Preliminary Steps

All community corrections staff and officers need to be notified of individuals on their caseload with an identified OUD and remain vigilant of the high overdose fatality risk they face upon release. According to the Binswanger study (Binswanger et al., 2007) of formerly incarcerated individuals in Washington State, mortality rates for state prisoners during the first 2 weeks post-release were 13 times greater than mortality rates of other state residents. Moreover, the formerly incarcerated group had 129 times the risk of dying of a drug overdose during the immediate post-release period than similar demographic groups composed of other state residents.

Checklist #5: Relapse Prevention and Overdose Risk Reduction

Plans for relapse prevention and overdose risk reduction are in place prior to release and, at minimum, include the following:

- ☐ Naloxone kits (provided just prior to or on the day of release)
- ☐ Frequent monitoring and drug screening by community corrections and/or treatment providers
- ☐ Education on how changes in tolerance increase post-release overdose risks and on avoiding other high-risk use behaviors that increase fatality risks
- ☐ Education on the increased overdose risks of combining substances, different types of opioids, or taking them with benzodiazepines, alcohol, or other central nervous system depressants
- ☐ Education on the life-threatening aspects of alcohol withdrawal and contacts for medically managed detox in the event of a return to a period of drinking
- ☐ Overdose prevention/response/risk-reduction education (reducing high-risk use, recognizing/responding to overdoses, local emergency contacts, and how to obtain and administer naloxone)
- ☐ Contact information and/or warm handoffs to harm reduction agencies, syringe

exchange programs, and overdose prevention coalitions

- ☐ Contact information and/or warm handoffs to community recovery support agencies
- ☐ Information on the benefits and risks of all types of MAT and how to access MAT providers
- ☐ Maps of recovery support networks, with steps reentering clients will take to expand them
- ☐ A listing of people who could threaten their recovery, rehearsal of refusals skills, and steps to make contact less risky

(See RSAT Relapse Prevention/Overdose Risk Reduction Manual for more information.)

Collaborative Reentry Planning

The RSAT pre-release phase requires the offender's active participation and involves other key stakeholders: correctional officers, clinical staff, case managers, community treatment providers, peer recovery coaches, community corrections officers, family members, mentors, sponsors, and others. Creating a plan requires facilitating collaboration between the supervising community corrections officer and RSAT and other facility staff, as well as community providers of clinical, rehabilitative, and recovery services and supports. Comprehensive plans address criminogenic, clinical, and practical needs (e.g., employment, housing, transportation, and peer support) to increase the likelihood of successful reintegration and continued recovery.

Results of pre-release assessments are shared with community corrections officers to inform them of the progress RSAT clients have made, levels of motivation, and to help them address identified reentry risks and needs through supervision, community services, and supports.

RSAT programs and community corrections need to establish agreements to facilitate information sharing with community-based treatment providers that comply with confidentiality laws pertaining to clients with SUDs. Client forms for consent to release information pertaining to SUD treatment designate with whom information can be shared, the specific types of information to be shared, and a time period for which the release is valid. For example, a report from an addictions counselor does not need to include information about other health issues or details of what is discussed in sessions. Providers only need to verify attendance/compliance and progress toward recovery goals.

Case Management and Warm Handoffs to Community Care

Case management provides a standardized framework for community corrections officers to integrate public safety and rehabilitation concerns. Throughout this process, the client remains an active participant in risk reduction. The National Institute of Corrections (NIC) describes case management as an integrated reentry process from the point of justice system admission to discharge. For reentering RSAT clients,

community corrections officers facilitate the planned transition from correctional to community-based treatment. This is intended to maximize the progress achieved through a continuum of aftercare and recovery support services. Community corrections officers also focus on risk reduction through case management by addressing criminogenic factors such as antisocial peers and criminal thinking errors. In some areas, a community agency may provide case management services to work collaboratively with community corrections and the client. (See the description of the Treatment Alternatives for Safer Communities [TASC] model below.) When such services do not exist, the community corrections officer will have to take a more active role in fulfilling these case management needs.

Pre-and post-release case management systems should be included in RSAT programming to help support a smooth transition to the community.

—Promising Practices Guidelines for RSAT, p. 25

Traditionally, probation and parole officers were assigned cases based on geographic or other convenient criteria. They generally had primary responsibility for supervision of diverse releasees, regardless of case management skills and varying levels of risks and needs among their caseloads (Clear & Dammer, 2003). This resulted in wide disparities in the quality and quantity of case management reentering offenders received. As caseloads increased and correctional systems began to consistently identify reentering individuals with high levels of specialized needs, it became clear more flexible models were required. Efforts to decrease recidivism required restructuring responsive supervision to effectively address the needs of the diverse reentry populations released to various communities. Some jurisdictions have specialized, limited caseloads made up of high-risk offenders with specific needs such as those with co-occurring disorders (CODs) or OUDs. Supervising officers may have specialized addiction and/or mental health training.

Caseloads for community corrections officers working with RSAT clients primarily include offenders who are at high risk for recidivism and require higher intensity supervision to remain compliant, particularly during the initial post-release period (Rapp et al., 2008). A collaborative transitional case management model developed to support community reintegration includes three stages (Prendergast & Cartier, 2008).

1. Clients finalize primary reentry goals at least 2 months pre-release.
2. Within a month prior to release, a case conference includes the supervising officer and key resources for transition to the community are put in place.
3. Regular post-release meetings with the supervising officer ensure compliance and continued adequate community supports and services.

Research also shows supervisees with an SUD require interactions with community corrections officers that include a specific focus on maintaining recovery and abstinence (Hawken, Davenport, & Kleiman, 2014). NIC recommends corrections officers act as “change agents,” reshaping behaviors by implementing case

management plans linking clients to services that effectively address identified needs (2004). An important aspect of success is motivating the client to actively engage in the process and progressively assume a greater share of responsibility for his or her recovery throughout each encounter (Aos, Miller, & Drake, 2006).

Despite the focus on addiction treatment, case planning must take into account other clinical, mental, and physical health care needs; criminogenic risks and needs; and the practical aspects of housing, transportation, employment, and job training—to name a few. Unmet post-release needs can become significant obstacles to maintaining recovery. Community corrections and RSAT staff can pre-emptively identify needs and begin the process of linking individuals to available community services prior to release.

The TASC Model

The TASC specialized transitional case-management model is tailored to justice-involved individuals. It combines clinically focused, multisystem service coordination with treatment placement and recovery management to promote a focus on building wellness and self-sufficiency. Individuals begin to manage their health conditions while learning to navigate complex public systems. The primary impacts are reduced incarceration of people with behavioral health conditions, reduced recidivism, increased health and recovery, and increased safety and satisfaction among crime victims. Components of the TASC case-management model include

- *Identification, Screening, and Assessment:* Clinical screens and assessments identify the nature and extent of clients' needs. Additional measures evaluate clients' strengths and natural supports to help facilitate appropriate levels of treatment and services. Drug testing may be used to determine clinical service needs, set a standard of accountability, and provide baseline information on the clients' drug use.
- *Recommendations and Service Planning:* Case managers recommend and prioritize services to meet their clients' needs and fulfill the conditions of release. Service plans may include SUD treatment, vocational/educational resources, medical/mental health services, domestic violence programs, and so forth. Clients play an active role in the planning process. Client strengths are an important factor, as is personal accountability.
- *Service Referrals, Linkage, and Placement:* Clients' unique service needs are matched with community-based resources. Case managers schedule intake appointments, share appropriate information with providers, transport clients to services as needed, follow up to ensure successful engagement, and make referrals for ancillary services across multiple systems, sectors, and levels of intensity.
- *Ongoing Monitoring, Reporting, and Service Plan Adjustments:* Case managers build relationships with clients to motivate ongoing engagement in treatment and other services. They keep in regular contact with providers to monitor progress,

which is routinely reported to referral sources. Drug testing may be incorporated. This allows for prompt reassessment, plan revisions, and early intervention in critical situations. Incentives, sanctions, or therapeutic adjustments are clinically guided. Individuals gradually begin to manage their own health.

- *Education and Advocacy:* Case managers advocate and negotiate with a variety of public systems on behalf of clients. TASC's court/probation and community reentry case managers help clients handle justice system requirements (e.g., court dates, parole appointments), practical obligations (e.g., identification, childcare), and the stigma of justice system involvement that can contribute to individuals dropping out or being dismissed from treatment.

Sanctions and Rewards

RSAT clients start their recovery in a controlled environment in prison or jail. The challenge upon release is to maintain recovery in the community, where they are exposed to many environmental cues that can trigger a desire to return to drug or alcohol use. It is important for corrections officers and treatment staff to have realistic goals and offer rewards that support achievement of these goals. Sanctions are also important when clear expectations are not met (Gendreau, Goggin, Cullen, & Andrews, 2000). It is recommended that rewards outnumber sanctions by four to one (Vera Institute of Justice, 2013), just as in RSAT programs. That may not always be possible. However, all clients can develop a pre-release relapse prevention plan that includes the steps they intend to take to get back on course should they have an episode involving a return to substance use.

Anticipated consequences following a relapse are a key element of any pre-release plan. For clients released to community supervision, the supervising agent clarifies the specific consequences at the pre-release case conference. Individuals who have high criminogenic needs have a lower likelihood of maintaining total abstinence. However, other factors, such as compliance with treatment, and interim steps, such as increased reporting, may be considered before sanctions are applied. This is especially important for RSAT clients who are motivated and compliant but may have a limited number of short episodes of substance use upon release. Graduated sanctions, along with involving the client in identifying the adjustments they need to make and enlisting the support of clinical care providers, can often stabilize such situations (Yeres, Gurnell, & Holmberg, 2005).

Case Management Models

Case management in custody: Some RSAT programs include dedicated case-management staff, but typically case management in custody is a shared responsibility between RSAT staff and correctional case managers or, in some cases, designated reentry case managers. RSAT staff can provide important information on the level of ongoing clinical care and other critical supports and services reentering clients will need. However, correctional case management stops on the day of release. RSAT clients continue to require varying degrees of case management upon reentry.

Transitional case management: These types of case-management services offer a distinct advantage since they reach into custody settings pre-release and extend into the community post-release. Clients have pre-release contact with case managers who they will work with upon reentry and who will already have some understanding of their needs and can begin to put key services and supports in place, arranging intake via video or phone conferences with community treatment providers prior to release. They also have more contacts among community providers.

Community case management: These types of services are almost exclusively available to people receiving community-based care, except for certain agencies that offer limited in-reach to clients nearing release. However, these services can be very helpful during reentry, especially for clients who are not released under supervision. SUD treatment programs, mental health centers, youth and children's services, the Veterans Health Administration, and HIV/AIDS service providers are among the agencies that offer them. Medicaid may cover certain case management services.

Community Partnerships *(Leveraging Existing Resources)*

Community treatment capacity may be unknown, under-resourced, or, in some cases, underutilized. Both RSAT programs and community corrections cultivate relationships with community service providers. Continuing care for SUDs is an obvious aftercare priority; however, not all treatment providers are eager to admit reentering individuals with criminal records, particularly those with a sexual offense history or COD and take medications for one or both disorders. (This is sometimes the case with low-intensity residential programs.) As a result, establishing partnerships with providers willing to accept individuals on community supervision and cultivating new relationships with potential partners is key to leveraging community resources.

Once potential providers are identified, face-to-face meetings with RSAT and/or community corrections staff can help clarify expectations and ensure providers have the capacities to meet them. Key considerations include wait list length, options for pre-release intake, intensity and duration of services, types of interventions, and arrangements for regular reporting and sharing of protected health information (in accordance with HIPAA and 42 C.F.R. Part 2). The conversation should cover capacities to address CODs and information about the provider's own referral

networks (where they regularly send clients for additional services), as well as payer sources accepted. The results of these agreements can be clearly defined in a memorandum of understanding (MOU) at the agency level and help to inform post-release treatment planning at the individual level. All parties, including the client, should understand the consequences for noncompliance with treatment plans from both provider and supervision perspectives.

