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The Residential Substance Abuse Treatment (RSAT) Study

The Characteristics and Components of RSAT Funded Treatment and Aftercare Services

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I. Introduction and Background

A. Statement of the Problem and Purpose of Research

Since 1994, the Bureau of Justice Assistance's (BJA) Residential Substance Abuse Treatment (RSAT) for State Prisoners Program has supported the implementation of treatment in the nation's prisons and jails. Authorized under the Violent Crime Control and Law Enforcement Act and administered by the BJA of the U.S. Department of Justice (DOJ), this program makes funding available to U.S. states and territories to establish or expand substance use disorder treatment in state prisons and local jails. In recognition of the growing number of studies that found that without effective aftercare, the recovery gains made while incarcerated could be lost in the pressures of reentry, Section 102(a) of the Second Chance Act (SCA) amended BJA's authorizing legislation under the Crime Control Act in 2007. Legislation was amended so that states receiving funds under RSAT were mandated to ensure that individuals participating in federally funded residential treatment programs receive aftercare services, including case management and other support services.

The SCA of 2007 also mandated that the Attorney General, through the National Institute of Justice (NIJ) and in consultation with the National Institute on Drug Abuse (NIDA), conduct a study on the use and effectiveness of funds used by DOJ for aftercare services under the amended legislation. NIJ awarded a grant to Advocates for Human Potential, Inc. (AHP) under the FY2013 solicitation for a Study of the Use of RSAT Program Funds on Aftercare Services (RSAT Study). AHP designed a research study to gather in-depth information on treatment and aftercare programs funded through RSAT, including: how states make decisions about funding programs; the full spectrum of programmatic activities delivered by these programs; and the challenges and facilitators to providing aftercare services.

This section of the report will present a brief review of the literature on substance use disorder treatment in correctional facilities and aftercare services. Chapter II, presents the specific research goals and objectives of the study, the study design and data collection methods, and the study analytic approach. The results of the State Coordinator Program Inventory and the Subgrantee Inventory are presented in Chapter III and IV respectively. And finally, Chapter V presents a discussion of the main findings, the study limitations and implications for BJA RSAT programs.

B. Literature

1. Substance Use Disorder Treatment in Correctional Facilities and Development of the Residential Substance Abuse Treatment for State Prisoners (RSAT) Programs

History of Substance Use Disorder and Treatment in U.S. Correctional Settings

The connection between crime and substance use disorders/addiction has long been understood as a serious problem by public policymakers in both the substance use disorder and criminal justice fields (BJA, 2005). Not only are drug possession and sale usually illegal, but other types of crimes are directly or indirectly related to drug use (Hiller, Knight, & Simpson, 1999). The National Institute on Drug Abuse (NIDA, 2014) reports that drug use is involved in at least five types of crimes: 1) drug possession or sales, 2) crimes directly related to acquiring drugs (such as theft to pay for drugs); 3)

crimes related to a lifestyle that includes associating with individuals with a criminal justice history, 4) violent behavior, including intimate partner violence and sexual assault, and 5) offenses related to driving under the influence of drugs and alcohol.

The scope of this problem is immense. A report by the National Center on Addiction and Substance Abuse (CASA) at Columbia University (2010) found that, of the 2.3 million inmates in U.S. prisons and jails in 2006, almost 1.5 million met the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) criteria for substance use disorders or addiction. In addition, another 458,000 individuals had histories of substance use disorders, were under the influence of alcohol or other drugs when committing their crime, committed a crime to get money to buy drugs, were incarcerated for an alcohol or drug law violation, or shared some combination of these characteristics. In total, these individuals made up about 85% of the U.S. prison and jail population.

The CASA report found that, although the overwhelming majority of prison and jail inmates had some history of substance use, only 11% received any type of professional substance use treatment while they were incarcerated, despite a growing body of research that documents positive outcomes from effective prison-based treatment programs (Taxman, Perdoni, & Harrison, 2007; CASA, 2010). The public policy case for providing in-prison treatment seems common-sense and compelling. According to NIDA, "findings show unequivocally that providing comprehensive drug abuse treatment to criminal offenders works, reducing both drug abuse and criminal recidivism . . . it is a matter of public health and safety" (Fletcher & Chandler, 2006, p. 9).

There is a long but uneven history of drug treatment within correctional facilities in the U.S. In 1935, the U.S. Public Health Service Hospital, known as the "Narcotic Farm," was established in Lexington, Kentucky—the first federal correctional facility built specifically to house and treat individuals with substance use disorders, jointly operated by the Bureau of Prisons and the Public Health Service (Campbell, Olson, & Walden, 2008). Most inmates were either sentenced for drug crimes or entered "voluntarily" to avoid a drug crime conviction. The program, which ended in 1975, combined a research facility, prison, and treatment center. Pioneering research on methadone and opiate blockers was conducted at the facility, but because the research was conducted before federal legislation protecting human subjects was passed in 1974, ethical concerns about the conditions of some of the research remain. Treatment provided at the Narcotic Farm was also not very effective; 93% of those who returned to the community later relapsed (Campbell, Olsen, & Walden, 2008). In 1966, Congress passed the Narcotic Addict Rehabilitation Act (NARA), which required in-prison and aftercare treatment for addicted inmates in federal facilities administered by the Bureau of Prisons. This led to the development of a network of substance use disorder treatment programs throughout the federal prison system by the mid-1970s (Diiulio, 2001).

In their review of drug treatment in state prisons, Fallin, Wexler, and Lipton (1990) outline the development of state prison treatment programs, from early opposition to prison-based drug treatment and rehabilitation in the 1970s and 1980s to evidence supporting the need for drug treatment in prison as a way to curb recidivism in the 1990s. The 1994 Violent Crime Control and Law Enforcement Act amended Title I of the Omnibus Crime Control and Safe Streets Act (1968) by allocating significant funds to substance use disorder treatment in state prisons (Farabee et al., 1999). Around the same time, several states funded substance use disorder initiatives for justice involved individuals (Farabee et al., 1999), but these varied across states. Fallin et al. conclude that

drug treatment in state prisons can reduce recidivism provided that the prisons have competent and committed staff, support of correctional authorities, adequate resources, a therapeutic program (such as the Therapeutic Community model) that addresses lifestyle and criminal thinking, and continuity of care post-release.

Early Studies of the Effectiveness of State-Level In-Prison Treatment Programs

Two state in-prison treatment programs of note were evaluated during the 1980s. These were the Stay 'N Out Program in New York State (a collaboration among the Division of Substance Abuse Services, the Department of Correctional Services, and the Division of Parole) and the Cornerstone program in Oregon (a collaboration between Divisions of Mental Health and Corrections). Both programs were based on the Therapeutic Community (TC) model, in which inmates actively participate in program operations and self-help activities. TC programs are based on social modeling and behavioral conditioning theories, have clearly articulated rules and consequences, and inmates can earn privileges for good behavior (Fallin, Wexler, & Lipton, 1999).

A 1984 NIDA-funded evaluation of the Stay 'N Out Program examined whether treatment of substance use disorders is possible within prisons and whether this model of treatment is effective (Wexler, Wexler, & Williams, 1986). This large-scale quantitative analysis looked at treatment outcomes (including rearrest and reincarceration) in relation to client characteristics and program attributes (time in program and termination status). The study included no-treatment and alternative treatment (non-TC model) comparison groups. The primary findings were that: 1) the Stay 'N Out therapeutic community was significantly more effective than both the no-treatment condition and alternative prison-based treatment modalities in reducing recidivism, and 2) reductions in recidivism were related to longer lengths of stay in the program.

Two evaluations were conducted of the Cornerstone Program. The first evaluation (Field, 1984) found that three years after program completion, graduates[1] achieved significantly higher success rates than three comparison groups (program drop-outs, a sample of Oregon parolees with substance use disorder histories who did not participate in the program, and a similar group of parolees from Michigan) on two outcome measures: not returning to prison and not being convicted of any crime. The second evaluation (Field, 1989) compared a group of Cornerstone graduates with a group that dropped out of the program and found similar results; 71% of graduates did not return to prison compared to only 26% of program dropouts, and slightly more than half of graduates were not convicted of any crimes compared to about 15% of the dropouts.

Key Elements of Correctional Substance Use Disorder Programs Identified by Subsequent Research

In the years since the evaluations of the Stay 'N Out and Cornerstone programs, TC programs have been the most widely used and most frequently studied form of in-prison substance use treatment (Wormith et al., 2007). TC programs within prisons are usually modified forms of the TC model employed in the community that are adapted to the security requirements of correctional facilities; a number of studies have found that such programs result in significant reductions in recidivism compared to control groups (Sacks, Chaple, Sacks, McKendrick, & Cleland, 2012). Inciardi

[1] Note: the comparison of graduates to program drop outs is a better predictor of treatment retention than outcomes.

et al. (2004) found that participants in a multistage TC program in a Delaware prison were significantly more likely to remain out of prison and arrest-free than a no-treatment comparison group over a five-year period.

Research studies have identified key elements of effective criminal justice-based treatment programs for adults with substance use disorders. These include conducting standardized substance use disorder and risk assessments to determine the severity of substance use disorder(s) and appropriate clients for services (Fletcher & Chandler, 2006; Peters & Wexler, 2005; Lowenkamp, Latessa, & Hoslinger, 2006; Taxman & Thanner, 2006). Simpson (2004) found that strong efforts to engage individuals in treatment were key to positive outcomes. In addition to TC, MacKenzie (2000) found that cognitive-behavioral treatment and standardized behavioral modification techniques were successful in-prison treatment modalities. Other important factors identified by research studies include: treatment lasting 90 days or more (Simpson, Joe, & Brown, 1997); family engagement strategies in treatment for juveniles (Henggeler, McCart, Cunningham, & Chapman, 2012; O'Farrell, 1993); a continuum of care approach as the individual moves through the criminal justice system (Butzin, Martin, & Inciardi, 2002; Taxman & Bouffard, 2000); programming that incorporates gender-responsive and trauma-informed care for women (Messina, Grella, Cartier, & Torres, 2010); and a strong aftercare component (Bahr, Masters, & Taylor, 2012).

The Residential Substance Abuse Treatment (RSAT) for State Prisoners Program

In recognition of the problems posed by the growing number of state and local prison and jail inmates with substance use disorders, the Violent Crime Control and Law Enforcement Act of 1994 authorized the Residential Substance Abuse Treatment (RSAT) for State Prisoners Formula Grant Program (BJA, 2005). The program, administered by the BJA of the U.S. Department of Justice (DOJ), makes funding available to U.S. states and territories to establish or expand substance use disorder treatment in state prisons and local jails. The purpose of the program is to "develop and implement substance abuse treatment programs in state, local, and tribal correctional and detention facilities and to create and maintain community-based aftercare services for offenders" (BJA, 2014).