Community corrections staff, RSAT staff, providers, and other stakeholders commonly work together, informally or through local reentry councils, to create resource guides that include up-to-date information on availability of slots in residential and outpatient treatment programs to facilitate prompt intake upon release.

Challenges and Considerations

It is important for RSAT programs to consider the capacity of the community corrections agencies they work with regarding collaboration on pre-release planning and aftercare. A study by the Vera Institute of Justice in 2013 highlighted the varying capacities, resources, and mandates of community corrections agencies. Some jurisdictions have just begun to work with policymakers and stakeholders on restructuring the functions and objectives of community supervision to reduce reliance on incarceration while improving public safety. These agencies may not currently have the capacity to integrate specialized supervision for RSAT clients into their operations. These considerations are important to ensure expectations are realistic and collaborative relationships between community corrections and RSAT programs continue to expand in concert with their capacities.

Module III: Continuity of Clinical Care

A. Paving the Way for Access to Clinical Care upon Reentry
B. Peer Support, Peer Recovery Services, and Recovery Capital
C. Levels of Care/Patient Placement Criteria Applied to Reentering Residential Substance Abuse Treatment (RSAT) Clients
D. Medication-Assisted Treatment (MAT) Continuity of Care

Learning Objectives

After completing this module, participants will be able to:

1. List the components RSAT programs can put in place to ensure reentering clients can access needed services.
2. Describe the difference between peer support and peer recovery support services.
3. Specify the American Society of Addiction Medicine (ASAM) level of care offered by their RSAT program and the different levels of community-based care that meet the needs of most reentering clients.
4. Describe the phases of MAT and the referral process for reentering clients continuing or initiating MAT.

A. Paving the Way for Access to Clinical Care upon Reentry

RSAT pre-release planning is a collaborative process aimed at preparing clients for transition from correctional to community-based clinical care for substance use and co-occurring mental health disorders. This involves some level of ongoing care management. RSAT staff of in-custody programs play a diminished role as soon as clients are released from facilities. However, RSAT programs can pave the way for access to appropriate levels of ongoing post-release clinical care through collaboration with community corrections, the courts, addiction and mental health services, and other community systems of care. This often involves handing off care coordination to the lead agency best suited to navigate and manage individuals' ongoing post-release clinical needs.

The National Reentry Resource Center (NRRC) offers information on a variety of topics that inform pre-release planning, including reentry programs, housing opportunities, criminal record expungement, and employment programs. The NRRC also offers information on the collaborative comprehensive case plan model for managing criminogenic risks and needs and behavioral health needs, which guides Second Chance Act grant–funded programs and Justice and Mental Health Collaboration Program (JMHCP) grantees and has been helpful to many local and regional reentry initiatives. The model offers information on how corrections can contribute to post-release planning frameworks for various lead agencies, including:

- Community supervision (e.g., probation/parole, reentry courts);
- Substance use disorder (SUD) treatment providers; and
- Mental health service providers.

Considerations determining which agency serves as the lead for ongoing care coordination include transitional, reentry, and release conditions; level of supervision and monitoring; and the degree and types of clinical care reentering RSAT clients initially require. The NRRC offers two additional release planning tools.

- Reentry Services Directory—The directory offers a national listing of statewide and local reentry resource guides, councils, services, programs, and initiatives.
- National Criminal Justice Initiatives Map—The map lists past and present recipients of federal funding related to recidivism reduction and reentry in all states and U.S. territories. Additional information on various reentry-related services, policies, resources, and advocacy groups are listed in Module IV.

Health Coverage

To incentivize providers to participate in an aftercare referral network, RSAT staff can enroll reentering clients in health benefit programs by working with community corrections, the state alcohol and drug services agency, the local Social Security office, the state Medicaid office, and behavioral health systems and providers. Many statewide efforts have developed processes to meet the goal of coverage upon release for reentry populations. Most of the 38 states with expanded Medicaid eligibility, either under the Affordable Care Act (ACA) or through a Centers for

Medicare & Medicaid Services (CMS) waiver program, offer suspension for Medicaid beneficiaries in custody.

Individuals who were enrolled prior to entering a correctional facility may be able to seamlessly reactivate Medicaid coverage upon release. When case management staff inside and outside the facility work together to assist reentering clients with this process, post-release clinical care needs are more likely to be met.

- In 34 states and in Washington, D.C., Medicaid benefits are suspended for the duration of time spent in custody (Bryant, 2019).*
- In approximately 17 states, suspension is time limited, for periods ranging from 30 days to 2 years.
- In the remaining Medicaid expansion states, individuals must re-enroll upon release, even if they were enrolled prior to incarceration.
- Suspension is an option in 13 non-expansion states where most single adults are not eligible for Medicaid, and generally, low-income pregnant and parenting women and individuals with disabilities qualify for coverage upon release.

*Note: Even in states that suspend Medicaid for the duration of time in custody, Medicaid eligibility may be subject to review every 12 months.

RSAT participants should be screened for their eligibility for Medicaid—and any other health insurance or public benefits—and should receive education on basic health care literacy.

—Promising Practices Guidelines for RSAT, p. 27

The pages that follow offer information on other options to help RSAT clients who do not qualify for Medicaid access receive continuing care upon release. Many RSAT clients, especially those in prison-based programs who have been in custody for long periods, may have never had health coverage. They need screening for Medicaid eligibility, assistance with enrollment, and general health insurance literacy education. Most of these clients will fall into one of the following categories:

1. They have never enrolled in Medicaid but may meet expanded eligibility criteria upon release.
2. They live in a state that has not expanded Medicaid eligibility and will not qualify for benefits upon release.
3. They will have private insurance or health coverage through their employer or spouse upon release.
4. They live in a in a state with expanded Medicaid eligibility, but their income upon release will exceed limits, making them ineligible.*

*CMS research shows 60 percent of people in prison had incomes below 133 percent of federal poverty level prior to arrest; most are unlikely to exceed Medicaid income limits upon release (Medicaid and Children's Health Insurance Program [CHIP] Coverage Learning Collaborative, 2015).

Medicaid coverage of SUD services for juveniles: Traditional Medicaid/Children's Health Insurance Program (CHIP) covers eligible children and youth under the age of 18 in *all states*. Medicaid is mandated to cover SUD screening, assessment, and appropriate treatment for youth who meet SUD criteria. In states with expanded Medicaid eligibility, youth over 18 living independently who meet eligibility criteria may qualify for and apply for Medicaid on their own. They can also remain on their parents' health care plan until their 26th birthday, even if they are not dependents.

Some states offer additional coverage options for juveniles seeking treatment for SUD. For example, Medi-Cal (California's Medicaid program) allows juveniles between the ages of 13 and 17 to access certain health services without parental consent, including SUD treatment. They can obtain covered treatment services without parental consent even if their family is not Medi-Cal eligible or has private insurance. In these cases, the juvenile does not receive full coverage for all health care but can receive confidential SUD treatment at no cost.

A new law (detailed in the text box below) applies to all youth under the age of 21 who become "inmate[s] of a public institution" after October 2019. The law requires jails and prisons to move to restore Medicaid eligibility prior to release for all persons under 21—not just RSAT clients—for whom continued access to clinical care and medications is critical. However, RSAT programs can set the standard by ensuring their institutions are in compliance and by applying the same pre-release eligibility redetermination and restoration protocols to all reentering adult RSAT clients.

Pre- and Post-Release Enrollment Support

In 2016, a Centers for Medicare & Medicaid Services (CMS) letter to all state health officials offered guidance on facilitating Medicaid enrollment for people in custody. Although Medicaid typically does not cover healthcare services provided to individuals in custody (with limited exceptions), CMS emphasized nothing prohibits enrolling eligible individuals in Medicaid while in custody. State and local correctional systems have implemented Medicaid eligibility screening protocols and procedures to either enroll individuals prior to release (or reactivate benefits) or to facilitate enrollment on the day of release (or reactivation).

> In the fall of 2018, a new provision of the ***SUPPORT Act for Patients and Communities*** was signed into law, providing protections for at-risk youth enrolled in Medicaid. Under the new law, states cannot terminate Medicaid benefits for eligible juveniles (defined as under the age of 21) who are "inmate[s] of a public institution." Medicaid coverage can be suspended for juveniles upon entry into custody (as of October 2019), but the law requires a pre-release eligibility redetermination and restoration of coverage upon release for all individuals under 21 who continue to meet eligibility requirements.

In some states, Medicaid offices assist with this process. States can also designate correctional facilities to conduct eligibility screening and temporary ***presumptive eligibility*** enrollment. Community-based treatment providers with established referral and intake partnerships with correctional facilities may also assist with presumptive

eligibility enrollment for individuals who will be clients post-release. This process can streamline coverage and ensure it is in effect at release. Individuals can also designate a representative to facilitate Medicaid enrollment on their behalf. Some nonprofits promote pre-release Medicaid enrollment for eligible individuals through in-reach and outreach programs. The matrix below can help RSAT programs organize the enrollment process and ensure responsibilities are outlined clearly.

Pre-Release Planning Benefits Matrix

Action	Responsible Staff	Tasks	Partners
Screen for health and behavioral health needs.		Align screening and assessment tools and processes.	
Screen pre-sentence population benefits and eligibility.		Implement a system for flagging and notifications.	
For SSI, track release dates and ensure reactivation upon release (also SSDI). Plan for new applicants.		Develop pre-release agreement with Social Security office; refer reentering clients to nearest local office; provide release documentation.	
Arrange to exchange information with Medicaid, Social Security, and providers.		Research electronic health record transmission, finalize releases and data sharing processes.	
Assist prisoners with pre-release or day-of-release health benefits applications.		Transmit applications to Medicaid; refer to enrollment support upon release.	
Identify diversified payment strategies.		Work with SSA to locate treatment resources; flag vets, people living with HIV/AIDS, etc.	
Expedite Medicaid benefits through presumptive eligibility		Develop pre-release agreements with state Medicaid office and providers.	
Ensure clients have a valid ID prior to release.		Contact state motor vehicle or non-driver ID resources.	
Facilitate use of benefits.		Develop client education on basic health insurance literacy.	
Build and enhance community partnerships.		Attend and convene provider summits; conduct active outreach.	

Michigan: Oakland Livingston Human Service Agency (OLHSA) is a nonprofit consortium focused on health care access for residents of Flint, Detroit, Saginaw, and Pontiac. In 2013, they hired a formerly incarcerated client, referred to them through the Michigan Prisoner Reentry Initiative, to conduct outreach with the reentry population and help them obtain health care coverage and other reentry resources.

New York: Correctional collaboration with the state Medicaid agency (SMA) involves transmitting data on daily intakes into the prison system. The SMA scans Medicaid enrollment data for matches, and recodes those identified as suspended (only eligible for coverage of off-site, inpatient overnight stays in a community hospital, the one exception Medicaid covers for incarcerated people). The SMA also receives daily release data from corrections and reactivates full coverage for beneficiaries whose coverage is suspended.

Illinois: Multi-agency collaboration through a dedicated workgroup consisting of the Illinois Department of Corrections (IDOC), the governor's office, the Illinois Department of Public Health (IDPH), and others created a resource guide for criminal justice professionals on health care enrollment, trained field services to cover Medicaid enrollment with parolees, and made use of health exchange navigators to enroll detainees in larger jails. (Jailed persons awaiting trial are eligible to use state insurance exchange services, but convicted persons are not.)

California: The Medi-Cal Inmate Eligibility Program (MCIEP) developed a pre-release Medi-Cal application process that extends coverage of inpatient, off-grounds hospital services to eligible state and county inmates and medical and mental health hospital stays for juvenile detainees. The California Department of Social Services (CDSS) and county sheriffs' and probation departments entered into memoranda of understanding (MOUs) to ensure jail intake screening for health care coverage and that CDSS provides brochures on enrolling in Medi-Cal and Covered California™ and conducts in-reach groups and/or individual application sessions for inmates.

Sources: Medicaid & CHIP Coverage Learning Collaborative, 2015, Medicaid eligibility & enrollment for justice populations; NACo, 2019, Reducing recidivism through access to health care; Californians for Safety & Justice, 2014, Medi-Cal enrollment for county jail and probation populations.

Other Medicaid and Low-Cost Health Care Options

The box above has examples of different collaborative approaches jurisdictions have taken to ensure eligible reentering individuals have access to Medicaid benefits upon release (see Module IV for more enrollment resources). However, it is also important to initiate the enrollment process even if a reentering RSAT client may appear to have an income that will exceed Medicaid eligibility thresholds (typically less than 138 percent of the federal poverty level). Some states offer buy-in programs with low premiums, managed-care options with limited covered services, or Medicaid "in and out" programs. These programs involve a spend-down for certain individuals with

incomes that slightly exceed Medicaid eligibility limits, and cover services once medical expenses exceed a certain amount in a given month.

Another health care safety-net resource for low-income, uninsured individuals is Federally Qualified Health Centers (FQHCs). An online FQHC locator is available on the Health Resources and Services Administration (HRSA) website; it allows people to locate the nearest FQHC anywhere in the United States. The box below describes FQHC services. More health centers have begun to offer SUD treatment, including MAT, especially in remote areas where they may be the only medical care available within 100 miles or more.

Medicare, Social Security, and Dual Eligibility

Federally Qualified Health Centers (FQHCs) are community health centers that receive funds from HRSA to provide primary care to underserved areas. FQHCs may be Migrant Health Centers, Health Care for the Homeless programs, or health centers for residents of public housing. FQHCs deliver care to vulnerable populations, including the nation's veterans. FQHCs often integrate access to pharmacy, mental health, substance abuse, and dental services in areas where economic, geographic, or cultural barriers limit access to affordable care. FQHCs serve patients regardless of ability to pay.

A significant proportion of RSAT clients have substance use and co-occurring mental health disorders that vary in severity. Serious mental illness among clients may:

- Have gone undiagnosed prior to contact with the criminal justice system;
- Become immediately apparent with a period of abstinence from substance use;
- Emerge at any point, including during RSAT program participation; or
- Be a chronic condition for which RSAT clients have been treated in the past.

RSAT clients with serious mental illness may have had periods of remission or times when their conditions have been well managed through behavioral therapies and medications. They also may have used drugs and alcohol in ways that exacerbated symptoms of their mental disorders, masked them, or temporarily relieved them.

For example, people with anxiety disorders may have started out using alcohol, sedatives, and other central nervous system depressants to control their symptoms; however, at some point they developed tolerance and physical dependence and progressed into addiction. This not only tends to aggravate anxiety symptoms, but also adds another disorder requiring treatment and ongoing recovery management.

Most RSAT staff are aware that co-occurring disorders (CODs) tend to be the rule rather than the exception among clients and routinely collaborate with mental health services during core treatment and pre-release phases. RSAT programs strive to include appropriate integrated SUD interventions that are effective with both disorders (e.g., motivational interviewing, cognitive behavioral interventions (CBIs), or Wellness

and Recovery Action Planning [WRAP®]).*

*For more detailed information on clients with CODs, see RSAT Training Tool: Integrated Substance Abuse Treatment for Clients with Co-Occurring Mental Health Disorders.

In some cases, serious mental health disorders, especially untreated psychotic disorders, are a responsivity issue and must be stabilized before participation in RSAT programs can benefit the client. For RSAT clients with CODs who have completed the core treatment phase of the program, integrated pre-release planning and comprehensive continuing care for both disorders is required (Prins & Draper, 2009).

Serious mental disorders and other chronic health conditions may qualify RSAT clients for disability benefits, certain types of health care coverage, or supportive housing programs upon release. They can apply for some of these benefits prior to release. Clients who were receiving disability benefits before they were incarcerated may be able to reactivate them upon reentry.

Social Security Disability: Supplemental Security Income (SSI) vs. Social Security Disability Insurance (SSDI)

The Social Security Administration provides two different types of disability benefit programs. Both types of benefits are awarded to people who are disabled due to a mental or physical condition (SUD by itself does not qualify), with a disability expected to last more than a year, that prevents them from gainful employment.

SSI *benefits are awarded based on financial need to adults and children who are disabled or blind and have limited income and resources. When filing an SSI disability claim, applicants will be expected to show the case reviewer they have very few financial resources or assets and a very low income.*

Many SSI recipients have never been able to consistently work full time. SSI has a strict set of financial eligibility requirements and is reserved for individuals who would otherwise have a hard time paying for food and shelter. Most SSI beneficiaries will receive less than $800 in monthly benefits, and if their earned income exceeds a certain amount, it can result in a deduction from monthly benefit amounts. Generally, these individuals automatically meet traditional Medicaid eligibility in all states.

SSI benefits are suspended after the first full calendar month in custody and may be reinstated upon release for beneficiaries who have not been incarcerated more than 12 consecutive months. If they are released prior to the termination deadline, they only need to present official release paperwork to the local Social Security office to initiate reinstatement. However, if the length of time in custody exceeds 12 full, consecutive months, they must reapply. If SSI benefits are terminated, Medicaid also must conduct a new eligibility determination.

SSDI *allows workers who become disabled to receive their Social Security retirement benefits early. In order to receive SSDI, individuals must have enough work credits based on taxable employment. SSDI is based on Federal Insurance Contributions Act (FICA) taxes paid throughout an individual's working career and entirely disregards how much money applicants have or do not have.*

SSDI beneficiaries do not need to meet any means limits to be eligible and may earn

up to $1,220 per month (as of 2019) without being considered gainfully employed. Therefore, they do not necessarily qualify for Medicaid. After a 24-month waiting period, SSDI recipients can obtain Medicare Part A coverage (basic coverage that pays most hospitalization costs). They can opt to pay premiums for other Medicare programs that cover doctor visits or prescription drugs.

SSDI benefits stop only after an incarcerated individual is convicted of a crime and has been in custody more than 30 days. They are suspended until the individual is released and can be reinstated upon release by presenting official release paperwork to the local Social Security office and requesting reinstatement.

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

—Promising Practices Guidelines for RSAT, p. 21

Dual eligibility refers to people who meet the federal eligibility requirements for Medicare (individuals with disabilities or who are over age 65) and state-specific requirements for Medicaid eligibility. There are different levels of assistance a dually eligible beneficiary can receive, depending on the income level of a Medicare beneficiary and the state Medicaid rules that apply.

Social Security allows incarcerated individuals to submit applications for disability benefit programs 30 days pre-release; however, correctional systems that enter into agreements with Social Security can increase this timeframe to up to 120 days pre-release. It is important to screen RSAT clients upon intake to see if they were receiving disability or other benefits before they were incarcerated and to begin the re-application process well in advance of release dates if RSAT clients may qualify for disability benefits upon reentry.

The Substance Abuse and Mental Health Services Administration (SAMHSA)-funded national SSI/SSDI Outreach, Access, and Recovery (SOAR) Technical Assistance Center (TAC) devotes a specific webpage to criminal justice SOAR topics and tools. The site offers infographics, eligibility screening tools to use in custody settings, online courses for case managers, and other case management resources. It also lists regional SOAR criminal justice TACs

Effective January 1, 2020, Medicare Covers Opioid Treatment Services

For more than a decade, advocates have persisted in efforts to extend coverage of MAT for opioid use disorders to the Medicare population. Medicare is not only the primary source of healthcare coverage for individuals over age 65 (an age group hit hard by the opioid crisis), but also for vulnerable individuals with disabilities receiving SSI, with few economic resources. Medicare Part A mainly covers most of the costs of hospital stays. Many beneficiaries opt to also enroll in Medicare Part B, which covers doctor visits and other outpatient services. However, opioid treatment programs (OTPs) authorized to *dispense* methadone (and now also buprenorphine) have been excluded from Medicare coverage. Moreover, since these medications are *dispensed* rather than *prescribed* to patients with opioid use disorder (OUD), they are not even covered for beneficiaries enrolled in Medicare Part D prescription drug programs, although plans are mandated to cover buprenorphine prescriptions for beneficiaries receiving office-based opioid treatment (OBOT). The SUPPORT Act requires CMS to develop a bundled payment plan for Medicare coverage of physician services, medication administration, counseling, and other recovery supports for OUD provided by OTPs to be implemented as of January 1, 2020.

What does this mean to the reentry population?

RSAT clients with disabling mental or physical conditions who were on SSI or SSDI prior to incarceration and were enrolled in Medicare will have access to MAT from certified OTPs as soon as benefits are reactivated upon release.

Eligible RSAT clients who begin the process of applying for disability benefits prior to release will have access to MAT from OTPs after benefits are awarded and they become eligible to enroll in Medicare.

Older clients approaching release who are near age 64 can begin applying for Medicare to ensure they are covered as soon as they turn 65 at the lowest possible premium rates. They will also have access to OTP services.

People turning 65, who have been receiving maintenance treatment from OTPs, will no longer face the possibility of having to discontinue treatment when they enroll in Medicare, are no longer covered by employer healthcare plans, and do not qualify for Medicaid.

CMS plans are currently under review; final rules should be released by the end of calendar year 2019.

Other Clinical Care Resources for Reentering Clients

A final step in paving the way for RSAT clients to access SUD services upon release is ensuring appropriate mechanisms are in place that allow sharing of protected health information, specifically information pertaining to SUD treatment with community-based providers, to ensure continuity of care.

Protected health information includes patient medical records, since the doctor–patient

relationship implies confidentiality. Protections that apply to health information fall under the Health Insurance Portability and Accountability Act (HIPAA), which makes allowances for patients to give blanket consent for disclosures of medical information for purposes such as billing and patient care.

Likewise, information sharing between state Medicaid offices and correctional facilities pertaining to Medicaid enrollment and suspension of benefits without the patient's consent is not a breach of confidentiality, since it does not involve disclosure of patient-specific PHI.

However, confidentiality regulations that govern disclosure of patient health information specific to SUD treatment under 42 C.F.R. Part 2 are much more restrictive and require patient consent even when disclosing information to other providers for purposes of coordinating care. These protections and patient consent requirements can only be overridden by court order, except in cases of medical emergencies and investigations of crimes committed on the premises of a treatment center.

Confidentiality requirements under 42 C.F.R. Part 2 do not permit protected information about substance use to flow to or from a correctional facility without an individual's consent. RSAT programs fall under Part 2, which applies to federally assisted programs, because:

- They are federally assisted programs; or
- They are identified specifically as SUD treatment programs.

Consent forms for pre-release planning and sharing of client information for purposes of continuity of care and community supervision can meet all procedural requirements for obtaining and documenting consent to disclose substance use information by:

- Naming the specific party or parties involved;
- Stating the purpose of the disclosure;
- Describing the type of information to be disclosed;
- Stating the duration of the consent; and
- Including a preclusion against re-disclosure of information.

The three components of a privacy framework

1. A privacy policy to articulate the entity's position to protect medical, mental health, and substance abuse diagnosis and treatment information (or PHI); describe its position to adhere to legal requirements; and specify the rules and procedures for such compliance. A well-developed and well-implemented PHI privacy policy protects the entity, the individual, and the public and contributes to reduced recidivism by establishing a mechanism for continuity of care and treatment.

2. Individual consent authorizations and/or court orders authorizing the sharing of PHI between corrections and community treatment providers. Obtaining permission from an individual to release his or her PHI is a straightforward way to facilitate information sharing.