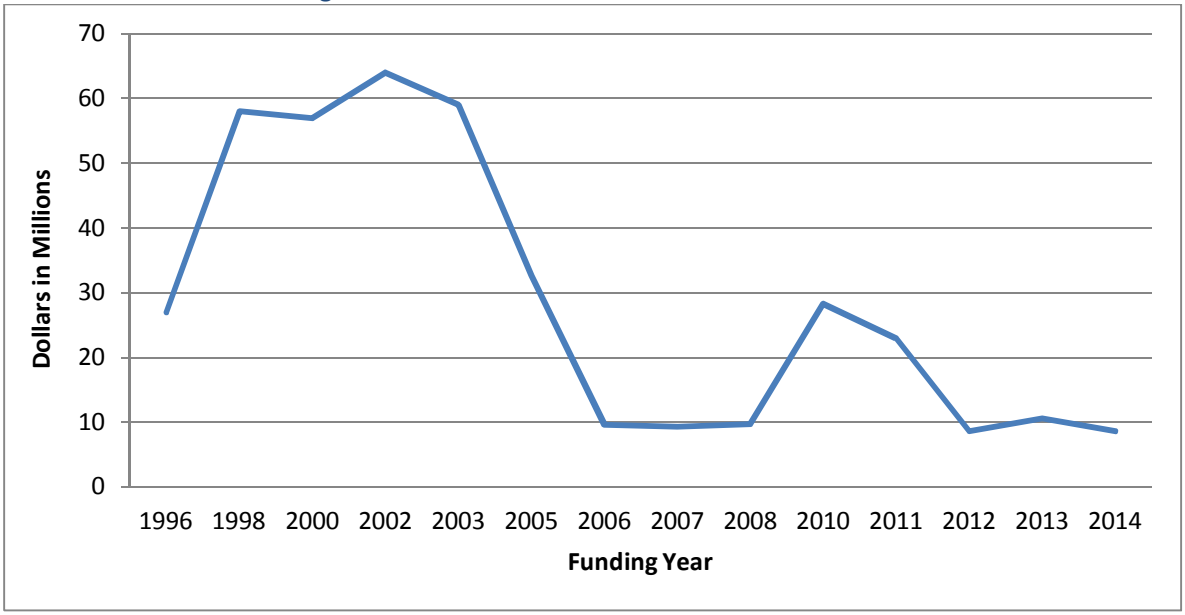
Each state is eligible to receive a base grant amount, supplemented by a proportionate share of additional funding based on each state's prison population. Although all states and territories are eligible, each must apply for grants and must adhere to certain requirements. For example, states must coordinate with the state-level alcohol and substance use disorder agencies and with substance use disorder treatment programs in the design and implementation of programs, and they must ensure that RSAT activities are coordinated with state and local programs funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (HHS) (BJA, 2005). RSAT grants may be used to fund three types of treatment programs: residential prison-based, residential jail-based, and community-based aftercare (BJA, 2014).

Additional requirements for RSAT-funded programs include the following: programs must use evidence-based modalities; programs must coordinate with mental health services for inmates who have co-occurring mental health conditions; prison programs must last between 6 and 12 months and jail programs must be at least three months long; prison programs must provide residential treatment facilities separate from the general correctional population; services must focus on

substance use disorders and must also assist individuals in developing social, cognitive, behavioral, and vocational skills; programs must conduct routine drug testing; and programs providing aftercare services are to be given funding preference (BJA, 2014). Finally, at least 10% of the total RSAT funds allocated to the state must be made available to local correctional and detention facilities (if such facilities exist) (BJA, 2014).

Since RSAT funding was first allocated in 1996, there have been major shifts in the amounts Congress has allocated to states as presented in Exhibit 2.1.

Table I-1: BJA RSAT Funding Allocation Between 1996–2014[2]*



*Data from some years were not available, and there are several years when an RSAT Request for Proposal (RFP) was not issued.

Starting at $27 million in 1996, states experienced their peak funding years during the early 2000s, with the high at more than $60 million dollars. Beginning in federal fiscal year (FFY) 2003–2004, states saw a precipitous decline in RSAT funding, with a low of about $10 million during FFY 2006–2008. Although there was some boost in funding in 2010 and 2011, RSAT funding has largely hovered around the $10 million mark for the last decade.

2. Importance of Aftercare Following Substance Use Disorder Treatment

Participation in treatment during the transition from prison back to the community has been shown to be effective in helping maintain positive outcomes of substance use disorder treatment (Butzin, Martin, & Inciardi, 2002, 2005; Wexler, Falkin, & Lipton, 1990). Although aftercare is considered an essential element of criminal justice-based treatment programs, there is no standard conceptualization or definition of aftercare. In criminal justice literature, aftercare refers to any type

[2] 2000-2011 RSAT Formula Grant Allocations https://www.bja.gov/Funding/05RSATAllocations.pdf https://www.bja.gov/Funding/06RSATAllocations.pdf, https://www.bja.gov/Funding/07RSATAllocations.pdf, https://www.bja.gov/Funding/09RSATallocations.pdf, https://www.bja.gov/Funding/10RSATAllocations.pdf; https://www.bja.gov/Funding/2011_RSAT_Alloc.pdf; https://www.bja.gov/Funding/12RSATAllocations.pdf, https://www.bja.gov/Funding/12RSATAllocations.pdf, https://www.bja.gov/Funding/13RSATAllocations.pdf, https://www.bja.gov/Funding/14RSATAllocations.pdf; Bureau of Justice Assistance. (2005). Residential Substance Abuse Treatment for State Prisoners (RSAT) Program, Program Update, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. http://www.prnewswire.com/news-releases/states-receive-first-installment-of-fy-1998-prison-funds-and-funds-to-continue-drug-testing-and-treatment-initiatives-77244117.html

of treatment or support services provided after release from prison. Common components of aftercare typically include relapse prevention, continued treatment for substance use disorders and/or peer support (e.g., 12-step programs), and assistance in areas that promote a stable lifestyle (such as employment, mental health, education, housing, health and well-being, and family reunification or support).

The finding that aftercare boosts the impact of TCs, one of the predominant treatment strategies used by RSAT programs, is well documented (Bahr, Masters, & Taylor, 2012; Mitchell, Wilson, & MacKenzie, 2006). Although some studies found that more than 50% of individuals who complete prison treatment programs relapse within 12 months, the rate drops to 30–40% for individuals who receive continued treatment in the community (Martin, Butzin, Saum, & Inciardi, 1999). The Inciardi et al. (2004) study of a multistage prison residential treatment program that included transitional and aftercare services found that five years after release from prison, treatment participation was the largest predictor of no illicit drug use between the treatment and no-treatment groups. Further, the authors found that participation in the program's transitional services more than tripled the odds of remaining drug-free.

In another study, Butzin et al. (2005) examined the effects of post-release transitional TC treatment (or work-release treatment) on drug use and employment rates among individuals who were formerly incarcerated. They found that individuals in post-release transitional TC programs (described as community-based work-release facility with TC treatment) had significantly higher rates of abstinence, a longer duration of abstinence, and higher rates of employment over a period of three years compared to individuals who received standard post-release supervision. The authors reported that even when controlling for other predictors of relapse (e.g., age, sex, race, treatment in prison, prior treatment), participating in a transitional treatment program halved the odds of relapsing.

The weight of evidence suggests that aftercare is critical immediately after release and that it is beneficial to concentrate resources during this period when individuals are most likely to commit new crimes or to violate the conditions of their supervision (Pew Center on the States, 2008). In addition to higher rates of relapse and recidivism, risk of death from drug overdose is elevated during this period; Schiraldi and Ziedenberg (2003) found that formerly incarcerated individuals are 13 times more likely to die during their first two weeks out of prison than the general population.

3. -Effective Aftercare Approaches

Although aftercare services begin, by definition, upon release, effective planning for aftercare should begin when individuals enter prison or jail (Miller, Braude, & Prueter, 2012; Roman & Travis, 2004). To have appropriate supports in place at reentry, needs assessment should occur at intake, with a reassessment six months prior to reentry. Aftercare should occur within a continuum of care that begins in the jail or prison and continued in a coordinated way with community providers. Best practice approaches to aftercare include the following stages (Miller, et al., 2012, p. 12):

- *Screening/assessment (pre-treatment)*: The individual is assessed using standardized tools to determine the presence of substance use or abuse and the level of appropriate treatment.
- *Program intake*: A pre-release plan is developed to guide future coordination with - community resources. -

- *Program participation*: The individual receives treatment through the residential program in the jail or prison (3–6 months in jails; 6–12 months in prisons).
- *Pre-release plan activated*: Coordination between the jail or prison and community providers paves the way for continued support in areas of critical importance to avoid recidivism and support recovery.
- *Step-down aftercare*: On release, the individual receives supports with decreasing intensity over time.

In addition to the stages described above, Wormith et al. (2007) suggested that enhancing community reentry and reducing recidivism can be achieved by using standardized, empirically based risk assessment procedures at prison/jail entry (Birmingham, Gray, Mason, & Grubin, 2000); screening for mental health conditions prior to release from prison/jail (Gagliardi, Lovell, Peterson, & Jemelka, 2004; Petersilia, 2004); providing more corrections-based educational and vocational training programs (Rakis, 2005); and better discharge planning with meaningful community linkages so services are available immediately upon release (Hammett, Roberts, & Kennedy, 2001). Other researchers echo many of these elements, indicating that a comprehensive reentry plan "should include links to health, employment, and community services and treatment, based on each individual's unique risk level, need, and gender" (Spjeldnes & Goodkind, 2009, pg. 325–326; Andrews, Bonta, & Wormith, 2006; Bobbit & Nelson, 2004).

Research does not identify the precise nature of aftercare services necessary to promote positive outcomes, but most studies of aftercare have focused on modified therapeutic communities (Pelissier, Motivans, & Rounds-Bryant, 2005). One recent study examined the effectiveness of a reentry modified therapeutic community (RMTC) for men with co-occurring disorders. While in prison, participants received standard care or treatment through a prison modified therapeutic community (MTC). Post-release, each participant was randomly assigned to a RMTC or parole supervision and case management (PSCM). Sacks et al. (2012) found that 12 months later, the experimental group (RMTC) was significantly less likely to be reincarcerated (19% vs. 38%). Further, participants who received MTC treatment in both settings (in prison and post-release) achieved the greatest reduction in recidivism rates (Sacks et al., 2012).

Enhanced case management is a post-release strategy used to increase the likelihood that individuals who were formerly incarcerated engage in community-based treatment services. However, there is less research in this area. Brown et al. (2001) examined the effectiveness of six-month community-based aftercare services for formerly incarcerated individuals involved with drugs that included individual counseling, case management, and peer support. The authors found that the aftercare group was less likely to report using drugs and had significantly less criminal activity than the no-aftercare comparison group in the six months post-enrollment. However, the differences between these two groups were reduced by the 12-month follow-up. Similarly, Wikoff, Linhorst, and Morani (2012) found that individuals participating in a voluntary case management program while on parole had a reduced likelihood of new convictions six months post-enrollment compared to individuals who did not receive these services. However, a multisite trial of strengths-based case management reentry programming found no differences in substance use participation, drug use, or crime for individuals receiving Transitional Case Management (TCM) and standard parole services (Prendergast et al., 2011) nine months post-release. The authors suggest that this

negative finding may be the result of problems with participant attendance at case management sessions, which may not have been sufficient to affect outcomes.

Research also shows that specific evidence-based strategies, such as Motivational Interviewing and Contingency Management, can improve release outcomes (CASA, 2010). Establishing intrinsic motivation in clients becomes critical after release because many clients are no longer under supervision or mandated to treatment. Contingency Management (CM), a system of rewards that reinforces target behaviors, such as negative urine screens, has demonstrated its effectiveness in helping formerly incarcerated individuals achieve stable recovery (Gendreau, Listwan, & Khuns, 2011). In their meta-analysis of the effects of CM programs, Gendreau et al. (2011) found that the intervention produced substantial improvements in institutional adjustment, as well as educational and work-related behaviors. The mean percentage change in participant improvement on target behaviors, or effect size, was estimated at 60–70%.

Other evidence-based practices shown to improve post-release outcomes include medication-assisted treatment (MAT) and Cognitive Behavioral Therapy (CBT). MAT uses prescribed medications in concert with behavioral therapies and can provide relief from cravings and support abstinence. Examples include disulfiram, which discourages the use of alcohol; buprenorphine, which relieves withdrawal and cravings for opioids; and Vivitrol, which blocks the effects of alcohol and opiates (Miller et al., 2012). Friedmann et al. (2012) indicate that inadequate knowledge and negative attitudes about MAT may be related to its underutilization during community reentry. They stated that ". . . better linkages to community pharmacotherapy during the reentry period might overcome other issues, including security, liability, staffing, and regulatory concerns" (p. 10).

CBT has long been recognized as an effective approach to relapse prevention. The approach is designed to change the thinking processes and patterns that lead to substance use disorders and can also address "criminal thinking." The latter refers to distorted cognition that may manifest as self-justificatory thinking, misinterpretation of social cues, displacement of blame, or deficient moral reasoning (Lipsey, Landenberger, & Wilson, 2007; Yochelson & Samenow, 1976). In their study of 20 in-prison drug treatment programs, Pelissier et al. (2005) concluded that CBT is an effective intervention for both incarcerated males and females in that it reduced the likelihood of recidivism and the use of this model "can yield uniformly positive outcomes despite differences in program implementation" (p. 73).