3. Contractual agreements between correctional entities and outside organizations that perform a specified set of functions or provide services to or on behalf of the entity. Such agreements define the parameters of PHI disclosure and specifically articulate what the organization has been engaged to do. They require assurances that the organization will comply with PHI privacy and security regulations.

Source: Abernathy, 2014.

When consent is obtained, information shared is limited to what is relevant to treatment and release planning (SAMHSA, 2018). Likewise, community-based treatment providers that obtain a release from clients, which allows them to share information with community corrections, can be expected to report attendance, participation, and progress, but not specific content of sessions. Clients must fully understand limits of confidentiality as they apply to all treatment and recovery support services while under community supervision.

Note: SAMHSA provides several fact sheets and a set of frequently asked questions (FAQs) on the application of 42 C.F.R. Part 2 on the section of their website about substance abuse confidentiality regulations.

B. Peer Support, Peer Recovery Support Services, and Recovery Capital

Peer Support vs. Peer Support Services

Generally, peer support refers people in recovery (from addictions, mental illness, or both) who connect with other recovering individuals to encourage one and another in achieving their mutual recovery goals. As the term implies, they function as equals without authority or any expectation of remuneration. Peers in long-term recovery may offer suggestions based on their own recovery experience or function as a sponsor at the request of someone in early recovery seeking guidance and support. This is typical of the type of informal support offered by 12-step fellowships and similar recovery support groups and meetings.

12-step fellowships and many other types of recovery support groups are heavily

influenced by the model of Alcoholics Anonymous (A.A.), founded in 1935, and Narcotics Anonymous (N.A.), which formed in the early 1950s (White, Budnick, & Picard, 2011). Since that time, many of the groups that have formed have shared common traditions and the 12 steps of recovery, which offer a pathway out of addictive thinking and a code by which to live in recovery based on "right thinking" and a decent way of life. These fellowships offer a set of pro-social beliefs and contacts that have played a central role in the rehabilitation of many offenders with SUDs.

A.A. and N.A. have a long history of outreach activities in custody settings and offer books such as *A.A. in Prison: Inmate to Inmate* and N.A. pamphlets such as "Behind the Walls" and "Staying Clean on the Outside." Outside speakers routinely conduct meetings inside secure facilities, and both fellowships offer bridge services to reentering individuals in recovery. A.A. and N.A. recovery support is also available online. In some areas, alternatives to 12-step recovery support groups, such as SMART Recovery, Women for Sobriety, or activities at local recovery community centers, are also available. Local religious congregations may offer faith-based recovery support meetings. Involvement in these informal networks of recovery support can be a critical component of reentry success for RSAT clients.

It is also important to make sure everyone involved in release planning understands 12-step meetings are not treatment any more than a support group for diabetics constitutes a medical intervention expected to regulate insulin levels. However, undergoing treatment along with participation in A.A. or N.A. has been shown to be more effective than treatment alone (Sheedy & Whitter, 2009).

Peer Recovery Support Services

Peers with lived experience in recovery may also receive training and/or certification qualifying them for paid positions as peer recovery specialists. At least 36 states offer peer recovery worker certification. These individuals may function as mentors, recovery coaches, health educators, or peer navigators. In some cases, RSAT and other in-custody SUD programs train participants to serve as peer educators or navigators who conduct groups on topics such as overdose prevention, HIV and HCV risk reduction, and health literacy. They may assist with pre-release planning by preparing reentering RSAT graduates to navigate health care and social service systems.

Winners' Circle Model—Peer Support for People Reentering Communities

Winners' Circles are peer-led support groups offering safe environments for former offenders to develop healthy lifestyles, learn and practice social skills, address problems that previously led to criminal activity, and expand networks of recovery support. Members are actively involved in family, recreational, and community projects, serving as volunteers, mentors, recovery advocates, and role models to other peer support groups and community organizations. This reentry peer support network benefits both the community and its members.

Like case managers, some peer recovery specialists provide transitional support by reaching into custody settings and meeting with individuals pre-release, as well as follow up with support in the community upon reentry. They may work with individuals post-release, as recovery coaches in probation/parole offices and recovery community centers, or as staff in treatment centers and other agencies.

It is important corrections agencies create protocols to encourage integration of peer recovery services and put clear policies in place. For example, it is important to clarify confidentiality limits and ensure peer specialists can effectively communicate these limits to individuals with whom they work. Placing excessive monitoring or reporting responsibilities on peer recovery coaches and other peer support specialists can compromise the effectiveness of the model by diminishing their status as peers.

> **Rather than cycling individuals through multiple self-contained episodes of acute treatment, recovery management provides an expanded array of recovery support services for a much greater length of time but at a much lower level of intensity.**
>
> —White, Kurtz, & Sanders, 2006

However, peer recovery support specialists can extend pre- and post-release case management capacities by acting as liaisons to provider-based case managers, conducting outreach activities with community and faith-based organizations to enlist additional resources for the reentry population, and working directly with clients. Peer recovery coaches and other peer support specialists can help clients develop and execute recovery plans, which differ from time-limited treatment plans, and highlight long-term daily or weekly recovery tasks that allow clients to maintain a substance-free lifestyle. Correctional systems must arrange for remuneration of peer support specialists and provide specialized forensic peer support training that includes agency-specific policies and protocols.

Access to peer recovery support services is even more critical for RSAT clients who will be released directly to the community without supervision. Peer recovery specialists can offer supports that help reentering individuals remain engaged in aftercare but are not appropriate for professional counselors to provide, such as rides to appointments, help finding an apartment and moving in, and so on. They can assist clients with benefit applications, help them obtain identification, accompany them to initial appointments, and help them navigate the myriad steps necessary for community reintegration. Research suggests even two post-release phone contacts weekly from a trained peer coach can have a positive effect on reducing recidivism among drug- and alcohol-involved offenders (Godley & White, 2011).

Recovery Capital

Consideration of levels of recovery capital for reentering RSAT clients can influence the level of post-release clinical care required. Recovery capital refers to the natural supports individuals can access (Granfield & Cloud, 1999). Measures of recovery capital include the Recovery Capital Scale (White & Cloud, 2008), which considers

problem severity in relation to recovery capital and includes planning prompts to increase it.

Peers are only one element of recovery support, albeit an important one. Some RSAT clients may have a spouse, intimate partner, family member(s), or close friends who have supported their every attempt to stop using. In addition to personal relationships, social determinants also impact recovery capital. Safe, drug-free housing, access to transportation, and drug-free interests and leisure activities boost recovery capital. In some cases, clients may be able to rely on or reconnect with a system of support when they return to the community, and it can impact the levels of clinical services they will require upon release.

Other RSAT clients do not know anyone that does not use drugs and alcohol and may be greeted upon reentry by friends who have procured a "welcome home" six-pack, gram of cocaine, or bag of heroin. They may be returning to neighborhoods with high liquor outlet density and an active street drug trade. These individuals have lower recovery capital and may initially benefit from higher intensity clinical SUD care. All RSAT clients must consider ways to increase recovery capital upon release and expand their networks of recovery support.

Cherokee Nation Coming Home Reentry Program

In Oklahoma, federally recognized Cherokee tribal citizens who reside within the tribal jurisdiction are offered support during their first 90 days post-release from state correctional facilities, with services including:

- Immediate $250 for clothing and hygiene items;
- Deposit/first month's rent for a transitional living facility or other arrangements, provided participants have income to support these arrangements after assistance is over;
- Fees and payments for reinstatement of driver's license (excluding fines);
- Access to tribal career services for placement in tribal employment and training programs such as job referral, vocational training, and adult education;
- Referral to tribal services such as health, behavioral health, food distribution, and housing; and
- Referral to outside behavioral health and inpatient residential transitional living agencies.

C. Levels of Care/Patient Placement Criteria for Reentering RSAT Clients

ASAM uses a model of patient placement criteria that organizes the delivery of treatment services along a continuum ranging from lowest to highest levels of care (ASAM, 2012). Treatment programs are classified as either long-term (more than 90 days) or short-term (fewer than 90 days). Most RSAT programs fall into the category of

long-term, high-intensity residential treatment (between levels 3.3 and 3.7).Although levels of clinical care upon reentry should be individualized, few RSAT graduates who have completed the program in custody and made reasonable progress will benefit from a repeat of the same modality of treatment upon reentry. Most are likely to benefit from long-term treatment and aftercare services that initially fall between levels 1 and 3.1, with higher intensity services front-loaded to be available during the first few months post-release.

Low-intensity residential services (level 3.1) may be appropriate upon release for RSAT clients who meet one or more or the following criteria:

- Have been away from the community for long periods
- Have long histories of heavy substance use
- Were released from jails before completing RSAT programs
- Will not have a stable, drug-free living situation upon release
- Will be released without community supervision

There may be other circumstances that make low-intensity, long-term residential care the best option. Individual RSAT clients who meet one or more of the conditions listed above may also benefit from a combination of recovery housing and outpatient treatment and, in some cases, admission to short-term residential treatment programs upon release, if the program offers comprehensive discharge planning that includes a solid long-term aftercare plan.

Partial or day hospitalization programs (level 2.4) are often designed for clients with CODs and may offer medication management and other

ASAM Patient Placement Criteria: Levels of Care

Level 0.5	**Early Intervention**
Level 1	**Outpatient** fewer than 9 hours per week
Level 2.1	**Intensive Outpatient** more than 9 hours per week
Level 2.4	**Partial Hospitalization** more than 20 hours per week
Level 3.1	**Clinically Managed Low-intensity Residential** 24-hr trained staff, at least 5 hours clinical services weekly
Level 3.3	**Clinically Managed Population-specific High-intensity Residential** 24-hr counselors, flexible TC* participation
Level 3.5	**Clinically Managed High-intensity Residential** 24-hr counselors, TC, prepare for outpatient
Level 3.7	**Medically Monitored Intensive Inpatient** 24-hr nurses and doctors, and 16 hours counseling available
Level 4	**Medically Managed Intensive Inpatient** 24-hr nurses, daily doctor care, and counseling available

*Therapeutic community

mental health services. In some communities, these types of programs are also tailored to justice-involved clients with OUD and may be combined with pre-release induction of MAT with long-acting injectable naltrexone or, in some cases, opioid agonist therapies.

Intensive outpatient programs (IOPs, level 2.1) may be an ideal initial level of post-release care, especially for RSAT clients who will be employed upon release. Most IOPs are 12- to 16-week programs that afford reentering RSAT clients the structure and support they will need during their first few months of reentry.

Outpatient treatment (level 2) consisting of fewer than 9 hours per week may be appropriate for motivated RSAT clients under community supervision who have sufficient levels of recovery capital and are involved in other structured activities (e.g., recovery meetings, employment, school, job training programs). At minimum, initial outpatient aftercare should offer weekly group and individual counseling sessions.

Outpatient and intensive outpatient programs may also be appropriate for reentering RSAT clients with OUD who are initiating MAT prior to release or upon reentry. None of the guidelines above represent a formula that can be applied to every client, nor are reentering RSAT clients in most communities typically offered a menu of different treatment options from which to choose. The individuals best qualified to make these plans are RSAT program staff and individual RSAT clients.

High-risk offenders require a significant number of hours of structured CBIs that address substance abuse, criminal thinking, and other criminogenic risk factors as part of post-release aftercare (Landenberger & Lipsey, 2005). Many community supervision programs provide some level of targeted group CBIs that complement structured groups offered by outpatient treatment programs. Some treatment programs that specialize in serving justice populations also offer these types of interventions.

Cognitive behavioral therapy (CBT) and interventions should not be limited to specific CBT sessions, but instead should be practiced and reinforced by all program and staff.