Although the benefits of prison-based treatment and aftercare are well-documented, Olson, Rozhon, and Powers (2009) found that improving rates of aftercare admission and completion hinged on providing enhanced pre-release planning and coordination to incarcerated individuals. This includes connection to residential aftercare, such as residential treatment, halfway houses and/or recovery homes that promote drug-free living, developing community-based partnerships and strong communication between parole and community providers, and having a longer period of post-release supervision.

4. RSAT Program and Aftercare

Despite the abundance of evidence for the effectiveness of aftercare, the previous National RSAT Evaluation found that very few RSAT programs had an aftercare component (Harrison & Martin, 2003; BJA, 2005). About a fifth of programs reported providing work-release treatment

(23%) or treatment services in a halfway house (20%), however no data were provided on parole-supported treatment (Harrison & Martin, 2003). Similarly, the results of two process evaluations of RSAT programs in Maryland and Virginia indicated that aftercare—specifically formal linkages to community treatment—was lacking (Taxman, Silverman, & Bouffard, 2001; Taxman & Bouffard, 2001). Taxman et al. (2001, p. ii) found that ". . . there was no continuum of care among offenders, moving from the prison program to work release to aftercare services involved in parole supervision. That is, the program had no continued involvement beyond the clients' residential treatment experience." During this period of time, RSAT funds could not be used for community treatment, although the use of aftercare to continue individuals' involvement in post-release treatment and to improve long-term outcomes was encouraged (Taxman & Spinner, 1996; Lipton, 1995).

Second Chance Act Makes Aftercare a Required RSAT Component

Congress passed the Second Chance Act of 2007, which, among other provisions, amended RSAT program funding requirements to make aftercare a required component. Beginning with the Federal Funding Year (FFY) 2008 RSAT solicitation for applications, programs were required to provide post-release aftercare treatment for up to 12 months for individuals who participated in RSAT programs within correctional facilities. However, grantees were not permitted to spend more than 10% of their funds on post-release services. BJA noted that "aftercare services include substance abuse and other medical treatment or health services provided by licensed providers, or case management and support services approved by authorized state or local agencies" (U.S. Department of Justice (DOJ), 2013, p. 4).

Prior to the changes in RSAT resulting from the passage of the Second Chance Act, the majority of BJA RSAT-funded programs focused on providing individuals with treatment in prison. A recent program review found that 124,094 participants were enrolled in residential or jail-based programs between January 2010 and March 2012 (BJA, 2012). During this period, only 7,159 participants were enrolled in BJA RSAT-funded aftercare services. In 2013, to more fully support aftercare services, BJA lifted the 10% funding restriction for aftercare put in place in 2008.

II. Study Design and Methods

A. Research Goals and Objectives

NIJ funded Advocates for Human Potential, Inc., (AHP) to conduct a study of the treatment and aftercare services provided under the BJA (BJA) Residential Substance Abuse Treatment (RSAT) Program. The goal of the RSAT Study was to provide NIJ with concrete programmatic knowledge about RSAT-funded treatment and aftercare services. The study focused on describing the range and types of substance use disorder treatment, reentry/release planning activities, and related aftercare services provided to individuals through BJA RSAT program funds. In particular, the study sought to identify the application and penetration of evidence-based practices in facilities (jail, prison, juvenile detention) and post-facility for RSAT-funded programs. Through two separate data collection activities, the study sought to understand states' approaches to distribution of RSAT funding for aftercare, as well as detailed information on subgrantee program activities and approaches and challenges and facilitators to aftercare services. Exhibit II-1 presents the three study aims and research questions.

Exhibit II-1: Specific Aims and Research Questions

AIM 1. Understand how states use BJA RSAT funds for treatment and aftercare services.
1.1. How do states decide what services to fund with RSAT dollars?
1.2 How do states assure RSAT-funded programs are connected to aftercare?
1.3. What is the relationship between states and RSAT-funded programs?
AIM 2. Describe the specific substance use disorder treatment and other services supported by BJA RSAT grants and the nature of these services.
2.1. What specific substance use disorder treatment services are supported through RSAT funding, how do services and programmatic characteristics vary by facility type (prison, jail)?
2.2. What types of evidence-based practices or other specific program models are used by RSAT grantees?
2.3 What types of substance use disorder treatment and related services are provided to individuals transitioning to the community generally?
AIM 3. Describe aftercare services supported by BJA RSAT grants and other sources, as well as the challenges and facilitators to implementing aftercare.
3.1. What types of aftercare services are supported through RSAT funding?
3.2 What aftercare services are available to RSAT participants transitioning to the community generally?
3.3 What challenges or facilitates the implementation of aftercare for individuals transitioning to the community, including pre-release planning?

B. Data Collection Methods

To address the research aims and questions, our study approach included collecting both quantitative and qualitative data centering on two main data collection activities: the RSAT State Coordinator Program Inventory (web survey) and the RSAT Subgrantee Program Inventory (semi-structured telephone interview).

1. The RSAT State Coordinator Program Inventory

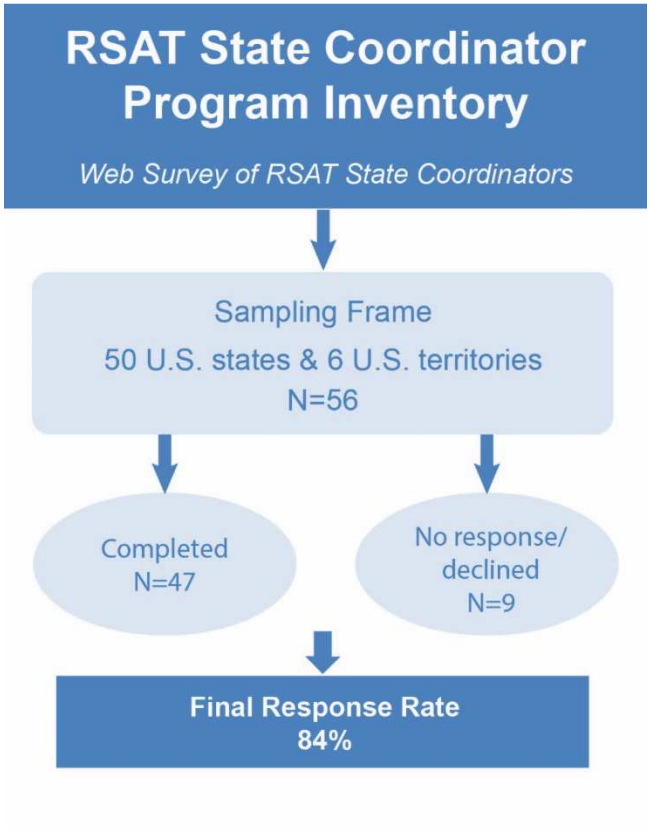
Sample. The sampling frame for the RSAT State Coordinator Program Inventory (State Inventory) included all RSAT state coordinators/Points of Contact (PoCs) from the 50 U.S. states and six U.S. territories. The PoC is the individual designated by their state or territory to monitor BJA funding. BJA provided a list of the state PoCs to researchers and staff, who then conducted phone calls to confirm and update relevant contact information to ensure the appropriate respondent received the invitation to participate in the web survey.

Measures. Questions were developed to ascertain how states make decisions about program funding and the efforts at the state level to support aftercare. The survey consisted of a series of close-ended questions and a handful of open-ended questions centering on the process for distributing state funds within each state/territory, the use of additional federal or state funding sources to support RSAT programs, dedicated funding for aftercare services, and the overall role and responsibility of the state PoC in funding and administering RSAT program funds. A copy of the instrument is in Appendix A.

Methods. The web survey was a self-administered questionnaire delivered to state PoCs via email and hosted by Snap Survey Software. Two state PoCs piloted the survey in advance of the full survey launch. Pilot participants completed the survey and provided feedback on its content, structure, and method of delivery. Researchers implemented a modified version of the five-contact system (Dillman, 2009), with all contacts recorded in a tracking database developed to manage survey administration. At the end of January 2015, an email invitation was sent to state PoCs containing a brief overview explaining the study's purpose and procedures as well as a link to the State Inventory.

Respondents were required to provide an electronic signature at the bottom of that page (before proceeding to the survey), confirming their consent to participate, and were able to print out a copy of the consent form if they wished. Non-responders received reminder emails at regular intervals, and after six weeks, calls were made to non-responders to encourage participation and confirm there should not be an alternate respondent. If the individual indicated that there was a new RSAT state PoC and/or someone better suited to respond to the types of questions in the survey, their contact information was collected and researchers sent them an initial invitation. Exhibit II-2 displays the final participation of n=47 or 84% of the n=56 states and territories.

Exhibit II-2: RSAT State Coordinator Program Inventory Sampling Frame and Response Rate -

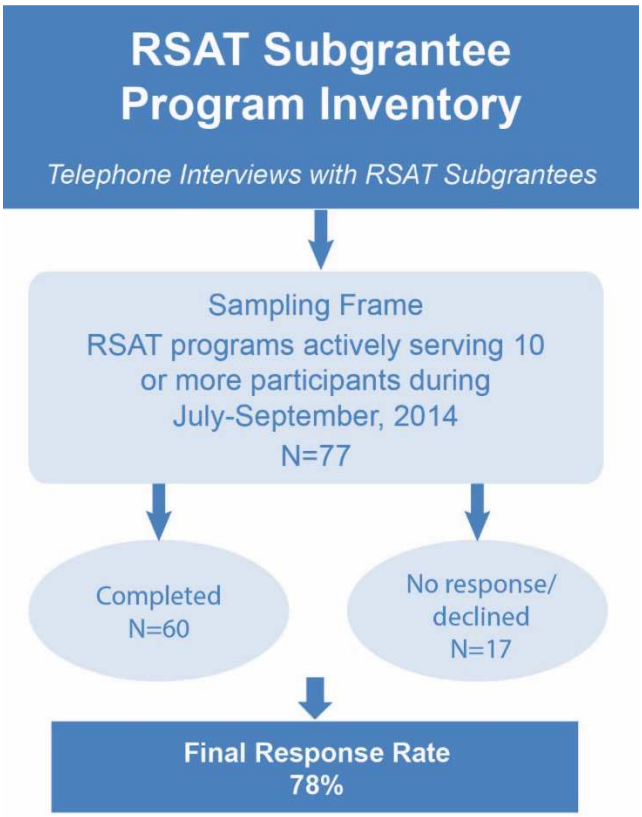


2. The RSAT Subgrantee Program Inventory

Sample. Subgrantees are RSAT programs funded by states. Some states may fund multiple programs, others may have one, and some states may have no active programs during a given quarter. The sample for the RSAT Subgrantee Program Inventory (Subgrantee Interview) included RSAT-funded programs reporting active programs serving 10 or more individuals during the July–September 2014 quarter. Prior to selecting the sampling frame, researchers conducted a thorough review of the most recent BJA Performance Management Tool (PMT) data, the performance measures required by BJA for all RSAT-funded programs. PMT data were submitted on a quarterly basis and designate programs as "prison," "jail," or "aftercare." This analysis revealed significant variation in RSAT program funding cycles by state from quarter to quarter, with some states initiating programs/reporting and others ceasing reporting, in each quarter. This means that programs reporting data in the first quarter of a year may no longer be active in the third quarter. To ensure that we would reach active programs, we chose to focus on a single reporting quarter using the most current PMT data, July–September 2014. Given the larger amount of resources telephone interviews entail, we decided to exclude programs that had served fewer than 10 individuals in the reporting quarter. The only exception to the criteria was for programs in the "aftercare" category. All identified aftercare programs were included in the sample regardless of the number of individuals served given the focus of the study.

Among the 56 states and territories, a total of 43 states had active programs serving 10 or more clients during the July–September 2014 reporting period, and only one territory had an active program. Of the 13 states/territories not included in the sampling frame, six states did not have any active RSAT programs during that period, one state had a program that served fewer than 10 individuals, and five territories did not report actively serving clients during that period. In total, there were 86 programs that met the sampling frame criteria. However, an additional nine programs were removed because they were found to no longer be active. The final sample for the Subgrantee Interview was 77 programs. Exhibit II-3 outlines the sampling frame and response rates of n=60 or 78% of the 77 programs actively providing services to 10 more RSAT participants during the sampling frame.

Exhibit II-3: RSAT Subgrantee Program Inventory Sampling Frame and Response Rate



The respondents for the Subgrantee Interview had a wide range of job titles. The most common titles included the terms clinical director/administrator (n=14), program manager (n=12), program/unit director (n=10), administrator (n=6), and warden (n=5). The number of years that respondents had been in their position ranged from 1–20 years; although the mean was five-and-a-half years, 72% of the respondents had been in their position six or fewer years, and 14% reported being there for one year or less.

Measures. The questions for the RSAT Subgrantee Inventory (Subgrantee Interview) were adapted from the National Criminal Justice Treatment Practices Survey (NCJTPS) (Taxman et al., 2007), a national survey of prisons, jails, and community correction agencies**.** Specifically, the

evaluation adapted questions and scales from the Survey of Treatment Staff. The Principal Investigator from the NCJTPS served as an expert consultant on the design and provided guidance on the content areas most relevant to this study. The RSAT Subgrantee Inventory was initially intended to be implemented in two separate sections, as a web survey with closed-ended questions about the types of services offered by the program, followed by a telephone interview component to gather more detail on programs reporting aftercare services. However, field testing of the instrument indicated that the study would not only obtain more accurate information on the programs but also a better response rate if it were conducted through telephone interviews. For many programs, the authorized individual on record was not the best resource for knowledge of the program services, and some programs were misclassified (e.g., as prison instead of jail). Further, some programs reported data from multiple programs under one program name. Collecting the information through a telephone interview allowed the interviewer to probe and improved the accuracy of the information collected.

The Subgrantee Interview included questions on: RSAT program funding, staffing, and enrollment criteria; screening and assessment procedures; program enrollment and completion rates; types of general treatment; wraparound, evidence-based practices; and transitional services provided to clients. There were also a range of open-ended questions that asked respondents to reflect on the strengths of their programs and the facilitators to implementing aftercare services, service gaps for aftercare, and challenges to providing aftercare services. Exhibit II-4 below outlines the main interview domains and the types of information collected. A copy of the instrument is available in Appendix B.

Exhibit II-4: Domains for RSAT Subgrantee Inventory

Interview Domain	Type of Information Collected
Respondent information	Title, role in RSAT, number of years in current role
RSAT funding and staffing	Total funding, match dollars, and other resources; fund allocations; staffing (FTE and funding source); non-staff expenses
RSAT program criteria	Population served; setting; eligibility/exclusion criteria
RSAT screening/assessment	Screening events, instruments, and settings
RSAT treatment planning	Treatment planning activities, reassessment, and updates
Enrollment and setting	Enrollment in 2014, average census in 2014, capacity, setting for housing and treatment, program duration
Types of services provided	Types of general treatment services, EBPs, and the percent of clients receiving each; wraparound services and funding source
Drug testing and compliance management	Conditions and frequency of testing; use of sanctions and incentives
Pre-release activities	Types of pre-release activities provided to RSAT clients and the general population
Program completion	Successful completion criteria, percent successfully completed, reasons for non-completion
RSAT-funded aftercare services	Participant identification and referral process; strategies to maximize enrollment; treatment planning; services and EBPs, types of partnerships, challenges and facilitators to implementation and service provision
Non-RSAT-funded aftercare	Participant identification, service setting, types of services, funding sources, referral process, and challenges and services gaps

One of the research goals of this study was to identify whether treatment and aftercare services are science based. Using the National Institute of Drug Abuse's (NIDA) landmark publication, *Principles of Drug Abuse Treatment for Criminal Justice Populations*, to partially guide our research in this area, we sought to understand the extent to which RSAT programs incorporate these principles. Revised in 2014, the NIDA guide outlines 13 research-based treatment principles relevant to criminal justice populations (NIDA, 2014). Two of the principles are about philosophical orientation to drug abuse and treatment, rather than program practices, and are therefore not addressed in this study. Exhibit II-5 presents the 11 NIDA principles and the proxy measures used in this study.

Exhibit II-5: NIDA Drug Abuse Treatment Principles for Criminal Justice Populations

Principle	Indicator Used in This Study
Treatment must last long enough to produce results	Program is longer than three months
Assessment is first step in treatment	Program conducts screening and assessment with valid instrument
Drug use should be monitored	Program conducts drug testing
Treatment should target criminal behavior	Program has a "criminal thinking" EBP
Criminal justice supervision should incorporate treatment planning; planning should incorporate transition to community	Program has treatment planning and transitional planning
Continuity of care is essential for reentry	Connection to aftercare program services
A balance of rewards and sanctions encourages participation	Use of rewards and sanctions
Individuals with co-occurring disorders require integrated treatment	Program has co-occurring services available
Medications are an important part of treatment	Linkage to MAT post-program
Treatment planning for reentry should include strategies to prevent and treat serious illness	Connection to medical services post-release

Methods. The RSAT Subgrantee Inventory was administered through telephone interviews with the RSAT programs between February–May 2015. Contact information (names, email addresses, phone numbers) from the PMT data was used to reach respondents. For at least half of the programs, the individual identified in the PMT was not the person who was most familiar with the program and we were referred to another individual for the interview. In other cases, the information did not lead to a response at all, and we made the effort to obtain new contact information from the RSAT state PoC. Ultimately, collecting the data via telephone had the added benefit of allowing us to locate the most appropriate respondent and allowed multiple individuals to participate in an interview if desired by the program.

Through the pilot interviews, we learned that one individual may be responsible for the oversight of multiple RSAT subgrantee programs, but these programs all appear as "one program" in the PMT data. Given the length of the interview (45–75 minutes), researchers determined it would be too burdensome to ask respondents to report on more than one program in an interview. Researchers added questions to the interview to determine whether there were programs potentially missed by the process. Respondents responsible for oversight of more than one program

were asked to select the program targeted to females or juveniles only (if applicable), to gather information on specialized populations, or, alternatively, to select the program that provided services to the largest number of individuals. Sixteen respondents reported that they provided oversight to multiple programs. However, 10 reported that the programs used the same treatment model. Among the four remaining respondents with multiple programs, three had oversight of one additional program and one had oversight of two additional programs, suggesting that the study only missed collecting unique information on five programs.

Research staff were trained on the telephone interview instruments and recruitment procedures. The recruitment process started with an email to the respondent describing the purpose and procedures for the study. If there was no response within a few days, the researcher left a voicemail for the respondent alerting them to the RSAT study email. After respondents agreed to participate in the telephone interview and established a date, researchers sent them a consent form. The researchers required the return of a signed and dated consent form prior to the interview, and researchers reviewed the contents of the consent form with the respondent prior to initiating the interview. Researchers recorded interview responses on paper and made audio recordings (with respondents' permission) of each interview for quality assurance and back-up. Researchers reviewed and cleaned all paper copies of the complete interviews prior to data entry.

C. Analytic Methods

Researchers used IBM SPSS Statistical software for quantitative data analyses and Dedoose software for qualitative analysis of open-ended questions.

I. SPSS

After data collection was complete, researchers retrieved the data from Snap Survey and reviewed, cleaned, and combined the data into a complete file for analysis purposes. Summary variables were computed and descriptive statistics, including frequency distributions, measures of central tendency, and cross tabulations, were created to document the key features of RSAT programs. However, due to insufficient statistical power, we did not test for statistical differences between jails and prisons (and other settings) because the samples were too small to make meaningful comparisons.

II. Content Analysis

Responses to key open-ended questions were uploaded into Dedoose's web platform for content analysis. Content analysis is a systematic, replicable technique that reduces textual data to categories based on explicit rules of coding. Following a preliminary examination of the data, two researchers established emergent coding categories. The coding schemes were then combined and reconciled. In addition, the validity of emergent constructs, including any derived quantitative indices, was documented. Questions centering on the following topics were included in the content analysis: unique program features, implementation challenges and strategies to overcome them, funding sources for aftercare, service gaps in aftercare, and challenges to facilitating access and engagement in aftercare. Subgrantees providing RSAT-funded post-release aftercare services responded to additional open-ended questions centering on treatment planning and coordination; partnerships/networks and collaboration; components of the aftercare continuum; and unique

features, challenges, barriers, and facilitators to aftercare services. These questions were also included in the content analysis.

III. Study Results: State Coordinator Inventory

This section focuses on the findings from the RSAT State Coordinator Program Inventory web survey (or State Inventory). As described in the previous chapter, the individual designated by their state/territory to monitor BJA RSAT funds was recruited to participate in the survey. The purpose of this section is to describe how states/territories make decisions about allocating RSAT funds, including funding for aftercare services.

A. Respondents

The BJA/RSAT state coordinator/PoC for 46 states and one territory completed the web survey. For ease of discussion, we will refer to respondents as the "state PoC" (point of contact) and all geographic entities as "states." The position titles of the state PoCs varied considerably. The most common title among the state PoCs was related to grants management/administration (n=12). At least 10 state PoCs had the term "justice" or "corrections" in their title. The remaining position titles were more generic: administrator, assistant director, director, and coordinator. Although the mean number of years in the position was five-and-a-half years, almost a quarter (n=11) had been in the position for one year or less. The longest tenure as the state PoC was 18 years; however, only 19% (n=9) had been in the position 10 years or longer. This indicates that state PoCs have diverse backgrounds and varying levels of experience.

B. Reporting and the Role of the State Coordinator

State PoCs were asked about their role and responsibilities overseeing the subgrantee programs. The majority of respondents reported reviewing quarterly Performance Management Tool (PMT) data (n=41) on a frequent basis. This is not surprising because PMT is the required performance measures for BJA. Almost three-quarters of state PoCs reported that they frequently monitor subgrantee contracts (70%, n=29), and half reported assisting with program implementation (50%, n=22). Very few RSAT state PoCs reported working with subgrantee programs on client eligibility or treatment quality on a frequent basis, although, notably, almost half of respondents reported that they frequently conduct monitoring visits (42%, n=19). Table III-1 below presents these data.

Table III-1: Frequency of state RSAT Point of Contact Activities (n=45)*

Types of Activities with Subgrantees	Frequently % (n)	Sometimes % (n)	Not at all % (n)
Review quarterly Performance Management Tool data	93% (41)	7% (3)	----
Monitor contracts	70% (29)	23% (10)	11% (5)
Monitor program implementation	50% (22)	46% (20)	5% (2)
Conduct monitoring visits	42% (19)	47% (21)	11% (5)
Involved with quality improvement issues	29% (13)	36% (16)	36% (13)
Involved with treatment quality issues	18% (8)	31% (14)	51% (23)
Involved with client eligibility issues	15% (7)	24% (11)	60% (27)

*Percentages may vary due to missing data. -

More than half of state PoCs (n=30) reported that subgrantees have additional reporting requirements beyond the PMT data, including quarterly reports about the program (n=22) and detailed budget/expenditure reports (n=13).

Table III-2 outlines the degree of state PoC involvement in various state-level activities. The vast majority of state PoCs reported active involvement with decisions around distributing RSAT funds to subgrantees (83%, n=38). The next most frequent category of involvement was work on state policy issues related to substance use disorder treatment and corrections, although less than a quarter (22%, n=10) of PoCs reported that this is an active part of their role.

Table III-2: RSAT State Point of Contact Involvement in State-Level Activities (n=46)*

State Level Activities	Quite a bit % (n)	A little bit % (n)	Not at all % (n)
Involved with decisions around distributing RSAT funds	83% (38)	11% (5)	7% (3)
Work on state policy issues related to substance use disorder treatment and corrections	22% (10)	31% (14)	47% (21)
Work with state legislature around issues relevant to RSAT programming	18% (8)	25% (11)	57% (25)
Work with state's/territory's DOC around health policy	19% (8)	16% (7)	65% (28)

*Percentages may vary due to missing data.