—Promising Practices Guidelines for RSAT, p. 13

Continuity of Care for RSAT Clients with CODs

Sequential, Parallel, and Integrated Care Models—Sequential treatment (attending to one disorder first, and then the other) is not appropriate for reentering RSAT clients with co-occurring substance use and mental disorders. They require continuity of care for both disorders and are not in a position to put one on the shelf, especially upon release. Integrated follow-up care is best, but parallel treatment from different providers working in different systems of care is preferable to neglecting one or the other.

Integrated Reentry Case Management—Case management needs vary among RSAT clients with CODs. The agency best suited to take the lead for ongoing care coordination is often determined by the severity of each condition. Reentering clients

with serious mental illness and moderately severe SUDs can benefit greatly from working with forensic assertive community treatment (FACT) teams and other mental health programs for justice-involved individuals. While SUD treatment providers may be best equipped to take the lead on case management for clients dealing with OUD or severe SUDs and manageable mood or trauma-related disorders. A warm handoff to the system of care with which the client feels most comfortable is most likely to result in continued engagement and retention in ongoing care (Osher & Steadman, 2007).

Peer and Community-based Support—People with co-occurring mental health problems may benefit from mental health peer support as well as addiction recovery support, or they may have a decided preference for one or the other. There are also some co-occurring recovery peer support groups. Offering choices and a variety of peer support resources encourages social connectedness and pro-social contacts critical to successful reentry and recovery. Peer support and the services of peer specialists can benefit people before they receive professional treatment, while they are receiving treatment and/or case management services, and after they are no longer involved with treatment.

In 2013, the Council of State Governments (CSG) developed a publication that can assist RSAT programs with pre-release planning for clients with CODs: *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison* (Blandford & Osher, 2013).

D. MAT and Continuity of Care

Data shows more than half of Americans who have a prescription opioid or heroin use disorder have had contact with the criminal justice system (Winkelman, Chang, & Binswanger, 2018). In some areas, jails in particular have been inundated with people in active opioid withdrawal. Many communities have established partnerships with local law enforcement, the courts, hospitals, and providers to prevent overdose fatalities and divert overdose survivors and low-level drug offenders from jail by connecting them with treatment. Some of these programs divert individuals pre-arrest or pre- and post-adjudication with collaboration from prosecutors and drug court programs, while others reach into jails to work with pre-trial detainees or reentering individuals. Treatment resources are limited in jails, and many low-risk offenders with OUD can be better served in the community.

Moreover, what was once characterized as an opioid overdose epidemic has morphed into a poly-substance overdose epidemic, with multiple drugs detected in most decedents whose deaths are attributed to opioids. Prescription opioids are still involved in a significant number of fatal and non-fatal overdoses; however, more potent illicit opioids are now trafficked and sold “on the street.”

Extremely potent, illicitly produced fentanyl formulations are imported into the United States by transnational criminal organizations. These are generally fentanyl analogues, illegally manufactured, largely in China, and trafficked through Mexico and other border points, with chemical formulas resembling pharmaceutical fentanyl but can be unpredictably potent, fast-acting, and deadly (Drug Enforcement Administration

[DEA], 2018b).

These fentanyl products are often mixed with heroin, stamped into counterfeit pills (fake prescription opioids and other commonly abused medications such as Xanax®), and even mixed with crack or powder cocaine and methamphetamine. These potent, fast-acting opioids are extremely dangerous to the user, and unintentional exposure can cause overdose symptoms in first responders, law enforcement, and correctional officers at the scene of an overdose (DEA, 2018b).

Even in regions where stimulants are responsible for most drug-related crime and overdose deaths, outbreaks of fatal and non-fatal opioid overdose spikes have occurred among crack and powder cocaine users and methamphetamine users who ingested stimulants adulterated with fentanyl. The majority of drug overdose decedents in 2018 had fentanyl in their system (Centers for Disease Control and Prevention [CDC], 2018).

Finally, retail heroin potency has increased dramatically. The DEA has been testing the potency of retail heroin in 27 cities since 1979, when purity was less than 10 percent. Even when no fentanyl is mixed in, heroin sold on the street now can be much stronger than it was even a year ago.

Heroin Purity						
	2011	2012	2013	2014	2015	2016
Mexican	17%	18%	20%	21%	29%	32%
South American	31%	35%	35%	31%	39%	26%

Source: DEA Intelligence Report (2018a), 2016 Heroin Domestic Monitoring Program

(See *Overdose Risk Reduction and Relapse Prevention for RSAT Programs* for detailed overdose prevention planning.)

These factors make the current drug threat environment extremely dangerous. Even in communities that have seen a slight decrease in drug overdose fatalities, the number of non-fatal overdose victims who have been revived with naloxone due to the efforts of first responders, law enforcement, public health officials, and others continues to rise (Massachusetts Department of Public Health, 2019). Among the populations most at risk are individuals with OUD recently released from custody (Joudrey et al., 2019)—and studies suggest reentering women are at even higher risk (Binswanger et al., 2012; Groot et al., 2016). The following three strategies can effectively reduce the extremely high rates of drug overdose fatalities during the immediate post-release period.

1. **Overdose prevention education** dispels dangerous myths and beliefs, such as the idea that the stimulating effects of cocaine counteract the sedating effects of opioids and make overdose less likely. In fact, *the opposite is true.* According to a study of recently released prisoners who survived an overdose, two common reasons they gave for the overdosing were a lack of knowledge about decreased

tolerance after a period of incarceration and the increase in potency of street drugs during the time they spent in custody (Binswanger et al., 2012).

2. **Access to naloxone** kits upon release, training on how to administer them, and training on Good Samaritan laws and how to respond to an overdose emergency (including providing them with local emergency contacts) can reduce deaths among people recently released from custody. These measures have resulted in cases of people trained in custody programs saving lives of overdose victims in the community after release (Anthony-North, Pope, Pottinger, & Sederbaum, 2018).

3. **MAT for OUD** with any of the three U.S. Food and Drug Administration (FDA)–approved medications reduces the likelihood of overdose fatality, decreases criminal behavior, and results in better treatment engagement and retention and longer periods of abstinence from illicit opioid use (Egll, Pina, Skovbo Christensen, Aebi, & Killias, 2009). An increasing number of correctional treatment programs are offering pre-release MAT induction and referring reentering individuals with OUD to MAT providers to begin treatment upon release.*

   *See sources listed in Module IV.

The RSAT training tool *Overdose Risk Reduction and Relapse Prevention for RSAT Programs* offers more information on the first two strategies. However, reentering RSAT clients with OUD who are receiving pre-release MAT and those who are referred to providers to begin MAT upon release require specialized pre-release planning.

Pre-Release MAT Induction and Continuity of Care for OUD

Pre-release, long-acting injectable naltrexone is the most common type of MAT offered to reentering RSAT clients and others with OUD, but an increasing number of correctional systems are offering access to one or both approved medications for opioid agonist therapy (OAT), depending on which is the most clinically appropriate and sustainable upon release. The outcomes reported in early research and evaluation studies of these programs are impressive. SAMHSA recently released Medication-Assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States, which highlights several promising programs, including research on the benefits of these types of programs and the important elements of pre-release planning and aftercare that apply to participants.

The RSAT website offers several resources, including films and practice guidance, as well as Recent Medication-Assisted Treatment Studies Relevant to Corrections and brief descriptions of prison and jail MAT programs.

Correctional policies regarding MAT in custody are very fluid, especially in jails. Case law has generally upheld an incarcerated person's right to continue with prescribed medications, including MAT drugs for treatment of an OUD. A handful of states have had policies in place allowing a period of continuation in custody. However, a recent federal case resulted in a ruling that has prompted more jails and prison systems to implement such policies (U.S. District Court for the District of Massachusetts, 2019).

Other jurisdictions are offering pre-release programs that allow individuals with OUD to begin to receive any one of the FDA–approved MAT medications in custody, with good results (Green et al., 2018). Still others arrange for immediate post-release induction by referring reentering individuals to qualified MAT providers, allied OTPs, and/or qualified physicians who provide office-based opioid treatment (OBOT) with buprenorphine (Nunn et al., 2009).

Guidelines for Referring to Community MAT Programs

Whether RSAT programs refer clients who have initiated MAT pre-release or will begin treatment post-release, some basic preparations can make the process easier for everyone involved.

Preparing for the First Appointment—Ideally, a reentering RSAT graduate who is a candidate for MAT has direct or mediated contact with the provider agency and completes all or part of the intake process prior to release. Collaborative arrangements between corrections and community-based providers can allow for in-reach to complete assessments, health plan enrollment, or pre-authorization (if required). These are some of the elements of a ***warm handoff*** to post-release continuing care.

Whenever possible, the further RSAT staff can move pre-release referrals beyond merely providing a name and address of a treatment center, the better chance the client will follow through. When this is not possible, the following steps can help prepare reentering individuals to make the most of their first appointments.

Checklist # 6—MAT Continuity of Care

General concerns, pre-release planning, and post-release referrals.

- ☐ If a client discontinued MAT when they became incarcerated but wants to resume upon release, a referral to a provider is appropriate.
- ☐ Even RSAT graduates who have been free of opioids for many months may derive great benefit from MAT in the community upon reentry, and a referral is appropriate.
- ☐ People who choose medication-assisted recovery may be stigmatized, even among sectors of the recovery community. It is important they have appropriate recovery support and counseling in the community.
- ☐ OTP certification requires programs that dispense methadone provide clients with or refer them to counseling and other services to support OUD recovery. (OTPs can also dispense buprenorphine formulations and many also offer them.)
- ☐ It is critical to ensure clients who begin any type of MAT pre-release have the means to continue upon release. This includes the following.
    - Transportation: Methadone treatment involves daily visits to an OTP until patients are stabilized. Several weekly visits are required on a long-term basis. Transportation is also required daily or several times per week for patients initiating buprenorphine through OBOT.
    - Payment/affordability: The costs of all services involved must be affordable,

including initial intake, testing, medication, and counseling.

- Medicaid/other insurance: If clients qualify for Medicaid or other health benefits upon reentry, it is important to know the details of coverage, co-pays, length of treatment, and preauthorization requirements.

- ☐ Clients referred to MAT providers benefit from pre-release education on the process, side effects, risks, and benefits.
- ☐ Clients referred to OBOT with buprenorphine need to understand they may be drowsy at the beginning but should adapt to the medication or discuss adjustments with their prescriber.
- ☐ Those who fall below the minimum ASAM recommended dose of 8 mg. daily due to selling part of their prescription or cutting down on their own may not succeed with their own recovery.
- ☐ Have clients prepare a list of all current prescribed medications, over-the-counter medications, and vitamins or supplements they are taking.
- ☐ Gather all medical tests, documentation of health conditions, and records prior to release, including behavioral health information. If these records cannot be transferred to receiving facilities, the client can hand-carry them.
- ☐ Make sure the client has signed any necessary releases with all required elements and copies of all releases, have reached the referral agency, and are retained in the client's file.
- ☐ Make sure clients understand they need to tell the doctor the details of any substances taken (prescribed or otherwise) so drug interactions can be avoided. The doctor must review possible interactions for clients taking medications for mental disorders.
- ☐ Finally, clients should understand that MAT is a long-term commitment requiring 12 months of treatment, at minimum. Discontinuing treatment early or tapering off too quickly reduces the chances of success.

Phases of Pre- or Post-Release OAT

Although both buprenorphine and methadone are sometimes used on a short-term basis for withdrawal management, is it not considered treatment, and there is little evidence of the effectiveness of their use for withdrawal alone. There are distinct differences between the two medications, but they are both long-acting opioid agonists, and the only ones approved for treatment of OUD in the United States. There are four distinct phases of maintenance treatment OAT.