C. States' Process for Making Decisions Around Funding

Among the 47 state PoCs, the majority (64%, n=30) reported that their states have a competitive application process for distributing BJA RSAT funds. As presented in Table III-3, 20 states issue a Request for Proposal (RFP) annually, and the remaining 10 states have a cycle of between 2–5 years, depending on the amount of funds available. Among the 17 states that do not have competitive process, the Department of Corrections (DOC) is responsible for allocating funds in 11 states, and six states fund the same programs every year.

Table III-3: RSAT State/Territory Funding Processes (n=47)*

	% (n)
Competitive application process annually	43% (20)
Department of Corrections allocates funds	23% (11)
Competitive application process every 2–5 years	21% (10)
Fund same programs every year	13% (6)

*Percentages may vary due to missing data.

State PoCs were asked to describe any challenges associated with distributing and/or using RSAT funds. Overwhelmingly, the challenge reported by the most respondents was how limited RSAT funds are and the reduction in funding over the years (n=23). Several respondents indicated that the need for services is great in their state, and so it is very challenging to determine the best, most effective use of the funds. As one respondent stated, "declining annual amounts prevent us from expanding the programs in [state]" and another indicated that "the amount available is sometimes

considered too low to start a new program, so we only receive interest from programs that are already up and running." Funding limitations also affect existing programs' service delivery. For example, one respondent reported that "[state]'s biggest challenge right now is funding issues; we are not receiving enough money to fund two RSAT programs. Most of the time, programs have to wait two or three months before the next year award comes in to start their program up again." A few respondents indicated that the limited funds are often spent on staff training and administration to ensure quality programming, leaving very little for actual service provision. This is especially true for new programs that require more resources for startup.

The second most frequently identified challenge was issues with local applicants (e.g., jails, community corrections). These challenges include identifying/attracting local applicants, the inability of local programs to meet RSAT model treatment requirements, and the inability of local programs to meet BJA reporting requirements. Several respondents indicated that local applicants are often unwilling to apply because of the small amounts of funds available for programming or the extensive reporting requirements for the limited funding. A few respondents reported that it is more difficult to implement RSAT programs in local communities due to limited resources and that local programs often require more technical support than prison programs.

D. Types of Programs Funded

A little more than half of the state PoCs reported funding both local/county corrections programs (e.g., jails, community corrections) and prison-based RSAT programs (n=25). Among the remaining states, 15 reported their state funds prison-based programs only, and the remaining seven states allocate all RSAT funds to county or local corrections-based programs. Eleven states reported that they use RSAT dollars to fund juvenile programs.

Table III-4: Types of Programs Funded in States/Territories (n=47)

	% (n)
Both prison and local/county corrections programs	53% (25)
Prison-based programs only	32% (15)
Local/county corrections programs only	15% (7)

As described in Chapter II, the RSAT funding allocations have vacillated tremendously since the program was initiated in 1996. For the past decade, the total RSAT funding allocation has been between $8.6 million and $10.6 million, with the exception of 2010 and 2011, when funding was boosted to $28.3 and $22.9 million, respectively. Among the study respondents, the total award allotted in 2014 ranged from $35,000 to $881,054.[3] Almost a quarter of the states received less than $70,000 (24%, n=11), the median amount was $144,055, and only five states received more than $300,000. As described in Chapter II, the amount of funds received by states is based on its prison population.

About half of the state PoCs (51%, n=24) reported that they use other funding sources to help support RSAT programs. The largest percentage of respondents, 67% (n=16), reported using state funds to supplement RSAT grants. Table III-5 presents the types of funding sources reported by state

[3] 2014 RSAT Funding Allocations https://www.bja.gov/Funding/14RSATAllocations.pdf

PoCs. The amount of these leveraged funds ranged from $40,809 to $1,500,000, with a median of $174,060. It is worth noting that the median leveraged dollars are actually higher than the median grants, effectively doubling resources (and sometimes more than doubling them) for many programs.

Table III-5: Additional Funding Sources Used to Support RSAT (n=24)

Additional funding sources for RSAT programs	% (n) states/territories
State funding	67% (16)
Justice Assistance Grant (JAG) funding	42% (10)
Local funding	21% (5)

*States may cite more than one additional funding source.

Regardless of whether states leveraged additional funds, a little more than half (53%, n=25) reported that RSAT subgrantees are encouraged to collaborate with other BJA-funded programs. Among the 15 state PoCs that specified the program(s) with which they collaborate, the most frequently identified programs were Second Chance Act grantees (n=10) followed by Adult Drug Court Discretionary Program grantees (n=4).

E. States' Approach to Transitional Planning and Aftercare Services

Among the 47 state PoCs, more than half (60%, n=28) reported that RSAT subgrantees are required to do pre-release planning coordination with parole/probation; only nine states indicated there is a formal Memorandum of Understanding (MOU) or protocol in place to support this coordination.

For aftercare services (services that facilitate the coordination between correctional treatment services and other social service/rehabilitation programs in a community setting), only nine respondents reported that their state *requires* a percentage of RSAT funds to be used for aftercare; this percentage ranged from 10% to 50%. Although not required by state mandate, three respondents reported that their state has routinely funded programs to provide aftercare services (see Table III-6).

Table III-6: State Requirements/Practices Related to Aftercare (n=42)

	% (n) states/territories
Require percentage of RSAT funds supports aftercare services	21% (9)
Require RSAT-funded programs to provide aftercare (regardless of funding source)	55% (23)
Require grantees to do pre-release planning (n=47)	60% (28)

Even when RSAT funding was not used, a little more than half of states required RSAT subgrantees (n=23) to provide aftercare. Among the states that did not require the provision of aftercare funded by RSAT or other sources, the most frequently reported reason (n=7) was that their state has existing aftercare programs that RSAT participants are linked with post-release. Several other respondents indicated that the limited availability of RSAT funds makes it challenging to require aftercare services.

F. -Relationship Between Level of State PoC Involvement and State Approaches to RSAT Program

The study also sought to explore the relationship between the state PoCs' level of involvement with RSAT programs and states' approaches to the RSAT program by developing an index of state PoC involvement based on the activities presented in Table III-1 in this section. All of the variables, except reviewing quarterly PMT data (a requirement of the PoC position), were summed and included in the index. The scores for the PoC Involvement Index ranged from 1–12, with a median of 6. The scores were then grouped into three categories as presented in Table III-7.

Table III-7: State Point of Contact (PoC) Involvement Index (n=43)

	% (#) states/territories
Passive involvement by state PoC [1–4]	28% (12)
Semi-active involvement by state PoC [5–8]	51% (22)
Active involvement by state PoC [9–12]	21% (9)

The level of state PoC involvement was not related to the state's level of RSAT funding. The mean amount of funds received by states in 2014[4] was relatively similar in all groups (ranging from 160K–170K). Each group had states that received less than $50,000 and states that had received more than $300,000. Other areas that were unrelated to the level of PoC involvement include the amount of funding from other sources, the proportion of states that require a percentage of RSAT funds to support aftercare services, and the proportion of states that reported collaboration with other BJA-funded programs (data not shown).

There were, however, a number of areas in which RSAT activities differed for states with semi-active and active state PoCs. Only 17% (n=2) of passive state PoCs had a competitive RFP process, as compared to 68% (n=15) and 89% (n=8) of semi-active and active state PoCs, respectively. Additionally, a larger proportion of states with active state PoCs (78%, n=7) required RSAT-funded programs to have aftercare (even if not funded with aftercare dollars) than semi-active (55%, n=11) and passive PoC states (17%, n=2). The majority of active PoC states also reported that pre-release planning was required for RSAT participants (87%, n=7), whereas only two passive PoC states reported that this requirement was in place (the remaining 10 state PoCs reported that they didn't know). Among semi-active state PoCs, 68% (n=15) reported pre-release planning requirements.

Finally, states with active PoCs were also more involved in state-level policy activities. As presented in Table III-8, no passive state PoCs were involved in state policy activities in a significant way. These data suggest that active state PoCs are more in touch with what is going on in their state related to substance use disorder treatment and corrections, ideally bringing this information to bear in their RSAT monitoring and quality improvement activities.

[4] 2014 RSAT Program Allocations https://www.bja.gov/Funding/14RSATAllocations.pdf

Table III-8: State Point of Contact (PoC) Involvement Index and State-Level Activities -

Activity	Active state PoC (n 9) % (n)	Semi active state PoC (n 21) % (n)	Passive state PoC (n 12) % (n)
	Involved quite a bit	*Involved quite a bit*	*Involved quite a bit*
Involved with decisions around distributing RSAT funds	100% (9)	82% (18)	58% (7)
Work on state policy issues related to substance use disorder treatment and corrections	75% (6)	14% (3)	0
Work with state legislature around issues relevant to RSAT programming	63% (5)	9% (2)	0
Work with state's/territory's Department of Corrections around health policy	50% (4)	14% (3)	0

*Percentages may vary due to missing data. -

IV. RSAT Subgrantee Telephone Interview

This section focuses on the findings of the Subgrantee Telephone Interview. The sampling method for programs is described in Chapter III. The purpose of this section is to describe the range and types of substance use disorder treatment and aftercare services provided to individuals through the BJA RSAT program. This section also describes the extent to which programs incorporate aspects of the NIDA treatment principles, the strengths of program services, and the challenges in delivering RSAT services. For programs providing aftercare through RSAT, we describe the challenges and facilitators to implementing aftercare intervention models for individuals transitioning to the community. Where feasible, the analysis examines the differences between prison and jail programming.

A. History and Funding

Among the 60 subgrantee programs in the sample, 40% (n=24) of RSAT programs have received funds for two to five years, with 27% in place for 10 years or longer. Notably, only two programs have been funded for one year or less. The range of RSAT funds received by programs varied tremendously, from $9,495 to $358,800. Although the mean program funding amount is $109,481, 31% (n=18) of programs received $50,000 or less in 2014. Table IV-1 groups the reported RSAT funding into ranges.

Table IV-1: RSAT Funds in 2014 (n=58)

Amount of RSAT funds in 2014	% (n)
$50,000 or less	31% (18)
$50,001–100,000	26% (15)
$100,001–200,000	26% (15)
$200,001 or greater	17% (10)

All RSAT programs are required to provide at least a 25% match to receive RSAT funds, which can be in dollars or in-kind services. Among respondents who provided an estimate (n=43) of the match and other resources for RSAT programs, the mean was lower ($57,170) and the range was smaller ($5,000–$177,400) than the distribution of RSAT funds described immediately above. Approximately half the programs had $50,000 or less in match/other funds and 14% had greater than $100,000. In general, respondents reported that BJA RSAT funding amounts were higher than match/other funds, but most programs reported that they leveraged more than the 25% requirement through match/other funds. In fact, eight programs had higher levels of match/other funds than RSAT funds. There were no differences between jails or prisons in the mean or the median level of RSAT funds.

B. Types of Programs Funded by RSAT

In terms of the types of services funded by RSAT, all programs provide some type of treatment services. The majority of respondents (82%, n=49) reported that their programs use RSAT funds to support correctional-based programs *only*. The settings for these services included prisons, jails, juvenile justice facilities, and community corrections-run programs. Seven respondents reported that their programs used RSAT funds for aftercare services and supports *only*. For the purposes of this study, we define aftercare as *any community-based step-down treatment or case management*

services to support the recovery of individuals who were formerly incarcerated. RSAT community-based correctional programs that serve as alternatives to jail/prison are not included in this category unless they used RSAT funds to support step-down services. Finally, four programs reported providing both correctional treatment and aftercare services. For the purposes of the discussion, programs that use RSAT funds to support correctional treatment programs will be referred to as *treatment programs* and programs that use RSAT funds to support aftercare or step-down treatment will be referred to as *aftercare programs*. Table IV-2 illustrates the variety of settings and program types funded with RSAT dollars.

Table IV-2: Primary Service Setting and Program Types (n=60)

Primary Settings for RSAT Services	Types of RSAT Funded Services		
	Treatment Services Only (n 49) % (n)	Treatment and Aftercare Services (n 4) % (n)	Aftercare Services Only (n 7) % (n)
Prison (n=21)	100% (21)	0	0
Jail (n=19)	80% (15)	20% (4)	0
Correctional-operated community-based facility (n=8)	88% (7)	0	12% (1)
Juvenile correctional facility (n=7)	86% (6)	0	14% (1)
Non-corrections-operated community-based facility/agency (n=5)	0	0	88% (5)

Male-only adult programs were most prevalent in the survey (53%, n=27), with an additional third of programs (29%, n=15) serving adult males and females. Only 11 programs were female-only, and seven served juveniles only. Table IV-3 presents the proportion of adult and juvenile programs that serve males and females.

Table IV-3: RSAT Program Target Populations (n=60)

Population	Male only % (n)	Female only % (n)	Male and Female
Adult (n=51)	53% (27)	18% (9)	29% (15)
Juvenile (n=7)	57% (4)	14% (1)	29% (2)
Both adult and juvenile (n=2)	50% (1)	50% (1)	----

Across RSAT programs, the average daily program census in 2014 was 43 beds/individuals, with a range of 7 to 153 (n=51). Almost a third of programs (31%, n=16) had an average daily census of 25. As presented in Table IV-4, the median capacity of prison programs was much higher than those of other settings. When examining average daily census by type of facility (data not presented), 72% of jail programs served 50 or fewer individuals on a given day, compared to 29% of prison programs.

Table IV-4: Program Capacity for RSAT Program Settings

Primary Settings for RSAT Program Services	Median Daily Census Beds/Individuals	Range Daily Census Beds/Individuals
Prison (n=20)	72	22–145
Jail (n=17)	40	12–160
Correctional-operated community-based facility (n=7)	20	7–44
Juvenile correctional facility (n=6)	25	18–34
Non-corrections-operated community-based facility/agency (n=1)	29	29

A little less than half of respondents (43%, n=26) reported that their program was not at maximum capacity in 2014. Many programs reported that this gap typically occurs because of participant attrition; participants turn over as they are released, transferred, moved to different security levels, or removed because of discipline problems, and it takes time to enroll new individuals. Several jail programs reported challenges in enrolling participants, in particular difficulty finding individuals who have a long enough sentence to complete the full program. Additionally, a few jail programs indicated that the pool of individuals is not as large as previous years due to the implementation of diversion and alternatives to incarceration programs in their community that draw against the eligible pool of RSAT participants. Although this is positive in that it minimizes the unnecessary incarceration of individuals who can be more appropriately served in the community, it also means that RSAT programs are working with a more challenging pool of individuals, a programmatic challenge that several respondents acknowledged.

C. Program Staffing

Respondents were asked to estimate the number and types of full-time equivalent (FTE) staff employed in their RSAT programs, as well as the funding source for the staff positions. Seventy-six percent (n=38) of programs reported that they used both RSAT and funding from other sources to support staff positions for RSAT programs. Only 13% (n=8) used only RSAT funds for staff positions and 8% (n=5) used only funds from other sources. Unfortunately, 15% (n=9) of respondents were not able to provide information on the source of funding for RSAT staff. There were no differences between jails or prisons in the sources of funding for program staffing.

Table IV-5 presents the proportion of programs that have a particular position type, the range of reported FTEs, and the most frequently occurring FTE. The vast majority (93%, n=54) of programs had .05 or greater FTE clinicians. The mode FTE for clinicians was also the highest (2.0). A large number of programs also had a program manager (62%, n=36). Correctional staff dedicated to the RSAT unit were among the lowest positions present in RSAT programs (12%, n=7), followed by peer

staff (10%, n=6). Not having a dedicated correctional officer (CO) for their RSAT programs was identified as a challenge by several respondents. Respondents indicated that it takes time to educate COs on the treatment philosophy of RSAT programs, and the frequent rotation of COs means they are effectively starting over with each new rotation.

Table IV-5: RSAT Program Staffing Positions (n=58)

Program Position	Present in RSAT Program (n)	Range FTE*	Mode FTE
Clinical staff (includes Substance disorder treatment and other types, including Mental Health)	93% (54)	0.5–10.0	2.0
Program manager	62% (36)	0.5–1.95	1.0
Case managers	38% (22)	0.10–4.5	1.0
Administrator	22% (13)	0.01–1.0	1.0
Correctional officer (dedicated to RSAT unit)	12% (7)	1.0–6.0	1.0
Peer support	10% (6)	.25–3.75	1.0

*Percentages may vary due to missing data.

A little more than two-thirds (66%, n=38) of RSAT programs reported that they used RSAT funds for non-staff expenses. As presented in the Table 5.6, the most frequently reported expense was training materials (49%), followed by training for clinical staff. We examined whether there were any differences in how prisons and jails used funds for non-staff expenses and found that almost twice as many prisons used resources for clinical training (40%, n=8) than jails (22%, n=4) and only prisons used RSAT funds for training correctional staff (20%, n=4). The study did not explore the type or frequency of trainings for either correctional or clinical staff.

Table IV-6: RSAT Funds Used for Non-Staff Expenses (n=58)

Non Staff Expenses	% (n)
Videos, workbooks, and other materials	49% (28)
Training for clinical staff	35% (20)
Drug testing	21% (12)
Training for correctional staff	9% (5)

D. Criteria for Enrollment

All RSAT programs reported they have one or more eligibility criteria; Table IV-7 presents the most frequent criteria identified by respondents. Meeting a specific level of need or disorder on a substance use/abuse screen (62%, n=37) was the most common criteria for program eligibility, followed by being within a certain timeframe of release (60%, n=36). Programs that did not require a specific score on a substance use/abuse screen had other substance use-related criteria, including: history of substance use or drug offenses, being court mandated to participate, or use of a specific type of drug. Almost a quarter of programs (23%, n=14) reported that participant motivation was a requirement for enrollment, and a slightly smaller percentage (22%, n=13) required a certain score on a risk assessment scale—a measure that identifies problem areas in individuals' lives and predicts the risk of recidivism. In terms of exclusion criteria, participants' security levels that would not allow

participation in the program (23%, n=13) was the most frequently identified. For example, individuals with certain security levels may not be permitted to enter certain areas of the prison where RSAT services, such as groups, are provided. Twenty-two percent indicated they excluded individuals whose mental health diagnosis was serious enough that it would prevent active participation in the program. However, there were four programs reporting that co-occurring substance use disorders and mental health conditions was a criterion for program enrollment.

Table IV-7: Types of RSAT Program Eligibility Criteria (n=60)

Eligibility Criteria	% (n)
Must meet certain criteria on substance use disorder screen	62% (37)
Enrollment within a certain timeframe of release	60% (36)
Motivated to work on substance use disorder	23% (14)
Restrictions around certain security levels	23% (14)
Screened on risk assessment/score on risk assessment for “high” level	22% (13)
No serious mental health diagnoses	22% (13)
Court-mandated to participate	13% (8)
Must be willing to participate in aftercare	10% (6)
No felonies	8% (5)
No violations or restrictions	8% (5)
Must have co-occurring disorders	7% (4)

Analysis comparing jail and prison eligibility criteria found few differences in types of eligibility criteria, with the exception of a specific timeframe for release. Among the 21 prison-based programs, 76% (n=16) reported this was an eligibility criterion, compared to only 50% (n=10) of jail-based treatment programs, which is related to the shorter length of incarceration and greater unpredictability of release among jail programs.

E. Screening and Assessment Practices and Treatment Planning

The vast majority of RSAT programs reported using standardized screening/assessment practices for substance use disorders, risk assessment, and mental health conditions. As presented in Table V-8, 97% of RSAT programs screen for substance use disorders. The one program that did not screen was a small jail-based treatment program.

Table IV-8: RSAT Program Screening Practice (n=60)*

Type of Screening	Programs That Conduct Screening	Programs That Conduct Screening with a Valid Instrument
Substance use disorders	97% (58)	77% (46)
Risk assessment	87% (52)	67% (40)
Mental health conditions	85% (51)	32% (19)
Trauma symptoms	40% (24)	23% (14)

*Percentages may vary due to missing data.

Respondents were also asked to identify the instruments used for screening and assessment. As Table IV-8 illustrates, not all programs conduct screening/assessment with standardized, validated instruments. A little more than three-quarters of programs, 77% (n=46), use a standardized tool for substance use disorders. The most common instruments identified are the Texas Christian University (TCU) Drug Screen (32%, n=19) and Addiction Severity Instrument (ASI) (25%, n=12). A little more than three-quarters of programs (76%, n=40) conduct risk assessment using validated instruments, including the Level of Service Inventory-Revised (LSI-R) (20%, n=12) and the Level of Service/Case Management Inventory (LSCMI) (13%, n=8). For mental health screening/assessment, a wide range of instruments was identified, with no instrument being utilized by more than one or two programs. Although 40% of (n=24) programs reported screening for trauma symptoms, less than a quarter of programs actually used a validated instrument. Much like the mental health instruments, there were no trauma symptom measures that were common to more than two programs. Although almost all prison programs reported screening for substance use with a valid instrument (95%, n=20), only two-thirds of jail programs (63%, n=12) did so. The screening and assessment process is critical to determine appropriate treatment services; this finding suggests that there are a number of local correctional programs that may not be appropriately matching individuals to treatment services.

About half of RSAT programs also screen for eligibility for income and health benefits, as presented in Table IV-9. The proportion of prison and jail programs screening for these benefits ranges from 47% for SSI to 54% for Veteran's benefits.

Table IV-9: Programs Screening for Income and Health Benefits at Entry (n=58) -

Type of Benefit	% (n)
Social Security Income	47% (27)
Social Security Disability Income	48% (28)
Medicaid	52% (30)
Veteran's benefits	54% (31)
Affordable Care Act enrollment (n=37)*	51% (19)

*Only includes programs in states that have implemented Medicaid Expansion under the ACA.

Almost all respondents (98%, n=59) reported that their RSAT programs developed written treatment plans for participants (data not shown). Table IV-10 presents the prevalence of activities associated with treatment plans among those programs. The vast majority of programs reported that RSAT participants have an opportunity to review the treatment plan (97%, n=57) and that the screening/assessment findings are tied to the plan. Finally, 73% (n=43) of programs reported planning for release/aftercare needs in the treatment plan.

Table IV-10: Treatment Planning Activities in RSAT Programs (n=59)*

Treatment Planning Activities	% (n)
Participants have opportunity to review/input	97% (57)
Screening/assessment tied to plan	95% (56)
Access to additional treatment sources if needed	93% (55)
Aftercare included in treatment plan	73% (43)
Adjust intensity of services for participants with higher risk or greater needs	66% (39)
Adjust treatment services based on clinical progress	54% (32)
Reassessment with standardized instruments while enrolled in RSAT Program	46% (27)
Family members involved in treatment planning	32% (19)

*Percentages may vary due to missing data.

The majority of the programs also reported that they use participant treatment plans to adjust services (type and intensity). A little more than two-thirds (66%) indicated that their programs adjust the intensity of services for participants with higher needs, and a little more than half reported that they adjust treatment services based on clinical progress. Among the programs that include family members in treatment planning (32%, n=19), there were no differences among prison, jail, or programs targeting females. However, as might be expected, most of the juvenile programs reported including family members in treatment planning (88%, n=7), whereas adult programs were far less likely to include family members in treatment planning (23%, n=10).

F. RSAT-Funded Treatment Program Services

This section focuses on the 53 programs that use RSAT funds for treatment services in correctional-based settings, those defined as "treatment programs" at the beginning of this chapter. RSAT-funded aftercare programs will be discussed separately in a later section.

1. *Program Setting*

As illustrated by Table IV-11, the majority of these RSAT programs have segregated housing and treatment services (77%, n=39) separate from the general population. In the most recent BJA funding announcement this was a requirement for prison-based programs and was encouraged among jail-based programs where possible. The analysis found that although 91% (n=19) of prison programs provide segregated housing and treatment, this was true for only 58% (n=11) of jail programs. Almost all juvenile facilities and community corrections facilities also reported providing RSAT in segregated treatment and housing settings.