1. Induction starts once assessments and a medical examination determine an individual is a candidate for MAT. The doctor will arrive at a reasonable starting dose of the medication. Side effects are pronounced at this stage, and providers should caution patients not to drive. Patients remain for observation after their initial dose, and if they do not experience sufficient relief from withdrawal symptoms after 2–3 hours, another small dose may be administered.

Patients starting methadone *are at highest risk of overdose during this stage. It is very important for RSAT staff to refer clients beginning methadone upon release to an OTP that delivers quality care and individualizes starting dosages.* Only a handful of correctional facilities are certified OTPs. It is much more common for facilities to contract with an OTP to administer methadone. Doctors must make sure clients adjust to the medication safely by starting with a low dose and increasing it slowly. Methadone's long half-life means daily dosages begin to have a cumulative effect. The full effect of the medication should not be expected until 5 days after initial induction (CSAT, 2005a).

Patients starting buprenorphine *must be free of opioids for 12–24 hours if they were using short-acting opioids and a minimum of 24 hours if long-acting opioids are involved or if they are switching from methadone. This prevents the onset of symptoms of precipitated withdrawal.* Because buprenorphine has a high affinity for but low intrinsic activity at mu receptors, it has a better safety profile than methadone (formulations include Suboxone® sublingual strips and generic combinations of buprenorphine and naloxone, as well as mono formulations used to treat OUD during pregnancy). Its effects plateau and do not continue to increase at higher doses. Its high affinity for mu means other opioids will detach from receptors when it is administered, which is the reason for a waiting period (Center for Substance Abuse Treatment [CSAT], 2004).

2. Stabilization begins when the client is on the right dose and the body and brain have adjusted to the new medication. There will be fewer highs and lows, and withdrawal and craving will be under control. If the dosage is correct, the client will not continue to feel drowsy or sedated, will be able to drive, and will not experience withdrawal symptoms. Dosages that are too low are associated with relapse and program attrition when patients reach maintenance (step 3).

In the case of methadone, after 7 days on a stable dose, blood levels may be checked after a dose is administered and re-checked three hours later to ensure peak levels are not overly sedating and the onset of withdrawal symptoms does not occur early (CSAT, 2005a).

*In the case of buprenorphine**, once a patient is stable on the right dose, a 14-to-30-day supply may be prescribed for the patient to self-administer.* Note: starting doses and maintenance doses are specified by some state Medicaid plans. Unlike methadone, some patients may gradually increase from an initial dose of no more than 8 mg. to a higher dose between 24 and 32 mg. for the initial months of treatment, then decrease to a maintenance dose, usually between 16 and 24 mg. (CSAT, 2004).

3. Maintenance is the long-term phase of treatment. It can free people from addictive use, craving, and anxiety for a sustained period while they build a life in recovery. People may remain on maintenance for many months or even years. The length of time an individual can benefit from MAT varies. They can periodically be reassessed for continuation or begin a program of medically managed tapered withdrawal. No additional risks are associated with long-term methadone or buprenorphine treatment. However, there are relapse risks associated with discontinuing treatment too soon.

During this period, participation in counseling and other recovery support activities is encouraged, and OTPs are mandated to refer clients to the services they require. In some states, Medicaid requires documentation of participation in counseling before they reimburse for MAT. Treatment with long-acting opioid agonist medications, over time, stabilizes metabolic functions and may help to restore a degree of normal regulation (World Health Organization, 2004).

During the maintenance phase of methadone treatment, individuals making good progress can receive a limited number of take-home doses of methadone (CSAT, 2005a).

During the maintenance phase of buprenorphine treatment, individuals making good progress can generally receive up to a 30-day supply of medication from their provider between appointments (CSAT, 2004).

Protocols and Procedures: Custody-Based OAT

- Rhode Island DOC Suboxone standard operating procedures
- Vermont MAT for Inmates: Work Group Evaluation Report and Recommendations
- Description and evaluation of the Rikers Island methadone Key Extended Entry Program (KEEP)
- National Institute of Justice (NIJ) Crime Solutions Program Profile: Prison-Initiated Methadone Maintenance Treatment (Baltimore Jail)
- NIJ Crime Solutions Practice Profile: Incarceration-Based Narcotics Maintenance Treatment (Meta-analysis)

4. Tapering is medically managed withdrawal through gradually reduced doses of opioid replacement medications over a period of months. The more gradual the withdrawal process, the greater the chance of success. Tapering minimizes withdrawal symptoms occurring when opioid replacement medications are discontinued. Methadone withdrawal can be unpleasant and protracted. Withdrawal from buprenorphine is reported to be less severe, but many patients report it becomes difficult during the final weeks, with dysphoria as the most problematic symptom.

Pre-release, long-acting injectable naltrexone is approved by the FDA for relapse prevention in clients with OUD who are detoxed from opioids completely. They must be opioid-free for at least 7 days if only short-acting opioids such as heroin were used, but at least 10 days if long-acting opioids such as methadone were used. Clinical protocols call for drug screens and an oral naloxone challenge prior to administering injections. No special training is required; any qualified medical provider can administer it (SAMHSA, 2012). Some jurisdictions offer directly observed oral naltrexone in prison settings, followed by an injection just prior to release. Others offer 1–3 months of treatment with the long-acting injectable form in anticipation of release. Some jail-based programs offer a single injection on the day of release.

Initial concerns regarding increased overdose risk after a period of treatment with naltrexone due to loss of tolerance do not appear to apply to programs for the reentering population. Early studies suggest pre-release injections of long-acting naltrexone can decrease overdose fatalities during the immediate post-release period and may provide an important deterrent to an immediate return to opioid use upon release. This can allow time necessary to engage clients in post-release treatment and recovery supports (Lee et al., 2015).

All protocols must include precautions regarding the increased risk of overdose at the end of the injection cycle and warning against attempts to override the blocking effects with high dosages of opioids. Pre-release arrangements for a provider in the community who will administer injections post-release are important, as is ensuring the client has the means to pay (as the monthly injection can be expensive). Some programs collaborate with community supervision to offer injections as part of post-release aftercare, while others refer to allied community-based providers.

It is critical reentering RSAT clients who receive injections pre-release, upon release, and/or post-release be connected with an appropriate level of ongoing community-based treatment, aftercare, and recovery support. The evidence of the effectiveness of long-acting injectable naltrexone is based on its use as part of a comprehensive treatment and recovery program (SAMHSA, 2012).

Protocols and Procedures: Custody-Based MAT with Injectable Naltrexone

- Kentucky DOC Substance Abuse MAT protocol (Vivitrol®)
- Rhode Island DOC Vivitrol Relapse Prevention Program Manual
- Massachusetts DOC MAT Reentry Initiative Clinical Guidelines (Vivitrol)
- New Hampshire DOC MAT and naltrexone oral augmentation clinical guidelines

Conclusion: MAT is the standard of care for OUD for individuals in both community and custody-based treatment (Whitten, 2011). RSAT programs help to promote access to the appropriate standard of care for justice-involved clients with OUD at whatever level possible. Although methadone is underutilized in U.S. prisons, internationally it has been used in prisons since the 1990s and is common in European and Australian prison programs (European Network on Drugs and Infection Prevention in Prison, 2007).

Long-acting, injectable buprenorphine formulations, implants, and other innovations that will reduce the risk of medication diversion are in the pipeline, and some pilot programs are underway in custody settings (MedlinePlus, 2019). Despite the issues with diversion, buprenorphine formulations have made it possible for reentering clients released to areas without an accessible OTP to initiate or continue OAT and improve their chances of maintaining abstinence from illicit opioid use upon release (Hedrich et al., 2012). MAT for alcohol use disorder is also effective and may be an appropriate option for some reentering RSAT clients. Although several studies have been

conducted on potential MAT formulations for stimulant use disorders, none are available yet.

Whether MAT is a part of the picture or not, treatment gains are better maximized and sustained for all RSAT clients when the appropriate level of aftercare services and supports is coordinated pre-release. The efforts of RSAT programs to increase in-reach from community agencies, work in concert with probation and parole, enter into collaborative agreements with providers, enroll clients in health benefits, integrate peer recovery supports, and share information with receiving facilities are making a difference—even if it's a difference that staff working in custody settings do not always see.

Module IV: **Reentry and Specialized Pre-Release Planning Resources**

A. Reentry Issues: Residential Substance Abuse Treatment (RSAT) Programs that Serve Women

B. Reentry Housing Support and Employment-Related Resources

C. Health Care and Clinical Resources

D. Reentry Resources: General and Population-Specific

Learning Objectives

After completing this module, participants will be able to:

1. Name some of the unique considerations involved in reentry planning for RSAT programs that serve women;
2. Locate information on federal and regional employment and housing resources to assist with reentry planning;
3. Find information on healthcare coverage and other resources to increase post-release access to medical and behavioral health clinical care; and
4. Understand the population-specific reentry resources available to subgroups of reentering RSAT clients.

A. Reentry Planning for Women

Most women in RSAT programs share common pathways to criminal activity that can include childhood trauma, intimate partner violence (IPV), substance use, mental health disorders, and poverty (Women's Prison Association, 2005). Not only are women more likely to have a co-occurring disorder (COD), but they commonly have multiple mental health diagnoses, compounded by complex trauma histories. Post-traumatic stress disorder (PTSD) alone co-occurs in 33 to 48 percent of women offenders with substance use disorders (SUDs) (Chesney-Lind & Sheldon, 2003; Najavits, 2007). Trauma-informed and appropriate integrated trauma-specific substance use disorder (SUD) interventions are beneficial.

Women's rates of incarceration have grown twice and fast as men's, with addictive illness identified as a driver of increases (Grella & Greenwell, 2007). Moreover, drug use is the top reason they return to prison after release (Miller & MacDonald, 2009). Yet, they remain a very small proportion of the prison population. As of 2019, women were 6.8 percent of the federal and 7.5 percent of the state prison populations.

Women in jails are the fastest growing segment of the custody population, and are now:

- Nearly 15 percent of the local jail population;
- More than 25 percent of arrestees (Prison Policy Initiative, 2019); and
- Approximately a quarter of probationers (Vera Institute of Justice, 2015).

Whereas a little more than half of justice-involved males are on probation, about three fourths of justice-involved females are probationers, which may become a pathway to incarceration for many women on probation for extended periods who have intersecting risks and needs that make compliance with release conditions difficult (Prison Policy Initiative, 2019). Advance planning to address the issues landing them in custody can help avoid a repeat offense when they are released under community supervision.

Sex-linked differences in physiological responses to substances are also a factor. In comparison to men, women sustain more severe organ damage from lower levels of substance use over shorter periods, become addicted more quickly, do not metabolize substances as efficiently, and experience more severe withdrawal symptoms (National Institute on Drug Abuse [NIDA], 2005). This also puts them at higher risk for a post-release overdose fatality. Women offenders are more likely to have serious health conditions, less likely to have accessed routine medical care, have at least three times the rate of HIV infection and higher rates of hepatitis C (HCV) as compared to male offenders (De Groot & Uvin, 2005).

Women in RSAT programs are more likely than their male counterparts to:

- Report intravenous (IV) drug use prior to incarceration;
- Have tested positive for substances upon arrest;
- Report homelessness in the 6 months prior to incarceration; and
- Report past suicide attempts and/or psychiatric hospitalizations.

Compared to men in SUD treatment in general, women in the same programs are:

- More likely to have a spouse or partner that encourages drug use;
- More likely to report having family or friends who use drugs; and
- Less likely to report having partners, family, or friends that support their recovery (Center for Substance Abuse Treatment [CSAT], 2009).

Among male offenders, family and intimate partners are often supportive, stabilizing influences. More than three quarters of women in ***community-based residential treatment programs*** are from families involved in alcohol- or drug-related activities (CSAT, 2009). Women in custody are also likely to have intimate partners who use drugs and/or who have treated them violently; however, their rates of sexual victimization across the lifespan are highest in childhood (Blackburn, Mullings, & Marquart, 2008; Clements-Nolle, Wolden, & Bargmann-Losche, 2009).

Reentry goals for women often include rebuilding a support system from the ground up—not only to support recovery upon release, but also to help ensure personal safety. It is also important that release plans address the gender-specific criminogenic risks listed below. Women often read as high-need, low-risk offenders on forensic assessments that are not specifically designed for females. This may lead to over-classification of the risk to public safety posed by reentering women, resulting in unnecessarily high levels of community supervision, or under-classification of recidivism risks due to high levels of needs that are a challenge to address. In some cases, women may be excluded from reentry programs reserved for high-risk offenders (Prison Policy Initiative, 2018).

Research on women's criminogenic risks and needs suggests they share several strong predictors of recidivism with male offenders but also have a set of gender-specific risk factors differing from men. Specific criminogenic risk and needs assessments developed for women associate the following risk factors with recidivism (Van Voorhis, Salisbury, Wright, & Bauman, 2008):*

- Mental health symptoms
- Past trauma and abuse
- Intimate partner violence
- Anger or hostility
- Parenting stress
- Relationship dysfunction
- Low self-efficacy
- Low parental involvement
- Housing safety

*See resource on gender-specific risk and needs assessments for women at the end of this section.

Most women in custody are mothers but may not be actively parenting immediately upon release. In states with expanded Medicaid eligibility, these women are likely to be eligible, since qualifying for coverage is not tied to their parenting status. Also, health plans are now required to cover additional preventive services for women, with co-pays prohibited, including domestic violence screening and counseling (National Women's Law Center, 2012). Pre-enrolling women in Medicaid and arranging a pre-release intake into supportive housing or long-term, low-intensity residential treatment programs allows them to use their benefits for SUD treatment, mental health services, preventive care, and treatment of chronic health conditions. Residential treatment programs for women that can accommodate minor children are suitable for women who may reunite with children post-release.

For pregnant women with opioid use disorder (OUD), treatment with methadone is the standard of care. If women receive methadone in custody, it is critical to ensure they can continue upon release. The following steps may be required:*

- If the client will be Medicaid eligible upon release, make sure methadone maintenance is covered, and pre-authorization and intake is arranged with the receiving opioid treatment program (OTP), along with transportation.
- It is important to know how long Medicaid will continue to cover methadone after delivery, especially in non-expansion states, and reunification may not be immediate upon release. In some cases, women have been required to taper off methadone within 6 weeks post-partum, putting them at extremely high risk for relapse.
- If the client will not qualify for Medicaid upon release, alternative sources, such as publicly funded treatment or dedicated opioid funding that will cover medication-assisted treatment (MAT) for uninsured patients, must be located.
- Guidelines on buprenorphine during pregnancy permit use of the mono formula for women already taking it, or if it is requested, with awareness of the risks and informed consent. In such cases, the goal is to minimize the onset of withdrawal symptoms to prevent fetal trauma.
- If an OTP will not be accessible upon release, pregnant women receiving methadone in custody may be able to switch to buprenorphine formulas after delivery. Clinical guidelines require tapering down to a low dose of methadone before making the switch.
    - Note: The same applies to men treated with methadone in custody or people who were on methadone maintenance prior to incarceration and are permitted to stay on for a limited time period. It is not unusual for opinions to differ among physicians regarding how low the dose of methadone should be and whether induction with mono formula buprenorphine is necessary.

*See clinical guidelines at the end of this section.

Treatment Issues for Women

There is no doubt serving women in SUD treatment, especially in custody settings, can present complex challenges. But research shows that although women are less likely than men to access treatment for SUD, they are more likely to benefit from it (Najavits, 2007). RSAT programs that serve women must rely on community partners to an even greater degree than men's programs. RSAT administrators have successfully maximized community support from public, nonprofit, faith, and recovery community groups, as well as women's organizations. Interagency coordination and partnerships may encompass

- Child welfare and family services
- Single state agency (SSA) alcohol and drug agency's designated women's services coordinator
- Family-based treatment providers
- Domestic violence coalitions or local service providers
- Women's health/minority health organizations
- Early childhood services and infant mental health services
- Mental health and women's counseling centers
- Housing programs
- Family-based SUD treatment centers for women
- Employment/workforce development/vocational rehabilitation
- Women's peer support/mentoring/faith/recovery support

Relationships with family, children, and others are often central for the reentry success of women offenders. Successful reentry case management helps women expand their networks of support and sort out unsafe relationships from supportive ones. Many reentering women are single mothers who were responsible for dependent children prior to incarceration. Involvement with the child welfare system may have preceded incarceration. In some cases, women can place their children with a relative while they are in custody, more likely the maternal grandmother than the biological father. This is in stark contrast to male offenders, most of whom leave their children in the care of the biological mother. At least 11 percent of all female offenders have children in the foster system, and for RSAT clients, that proportion may be higher (Council of State Governments [CSG], 2009).

Mothers with children in foster placement have a finite number of months before the family court system moves for permanency and terminates parental rights. For this reason, RSAT programs serving women need a direct line of communication to the state's family division. Visitation, court dates, and reunification plans should be monitored carefully as release approaches.

RSAT programming can help women be successful mothers upon release. The

resource pages (below) list evidence-based parenting groups appropriate for women in SUD treatment, resources for children of incarcerated parents, and cross-training on the child welfare system for substance abuse counselors. During the pre-release phase it may be possible to increase contact with children through video visitation and programs like Girl Scouts Beyond Bars.

Reentry sometimes includes the overwhelming experience of "shock motherhood." Within hours of release, children arrive with their own adjustment needs, emotional responses, and new limit-testing behaviors. Reunification planning prior to release can enlist available family supports. Respite care, parent aides, and other services may be available if the state is involved. Dedicated RSAT reentry staff can assist in locating summer camps, weekend high-school prep programs, prevention coalitions, and mentoring programs for children of incarcerated women (and men).

Safety Planning: Studies show that 40–80 percent of women with SUDs have experienced intimate partner violence (IPV) at some time in the past and 47–70 percent are current victims. Women in custody with SUDs are at even higher risk (Bennett & Lawson, 1994; Stark & Flitcraft, 1988; as cited in Domestic Violence/Substance Abuse Interdisciplinary Task Force). RSAT staff can enlist community based IPV service providers to conduct pre-release safety planning groups and link women to post-release resources.

Research clearly indicates the presence of substance use increases the severity of injuries and lethality rates among victims. Substances are involved in 68 percent of female IPV homicides. Homicide at the hands of an intimate partner is the leading cause of injury-related deaths among pregnant women (Chang, Berg, Saltzman, & Herndon, 2005). Victims who use substances are much more vulnerable. A coroner's report of IPV fatalities in New Mexico, for example, looked at toxicological data from autopsy records of female victims and found 33 percent had evidence of elevated ethanol (alcohol) levels, and an additional quarter of victims had cocaine, marijuana, opiates, or amphetamines in their systems at the time they were murdered (Olson, Crandall, & Broudy, 1999).

When referring female RSAT clients to community SUD treatment providers, RSAT staff may want to make sure they have adequate policies in place regarding screening for IPV, helping victims obtain orders of protection, and safety planning, especially in smaller communities. Partnerships with treatment providers can also be based on availability of family services and accommodations for children.

(Also see the RSAT training tool Trauma Informed Approaches in Correctional Settings, the resource guide for staff development Women and Girls in Substance Recovery Programs in Correctional Settings in the Research and References library, and the RSAT trauma training manual.)

Reentry Resources for Women's RSAT Programs

- Women Offender Transition and Reentry: Gender Responsive Approaches to Transitioning Women Offenders from Prison to the Community, by Judith Berman, Ph.D., Center for Effective Public Policy, for National Institute of Corrections (NIC).

- National Directory of Programs for Women with Criminal Justice Involvement (NIC). Fifty-state searchable database of women's prison and jail programs, descriptions, practices, and contact information.
- National Resource Center on Justice Involved Women (NRCJIW). Technical assistance (TA) center for justice programs working with adult women.
- Women's Prison Association (WPA). Reentry resources and practical tools that address employment, housing, and more.
- Overlooked: Women and Jails in an Era of Reform (2016), Elizabeth Swavola, Kristine Riley, and Ram Subramanian, Vera Institute of Justice.

SUD Treatment for Women and OUD Treatment During Pregnancy—Clinical Guidelines

- Substance Abuse Treatment: Addressing the Specific Needs of Women, Treatment Improvement Protocol (TIP) Series, No. 51 (2009), Center for Substance Abuse Treatment (CSAT).
- Pregnant, Substance-using Women, TIP Series, No. 2 (1993), CSAT.
- Pregnancy and Buprenorphine Treatment (2014), by Judith Martin, M.D. MAT training for Providers Clinical Support System (Substance Abuse and Mental Health Services Administration [SAMHSA])

(Note: Also see the MAT section for clinical guidelines for OUD treatment during pregnancy, TIPs 40 and 43.)

Family and Parenting

- Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues, TIP Series, No. 36 (2004), CSAT.
- Understanding Child Welfare and the Dependency Court: A guide for substance abuse treatment professionals, National Center on Substance Abuse and Child Welfare (online tutorial).
- Compilation of Evidence-based Family Skills Training Programmes (2010), United Nations Office on Drugs and Crime.

Intimate Partner Violence

- Incarcerated Women / Female Offenders, National Center on Domestic and Sexual Violence. Resource center with tools and information on model programs.
- Substance Abuse Treatment and Domestic Violence, TIP Series, No. 25 (1997), CSAT.

B. Housing and Employment Resources

This section offers federal work-related resources, listings of state requirements for expungement of criminal records, and websites that list state rules pertaining to employment, trades, and criminal justice histories. It includes the one-stop

employment center locator for centers anywhere in the United States. Other U.S. Department of Labor (DOL) resources for the reentry population, such as the Federal Bonding Program and national Dislocated Worker Grants (DWGs) awarded to states with a workforce impacted by the opioid crisis, are also listed.

The housing section includes federal resources; reentry housing organizations; U.S. Department of Housing and Urban Development (HUD) and SAMHSA reentry housing programs, tools, and resources; and examples of state reentry housing initiatives.

Housing

- Oxford House national online directory. Gives address and pictures of each property, capacity, current vacancy information, and type (e.g., male or female, whether children are accepted).
- A Record of Progress and a Roadmap for the Future: Housing (2016), The Federal Interagency Reentry Council.
- Homeward Bound: The Road to Affordable Housing (2019), The National League of Cities.
- Where 'Returning Citizens' Find Housing After Prison (2019), by Teresa Wiltz. Pew Charitable Trusts, Stateline.
- Assessing Housing Needs and Risks: A Screening Questionnaire (2017), National Reentry Resource Center.
- It Starts with Housing: Public Housing Agencies are Making Second Chance Real (2016), HUD.
- Office of General Counsel Guidance on Application of Fair Housing Act Standards to the Use of Criminal Records by Providers of Housing and Real Estate–Related Transactions (2016), HUD.
- Reentry and Housing Coalition, National and local organizations focused on reentry housing issues
- Connecting People Returning from Incarceration with Housing and Homelessness Assistance (2016), tip sheet from the U.S. Interagency Council on Homelessness.
- National Low Income Housing Coalition. Webpage devoted to housing and criminal justice with current information on policies and programs
- Reentry Housing Options: The Policymakers' Guide (2010), Katherine Cortes and Shawn Rogers, CSG Justice Center and Bureau of Justice Assistance (BJA).
- SAMHSA Homelessness Programs and Resources. Links to information on various housing programs for people with substance use and mental disorders.
- U.S. Interagency Council on Homelessness. Webpage on criminal justice involvement and related information.