Table IV-11: Setting for Correctional-Based Treatment (n=51)*

Residential and Treatment Setting	% (n)
Segregated housing and segregated treatment	77% (39)
Non-segregated housing and segregated treatment	14% (7)
Non-segregated housing and non-segregated treatment	8% (4)
Segregated housing and non-segregated treatment	2% (1)

*Two missing cases

2. *Treatment Services*

Respondents were asked about the types of general treatment services provided to participants in their RSAT program and the approximate percentage of participants that receive each service. Table IV-12 presents the types of treatment services by the most common to the least common; the first column indicates whether the program provides the service, and the second column indicates whether the majority of participants (76% to 100%) receive these services. As demonstrated by Table IV-12, for the majority of services, there is a gap between the number of programs that reported providing the service and the number of programs that reported the majority of program participants (76% to 100%) receive the services. It is important to recognize that there are some types of services one would not expect all participants to receive because they are voluntary (e.g., spiritual programming) or may only apply to specific populations (e.g., parenting). It is important to note that the study did not collect information on the proportion of participants who *needed* a specific service, only the percent that received it, based on feedback from the survey pilot-test. Pilot respondents felt this information would be difficult for RSAT program managers to report accurately.

The greatest disparity between the proportion of programs that reported providing a service and the proportion reporting that most/all clients receive it is trauma services. Although nearly three-quarters of respondents (68%, n=36) reported that their RSAT program provides trauma services, only 21% (n=11) reported that they provide trauma services to 76 to 100% of their participants.

Analysis examining the 11 female-only programs found that 9 of these programs (82%) reported providing trauma services and 6 (54%) reported providing these services to most or all program participants. Given the high rates of trauma among women involved with the criminal justice system, this appears to be a significant gap.

Table IV-12: Treatment Services Provided in Correctional-Based Setting (n=53)

General Treatment Services in Correctional Based Programs	% (n) Programs Providing Services	% (n) Programs Providing Services to 76% to 100% RSAT
Group therapy substance use disorder treatment	100% (53)	98% (52)
Case management	94% (50)	81% (43)
Social skills development	94% (50)	77% (41)
Individual counseling sessions for substance use disorder treatment	93% (49)	70% (37)
Role-playing	91% (48)	68% (36)
Substance use disorder education	91% (48)	91% (48)
Therapeutic community	72% (38)	70% (37)
12-step meetings	70% (37)	36% (19)
Trauma services	68% (36)	21% (11)
Parenting classes	66% (35)	21% (11)
Peer mentor services	60% (32)	43% (23)
Spiritual programming/services	57% (30)	15% (8)
Family therapy/counseling	43% (23)	23% (12)
Alternative therapies (e.g., yoga, meditation)	36% (19)	11% (6)
Batterer services	32% (17)	8% (4)
Detoxification for substances	13% (7)	8% (4)

There also appears to be a disparity between the screening/assessment activities documented in Table IV-8 and the treatment activities presented in Table IV-12. Whereas only 40% (n=24) of programs reported any type of trauma screening (and 23%, n=14, with a valid instrument), 68% (n=36) of programs reported providing participants with trauma services. This suggests that some programs may be providing services to individuals, such as trauma-specific treatment, without a valid assessment to determine whether the treatment services are appropriate.

Respondents were asked to identify evidence-based practices (EBPs) provided by their RSAT programs. For this series of questions, respondents were asked whether they provided the EBP and what the proportion of participants who received it is. Similar to the general treatment services, there were gaps between the proportion of programs reporting they provide a specific EBP and the proportion of programs where the majority (76% to 100%) of participants received it; this disparity ranged from 4% to 18%. Faithful implementation of EBPs frequently includes ensuring that all program participants receive the intervention. Therefore, Table V-13 focuses only on programs that provided EBPS to most or all participants.

Eighty-five percent of programs reported providing at least one EBP to most or all participants. As presented in Table IV-13, the majority of programs reported providing Cognitive Behavioral Therapy (CBT) (78%, n=40). Fewer than a quarter of the programs provided many of the EBPs.

Table IV-13: Evidence-Based Practices (EBP) Provided in Correctional-Based Treatment (n=51)

Evidence Based Services/Practices in Correctional Based Programs	% (n) Programs Providing EBP to 76% to 100% RSAT Participants
Cognitive behavioral therapy (CBT)	78% (40)
Relapse prevention therapy (RPT)	55% (28)
Motivational enhancement therapies (METs)/Motivational Interviewing (MI)	51% (26)
Thinking for a Change (T4C)	37% (19)
Hazelden Model/Series	32% (16)
Co-occurring treatment/integrated mental health and substance use disorder services	22% (11)
Trauma-specific services (Seeking Safety, TREM, Covington)	18% (9)
Moral Reconation Therapy (MRT)	16% (8)
Contingency management	18% (9)
Illness Management and Recovery (IMR)	14% (7)
The Matrix Model	14% (7)
Juvenile EBP (multisystemic therapies (MST), TARGET, adolescent relapse prevention)	6% (3)

The EBPs were grouped into four categories to better explore combinations of services: 1) CBT/RPT, 2) MET/MI, 3) Criminal Thinking EBPs combined (Thinking for a Change (T4C)/Moral Reconation Therapy (MRT), and 4) Targeted EBPs combined[5] (Hazelden Model/Series, Seeking Safety, TREM, Matrix, IMR, MST). The analysis found that 84% (n=43) of programs reported providing CBT/RPT to most or all participants and that all programs providing MET/MI did so in combination with CBT/RPT. A little less than half of programs reported providing a Targeted EBP (49%, n=25) or a Criminal Thinking EBP (45%, n=24). Table IV-14 presents the combinations of treatment services for CBT, Criminal Thinking, and Targeted EBPs. As demonstrated by the table, less than a quarter of programs provide all three types of EBPs. MI is excluded from this analysis because it is provided in combination with CBT.

It is important to point out that we did not ask respondents about the training, supervision, or fidelity assessment activities to support EBPs. Therefore, the study cannot comment on the extent to which programs are providing EBPs with fidelity.

[5] For purposes of analysis, a Targeted EBP is defined as an EBP more focused a specific problem area (e.g., TREM—trauma or Hazelden—co-occurring disorders) than a generalized treatment approach like CBT, which is infused into many EBPs.

Table IV-14: Evidence Based Practice (EBP) Grouping for Correctional-Based Treatment (n=49) -

Evidence Based Services/Practices in Correctional Based Programs	% (n) Programs Providing EBPs to 76% to 100% RSAT Participants
Only providing one type of EBP: Cognitive behavioral therapy (CBT), Criminal Thinking, Targeted EBP	29% (14)
Providing Cognitive behavioral therapy and Targeted EBP	27% (13)
Providing Cognitive behavioral therapy and Criminal Thinking EBP	22% (11)
Providing all three: Cognitive behavioral therapy, Criminal Thinking, and Targeted EBP	20% (10)
Providing Targeted EBP and Criminal Thinking	2% (1)

*MI is excluded from this analysis because it is provided in combination with CBT.

In terms of family participation (Table IV-15), 30% reported that they include family members in RSAT programming. Among the programs that allowed this activity, the most common way families participated was in support sessions. Among the seven juvenile-only programs, five allowed family participation. However, there were no differences in male and female-only programs for family involvement in RSAT programming.

Table IV-15: Family Participation in RSAT Programming (n=15)

Mechanisms for Family Participation	% (n)
Routine family support sessions (may be video conferencing)	73% (11)
At discharge planning for treatment	27% (4)
At intake	27% (4)
Allow RSAT participants to read to children via phone or videoconferencing	20% (3)
Case-by-case basis, usually via telephone	20% (3)
Through video conferences	13% (2)
Weekly visitation	13% (2)
Review treatment plans	7% (1)
Family weekend	7% (1)

3. Drug Testing and Compliance Management

All RSAT programs reported testing for drug use—a requirement of the RSAT program funding. The most common circumstances are random drug testing (79%, n=42) and when a participant is suspected of drug/alcohol use (77%, n=41). Less than half of programs (43%, n=23) reported testing participants at program admission, and only 15% (n=8) of programs test at discharge. Very few programs reported drug testing on a routine basis, with 8% (n=4) testing monthly and 4% (n=2) testing weekly. The study did not include questions about the types of drugs tested during the screens.

Most programs reported providing incentives for good behavior (81%, n=43) and sanctions for program violations (79%, n=42), and 74% (n=39) of programs reported using both. Although almost all prison programs used sanctions (91%, n=19) and incentives/rewards (95%, n=20), only a little more than two-thirds of jail programs used sanctions (69%, n=13), and slightly more than half (58%, n=11) used rewards. It is likely that these compliance management techniques are less frequently used because of the shorter length of stay in jail programs.

4. *Transitional Services for Correctional Treatment Programs*

The vast majority of respondents reported that RSAT participants receive transitional services as they prepare for release. Nearly all (98%) reported that participants have a written pre-release plan and a designated case manager who facilitates their transition to the community (94%). Approximately three-quarters of programs reported that they provide assistance with re-enrolling or reinstating mainstream benefits, as well as with health insurance through Medicaid expansion. Additionally, most programs reported releases of information with treatment, health, and supervision agencies. As presented in Table IV-16, respondents reported that individuals in the general population also receive the same types of support. However, the rates were lower, particularly for sharing information with treatment, supervision, or health providers.

Table IV-16: Transitional Support Provided to RSAT Participants in Correctional-Based Treatment

Types of Transitional Support for Correctional Based Programs	% Programs Providing Support to RSAT Participants % (n) n 51*	% Programs Providing Service to Non RSAT Participants % (n)
A written pre-release plan	98% (50)	75% (38), n=51
Designated personnel/case management staff who facilitate the RSAT participant's transition from the correctional facility to the community	94% (48)	67% (34), n=51
If not previously enrolled in mainstream benefits, assistance applying for and securing benefits (SSI, SSDI, Medicaid) prior to release	82% (41)	72% (33), n=46
HIPAA form is provided to share information with treatment provider(s)	77% (39)	56% (24), n=43
HIPAA form is provided to share information with a supervision agency	75% (38)	54% (22), n=41
If previously enrolled in mainstream benefits, assistance having benefits (SSI, SSDI, Medicaid) reinstated prior to release	74% (37)	60% (28), n=47
HIPAA form is provided to share information with health provider(s)	72% (36)	55% (22), n=40
Assistance provided to apply for and securing health benefits through Affordable Care Act (ACA) (n=31)**	71% (22)	61% (19)

*Percentages may vary due to missing data.

**Only includes states with Medicaid expansion.

Respondents were asked about the types of connections made to community-based services for RSAT participants. The majority of RSAT programs reported that connections were made with a range of providers. Almost all provided a connection to substance use and mental health services (96% and 98%, respectively). Connections to housing services (88%, n=44), parole/probation (88%, n=44), and vocational/education (84%, n=43) were also high.

Table IV-17 presents the ways in which RSAT participants are connected to community-based services. In general, referrals are the primary way participants are connected to community providers, with approximately 80% of programs providing these connections. Connections made by personal contact were made by half as many programs. Analysis comparing the types of connections made by prisons and jails found few differences, with the exception of substance use disorder treatment. Twice as many jail programs used a personal contact/appointment for connecting RSAT participants to substance use disorder treatment than did prison programs (65%, n=12 vs. 29%, n=6), suggesting that jails have an easier time making this connection.

Table IV-17: Types of Connections to Community-Based Services

Connections to Community Based Services	By Referral	By Pre Arranged Appointment	By Personal Contact
Mental health treatment (n=50)	80% (40)	54% (27)	40% (20)
Substance use disorder treatment (n=49)	84% (41)	61% (30)	43% (21)
Parole/probation agent (n=44)	68% (30)	52% (23)	39% (17)
Housing services (n=44)	80% (35)	48% (21)	39% (17)
Vocational/educational services (n=43)	79% (34)	40% (17)	35% (15)

5. Program Completion for Facility-Based Correctional Treatment

All of the correctional-based treatment programs had multiple requirements for completing the RSAT program. Length in program (81%, n=43) was the most frequently reported completion criterion. The required length ranged from three months to 18 months; the most common length was six months (35%, n=18) (data not shown). Completing program requirements and making clinical progress were the next most commonly reported criteria. Analysis comparing the criteria across prison and jail programs found only a few differences. More prison programs had length in program as a requirement (91%, n=19) than jails (68%, n=13), and more prison programs required making clinical progress (81%, n=17), as compared to jails (68%, n=13).