Examples of State Reentry Housing Initiatives

New York—Reentry Permanent Supportive Housing

Oklahoma—Reentry Housing

Missouri—Department of Corrections (DOC) Reentry Housing

California—Housing First and Prison Reentry in California Webinar (2019)

Georgia—DOC Reentry Partnership Housing

Employment

National Clean Slate Clearinghouse: Information about record-clearing laws and rules in various states, including court forms and practice guides.

National Helping Individuals with Criminal Records Reenter Through Employment (HIRE) Network criminal records information clearinghouse: Information about governmental agencies and community-based organizations that assist people with criminal records, as well as practitioners, researchers, and policymakers from the Legal Action Center.

The Restoration of Rights Project offers the following resources and more:

- An online summary of restoration and loss of civil rights by state
- A state by state listing of consideration of criminal records in licensing and employment
- A state directory of judicial expungement, sealing, and set-aside of criminal records

A Record of Progress and a Roadmap for the Future (2016), The Federal Interagency Reentry Council.

Best and Promising Practices in Integrating Reentry and Employment Interventions, (2018), CSG Justice Center.

Strategies to Engage Employers in Conversations about Hiring Applicants with Criminal Records (2018), tip sheet from the National Reentry Resource Center.

DOL Resources

- National Locator for American Job Centers and other state job services anywhere in the United States.
- Job Search Help for Ex-offenders offers training, employment readiness tools, and state resources.
- Federal Bonding Program website explains the benefits of bonding and lists state program coordinators.
- National Dislocated Worker—Opioid Crisis Demonstration Grantees
- National Dislocated Worker—Opioid Disaster Recovery Grantees

C. Health Care, Benefits, and Clinical Resources

This section has resources on benefit enrollment, including enrollment in health and disability benefit programs. It lists TA centers, information on suspension and reactivation of benefits, prescription drug assistance programs, and publications on benefit enrollment. Clinical resources include practice guidelines pertaining to care transitions, MAT, and effective interventions relevant to continuing care and community supervision.

- Toolkit on restoring Medicaid upon release from prison, the Legal Action Center.
- County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage (2012), Community Services Division, National Association of Counties.
- Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System (2013), the CSG Justice Center.
- *Mapping the Criminal Justice System to Connect Justice-involved Individuals with Treatment and Health Care under the Affordable Care Act* (2014), Lore Joplin, National Institute of Corrections, U.S. Department of Justice (DOJ).
- Critical Connections: Getting People Leaving Prison and Jail the Mental Health Care and Substance Use Treatment They Need*: What Policymakers Need to Know About Health Care Coverage* (2017), Martha Plotkin and Alex Blandford, CSG Justice Center.

Centers for Medicare & Medicaid Services (CMS) Guidance

- Heightened Scrutiny Review of Newly Constructed Presumptively Institutional Settings (2019), Calder Lynch, CMS.
- Guidance for States on the Availability of an Extension of the Enhanced Federal Medical Assistance Percentage (FMAP) Period for Certain Medicaid Health Homes for Individuals with Substance Use Disorders (SUD) (2019), Chris Traylor, CMS.
- To Facilitate successful reentry for individuals transitioning from incarceration to their communities (2016), Vikki Wachino, CMS.

Social Security

- Criminal justice SSI/SSDI Outreach, Access, and Recovery (SOAR) topics and tools. National SOAR TA center criminal justice webpage.
- Regional SOAR criminal justice TA centers.

Prescription Assistance Programs ***(PAPs)***

Three types of PAPs offer help to people whether they have health care coverage or not. Assistance programs for discounts on medication used for MAT of opioid addiction are included.

Need-based Programs: Low-income applicants who do not exceed specified earning limits can qualify. These programs offer most medications at low cost:

- Rx Outreach is a fully licensed, nonprofit, need-based mail-order pharmacy that offers many types of prescription drugs at a significant discount. The income limits are somewhat higher than other need-based programs (up to $35,000 annually for a single person).
- NeedyMeds is a nonprofit organization that provides a prescription drug discount card to eligible individuals at no cost and helps locate low-cost services and providers.

Consumer Discount Programs: These programs offer free discount cards or coupons for most, but not all medications. Some are accepted everywhere, but others can only be used at affiliated pharmacies.

- GoodRx provides a free prescription drug discount card or a free phone app that functions like a discount card but includes a mapping tool that compares prices at nearby pharmacies. For people without insurance, it can reduce some drug costs by 50–80 percent.
- HelpRx.info offers a free prescription drug discount card accepted at participating pharmacies, as well as a searchable database of manufacturer's coupons and specific conditions. It includes a section on SUDs with coupons for buprenorphine and other drugs.

Drug Company Programs: Nearly every drug manufacturer offers some level of assistance to people who cannot afford their medications. The degree of assistance and processes for determining eligibility vary. The programs listed here include some medications for treatment of addictive disorders.

- Medicine Assistance Tool: Sponsored by the drug industry's primary trade group, the Pharmaceutical Research and Manufacturers of America, the site also claims affiliations with 1,300 national and local organizations and assistance programs that enroll people who qualify. It includes links to 475 public and drug-company-sponsored assistance programs.
- Indivior Here to Help Patient Assistance Program: The pharmaceutical company Invidior provides free Suboxone for up to a year to U.S. citizens without coverage who are 16 or older and earn around $2,500 monthly or less. Indivior also offers a discount card for uninsured patients or those with high co-pays. It covers up to $75 per month of co-pays for insured patients and a larger proportion for uninsured patients.
- Zubsolv® Patient Assistance Program: Orexo makes a relatively inexpensive generic buprenorphine product, Zubslov. Their assistance program is administered by NeedyMeds. U.S. citizens may apply to receive free medication for up to 1 year with a 6-month renewal process. A Zubsolv discount card also offers maximum savings of $225 on a monthly supply.

- Alkermes Vivitrol Co-pay Savings Program: Patients 18 or older can apply for a co-pay savings card if they are uninsured or have commercial insurance. This program excludes patients covered by the following government or public health benefit programs: Medicaid, Medicare (including Medicare Part D), VA benefits, and TriCare. Alkermes also offers a program for needy patients to apply to receive Vivitrol at no cost.

Clinical Resources

Motivational Approaches

- The NIDA/SAMHSA Blending Initiative offers
    - Promoting Awareness of Motivational Incentives (PAMI)—introductory training
    - Motivational Incentives: Positive Reinforcers to Enhance Successful Treatment Outcomes (MI:PRESTO)—online course
- *Contingency Management Strategies and Ideas* (2005), N. G. Bartholomew, G. A. Rowan-Szal, & D. D. Simpson, Institute of Behavioral Research at Texas Christian University (TCU).
- Motivational Interviewing: NIC webpage with multiple resources.
- Enhancing Motivation for Change in Substance Abuse Treatment, TIP Series, No. 35. (1999), CSAT.

Mapping Interventions and Tools

- Simple Guide To Genograms, Jesuit Social Services.
- *Mapping Your Reentry Plan: Heading Home* (2007), N. G. Bartholomew, D. F. Dansereau, K. Knight, & D. D. Simpson, Institute of Behavioral Research at TCU.
- *Mapping-enhanced Counseling: An Introduction* (2008), N. G. Bartholomew & D. F. Dansereau, Institute of Behavioral Research at TCU.

Medication-assisted Recovery

- Medication-assisted Treatment Inside Correctional Facilities: Addressing Diversion (2019), SAMHSA.
- *Clinical Guidelines for the use of Buprenorphine in the Treatment of Opioid Addiction*, TIP Series, No. 40 (2004), CSAT.
- *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*, TIP Series, No, 43 (2005), CSAT.
- *An Introduction to Extended-release Injectable Naltrexone for the Treatment of People with Opioid Dependence*, SAMHSA Advisory
- *Legality of Denying Access to Medication Assisted Treatment in the Criminal Justice System* (2011), Legal Action Center.

- Best Practices for Successful Reentry for People Who Have Opioid Addictions (2018), CSG fact sheet.
- Medication-Assisted Treatment in the Criminal Justice System: Brief Guidance to the States (2019), SAMHSA.

D. Reentry Resources: General and Population-Specific

General

- Legal Action Center criminal justice resources. Webpage of helpful publications on voting rights, housing, expunging records, and more.
- The Jail Administrator's Toolkit for Reentry (2008), Jeff Mellow, Debbie A. Mukamal, Stefan F. LoBuglio, Amy L. Solomon, & Jenny W. L. Osborne. The Urban Institute, John Jay College of Criminal Justice, & BJA.
- National Reentry Resource Center (NRRC). Website offering comprehensive tools and information for reentry.
- Reentry Services Directory from the NRRC.
- National Criminal Justice Initiatives Map from the NRRC.
- The Center for Prisoner Health and Human Rights, reentry page.

Justice-Involved Veterans

- Justice Involved Veterans, NIC resource page.
- Veterans Justice Outreach (VJO) Program, U.S. Department of Veterans Affairs (VA). Includes listings for VJO specialists in 50 states.
- Veterans Treatment Courts and other Veteran-focused courts served by VA VJO Specialists (2018), VA fact sheet.
- Health Care for Reentry Veterans (HCRV) Services and Resources, webpage from VA.

People Living with HIV/AIDS and Viral Hepatitis

- National Directory of Local AIDS Service Organizations (ASOs).
- National Directory of AIDS Drug Assistance Programs (ADAPs).
- Overview and Inventory of U.S. Department of Health and Human Services (HHS) Efforts to Assist Incarcerated and Reentering Individuals and Their Families: HIV/AIDS Health Improvement for Reentering Ex-offenders (HIRE) Initiative.
- HIV Resource Library, Division of HIV/AIDS Prevention (2019), Centers for Disease Control and Prevention (CDC)
- Minority HIV/AIDS Fund. Information on activities and grantee programs.
- Hepatitis C in Corrections—A New Resource for Incarcerated People (2015), by

Rich Feffer for HIV.gov. Informational booklet and screening and practice guidelines.

- HIV/AIDS Resources for Professionals, Stop the Virus., Gilead Sciences, Inc.
- The Ryan White HIV/AIDS Program: The Basics (2019), Henry J. Kaiser Family Foundation. Webpage explaining funding and services.

Mental Health

- Judge David L. Bazelon Center for Mental Health Law. Offers many resources, including staff training.
- SAMHSA's Gather, Assess, Integrate, Network, and Stimulate (GAINS) Center. Focused on increasing access to mental health service for justice populations.
- CSG Justice Center's Mental Health Program website. Resources for all justice system intercepts.
- CSG Justice and Mental Health Collaboration Program (JMHCP). Information on grantee programs, learning collaboratives, and more.
- SAMHSA Forensic Assertive Community Treatment (FACT) Brief.

Opioid Overdose Prevention

(Also see *Overdose Risk Reduction and Relapse Prevention for RSAT Programs*.)

- Law Enforcement Naloxone Toolkit, BJA National Training and Technical Assistance Center (NTTAC).
- Be Aware Be Prepared: Understanding an Opioid Emergency. Overdose education materials, basic presentation slides, handouts, and naloxone and emergency response education.
- Harm Reduction Coalition. National center provides online training, overdose education materials, policy guidance, and training materials used in collaborative programs in the New York State prison system and San Francisco jails. Also lists contact information for state and local harm reduction services.
- Opioid Overdose Rescue. Short step-by-step training videos and a free app, 3 Steps to Save a Life.
- NaloxoneInfo.org. Offers a specific section on naloxone distribution programs in prisons and jails and other resources for implementing naloxone programs.
- Follow Directions: How to Use Methadone Safely (2009), SAMHSA.
- Be a Lifesaver: Overdose Prevention and Survival, pamphlet from the Drug Overdose Prevention Education (DOPE) Project.
- Excellent! Educational video from the Center for Prisoner Health and Human Rights at Brown University (19 minutes): Staying Alive on the Outside

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