Table IV-18: Criteria for Completing Correctional Treatment Programs (n=53) -

Criteria for Completing Program	% (n)
Length in program	81% (43)
Completing all required program components	77 % (41)
Making clinical progress	72% (38)
Not making trouble in groups	43% (23)
Agreeing to participate in aftercare	34% (18)
Becoming a facilitator or a team leader	17% (9)

Sixty percent of programs reported a completion rate of less than 75%. A similar proportion of jail and prison programs reported that the majority of participants successfully completed their RSAT program (76% to 100%).

As presented in Table IV-19, the majority of programs reported that involuntary discharge was a reason that participants do not complete the RSAT program. An involuntary discharge refers to a program removal because of a violation of the rules. All prison programs identified involuntary discharge as a reason for program discharge, but only 75% (n=12) of jail programs did so. Surprisingly, a larger proportion of jails (69%, n=11) identified facility transfer than prisons (53%, n=10). Additional analyses were not conducted with other categories (juvenile programs, community corrections) due to their small N.

Table IV-19: Reasons for Discharge from Correctional-Based Treatment (n=45)*

Reasons Participants Do Not Complete	All Programs (n 45) % (n)	Prison Programs (n 19)	Jail Programs (n 16)
Involuntary discharge (n=45)	89% (40)	100% (19)	75% (12)
Voluntary discharge (n=44)	61% (27)	68% (13)	56% (9)
Facility transfer before program completion (n=44)	59% (26)	53% (10)	69% (11)
Early release, sentence up before program completion (n=44)	52% (23)	63% (12)	60% (9)

*Percentages may vary due to missing data.

The average duration of RSAT program services across the sample of correctional-based programs was 6.4 months, with a range of 3–11 months. Not surprisingly, jail programs were, on average, shorter than prison programs. The mean duration is 8.2 months for prison programs and 4.6 months for jail programs.

Table IV-20: Average Duration of Correctional-Based RSAT Programs -

Program Duration	All Programs (n 48) % (n)	Prison (n 20) % (n)	Jail (n 18) % (n)
3–5 months	29% (14)	0	56% (11)
6 months	33% (16)	35% (7)	28% (5)
7–8 months	15% (7)	10% (2)	11% (2)
9 months	15% (7)	35% (7)	0
10–11 months	8% (4)	20% (4)	0

6. *Strengths and Challenges of Correctional RSAT Programs*

As part of the telephone interview, respondents were asked to discuss what they considered the strengths of their programs. A total of 47 programs identified one or more unique features or strengths of their RSAT programs. The most frequently reported strength was the treatment services/model used (n=19). For example, many of these programs indicated that they had a strong implementation of the Therapeutic Community (TC) model. Eight specifically identified the inclusion of an EBP as a strength, including Seeking Safety, Cognitive Behavioral Interventions for Substance Abuse (CBI-SA), and co-occurring treatment. Further, six programs identified the use of peers and recovery coaching in their RSAT programs as a programmatic strength.

The second most frequently reported strength was facility-based pre-release services or linkages to community-based programs (n=12). One respondent reported that the RSAT program is part of a larger community criminal justice committee that helps facilitate and problem solve reentry issues for individuals; another reported its strong connections to community providers. Among other areas frequently reported was strong collaboration between RSAT programs and criminal justice systems (n=10). Some programs reported that they had strong support from jail/prison administrators and correctional officers or had dedicated correctional officers with whom they had developed strong working relationships. Seven programs also identified highly qualified/trained staff as a program strength, highlighting the substance use disorder and mental health credentials of staff. Finally, five programs reported that their ability to provide individualized services and/or have small caseloads was a strength, and five reported that their services to unique populations (e.g., Native Americans, women, individuals with co-occurring mental health conditions) were noteworthy aspects of their program.

Respondents were also asked about the challenges to implementing correctional-based programs. The 34 programs that responded to this question identified a broad range of challenges. The most frequently reported challenge was related to issues implementing their treatment program in prison or jail settings (n=16), these issues include:

- Philosophical differences between corrections and treatment that do not support the RSAT goals; some respondents reported that rules and regulations, physical setup, and staff roles associated with correctional facilities are not conducive to recovery.
- The lack of assigned correctional officers (COs) to RSAT program, which means that, by the time COs understand the program and treatment philosophy, they are rotated to a new position and the program must reorient the new COs;
- The lack of space or appropriate amenities for programming (such as available space for groups or treatment and housing separate from the general population);
- And finally, changing the security classification of participants without notice. Programs also reported that changes in RSAT funding over the years and uncertainty about the level of funds to support the program have been a challenge to implementing RSAT programs (n=6); several reported that they have had to scale back their programs due to reductions in funding.

Five programs reported treatment/service gaps within their programs, including lack of co-occurring services; the need for more culturally appropriate services; and the need to create opportunities to include family participation in services. Other challenges identified by programs include the absence of transitional services for RSAT participants (n=3); limited program capacity and long waiting lists (n=3); and challenges finding qualified treatment staff.

G. -Endorsement of NIDA Drug Treatment Principles for Criminal Justice Populations

As described in Chapter II, one objective of the study is to examine the extent to which RSAT treatment programs incorporated the NIDA drug abuse treatment principles for criminal justice populations. We developed proxy indicators for 11 of the 13 principles from the study data. Programs that met the criteria for the study indicator were coded as '1' and those that did not were coded as '0'. Table IV-21 presents the proportion of programs that endorse the proxy indicator that supports the NIDA principle. The only principle endorsed by all programs was drug testing (100%), although more than three-quarters of programs endorsed treatment and transitional planning, screening and assessment and program length, closely followed by sanctions and incentives.

Table IV-21: Proportion of NIDA Treatment Principles Endorsed by RSAT Correctional Treatment Programs (n=53)

Principle	Study Indicator	% (n)
Drug use should be monitored	Drug testing conducted	100% (53)
Criminal justice supervision should incorporate treatment planning; planning should incorporate transition to community	Program does treatment planning and transitional planning	87% (46)
Assessment is the first step in treatment	Program conducts substance use screening/assessment using valid instrument	79% (42)
Treatment must last long enough to produce results	Program length is longer than 3 months	76% (40)
A balance of rewards and sanctions encourages participation	Use of both rewards and sanctions	74% (39)
Individuals with co-occurring disorders require integrated treatment	Program has co-occurring services available	57% (30)
Continuity of care is essential for reentry	Program connects RSAT participants to aftercare program services	53% (28)
Treatment should fit the needs of the individual	Program may adjust treatment sessions and intensity of service based on clinical needs of client	45% (24)
Treatment should target criminal behavior	Program has a "criminal thinking" evidence-based practice	45% (24)
Treatment planning for reentry should include strategies to prevent and treat serious illness	Connection to medical services post-release	36% (19)
Medications are an important part of treatment	Linkage to medication-assisted treatment (MAT) post-program	23% (12)

The 11 indicators supporting each principle were then summed to create an index. The summary index scores ranged from 3–11, with a mean score of 6.7. Notably, there were three programs that endorsed all 11 principles and 2 programs that endorsed only three. To facilitate further analysis, the index was reduced to three categories. Table IV-22 presents the proportions of programs in each category. For ease of discussion, we will refer to the groups as the Low group, Medium group, and High group.

Table IV-22: Level of NIDA Treatment Principles Endorsed (n=53)

	% (#) Programs
Low (3–5 principles)	28% (15)
Medium (6–8 principles)	58% (31)
High (9–11 principles)	13% (7)

Analysis examining the characteristics of programs in these three groups found differences between the Low and High groups on a variety of factors that differentiate prisons and jails. Programs in the Low group generally served fewer individuals (40%, n=6); had an average daily census of 25 or less; received $100,000 or less in RSAT funding, 46% (n=9); and the majority (73%, n=11) are located in local corrections programs (jails, community corrections). In contrast, the majority of the High group programs served 51 or more individuals on a daily basis (71%, n=5); received more RSAT funding (71%, n=5 received $200,001 or greater); and most were located in prisons (71%, n=5).

Regarding types of services provided by programs in each group, there were no large differences in the proportion of programs providing trauma services, peer services, and counseling services. However, a smaller proportion of the Low group provided services in a Therapeutic Community, 40% (n=6), compared to the Medium (81%, n=25) and High groups (85%, n=6). Very few Low group programs include 12-step programs (13%, n=2), compared to 41% (n=13) and 57% (n=4) of Medium and High groups, respectively. The one service type that was more common among the Low group was family therapy/parenting services (40%, n=6 vs. 32%, n=10 and 29%, n=2) compared to Medium and High groups, respectively. There are several possible reasons for this. First, the Low Group is principally made up of local corrections programs (e.g., jails and community corrections) as described above, and the proportion of programs targeting females (this includes female-only and male/female) is higher among the Low group.

Among the EBPs, a similar proportion of programs in each group reported providing Cognitive Behavioral Therapy or relapse prevention therapy. For Motivational Interviewing/Motivational Enhancement Therapies, only a little over a quarter of the Low group reported providing this service (27%, n=4), compared to a little more than half of Medium (58%, n=18) and High (57%, n=4) groups. Notably, almost all programs in the High group reported providing at least one targeted EBP intervention (86%, n=6), compared to only 27% (n=4) and 54% (n=17) in the Low and Medium groups, respectively.

Table V-23 presents the proportion of RSAT programs endorsing each of the NIDA treatment principle indicators by group. The purpose of the table is to examine which indicators are less frequently endorsed within each group (low, medium, high). When viewed in this manner, there are a few interesting items. Among the High group, the criminal thinking evidence-based practice was the only variable that was not endorsed by the majority of programs. Notably, although a large proportion of programs endorse the screening and assessment principle when all groups are combined, (see Table IV-21), less than half of programs in the Low group (47%, n=7) endorse it. Also, only 13% (n=2) of programs in the Low group provided a connection to aftercare program services, and even fewer provided a linkage to medication-assisted treatment (MAT) (7%, n=1). This table suggests that all programs could benefit from technical support around criminal thinking EBPs and that many programs still need assistance linking to community-based aftercare, medical services, and MAT, if available in their community. It also suggests that some principles are more difficult for jails to implement than prisons.

Table IV-23: NIDA Treatment Principles by Summary Index Groups

Principle Indicator	High # Principles n 7 % (n)	Medium # Principles n 31 % (n)	Low # Principles n 15 % (n)
Program conducts drug testing	100% (7)	100% (31)	100% (15)
Program conducts substance use screening and assessment	100% (7)	90% (28)	47% (7)
Program conducts treatment planning and transitional planning	100% (7)	84% (26)	87% (13)
Program lasts longer than three months	100% (7)	84% (26)	53% (8)
Use of rewards and sanctions	100% (7)	77% (24)	53% (8)
Connection to aftercare program services	100% (7)	61% (19)	13% (2)
Connection to medical services post-release	100% (7)	32% (10)	13% (2)
Linkage to medication-assisted treatment (MAT) post-program	100% (7)	13% (4)	7% (1)
Program has co-occurring (COD) services available	86% (6)	61% (19)	33% (5)
Program adjusts treatment sessions and intensity of services based on clinical needs	86% (6)	45% (14)	27% (4)
Program has a "criminal thinking" evidence-based practice	57% (4)	52% (16)	27% (4)

H. Aftercare Services

This section of the report will focus on aftercare services for RSAT participants. First, we will describe aftercare services funded directly by RSAT, and then we will describe aftercare services linked to non-RSAT-funded aftercare. For this study, we define aftercare as "any community-based step-down treatment or case management services to support the recovery of individuals who were formerly incarcerated."

1. RSAT-Funded Aftercare

Among the 11 RSAT-funded aftercare programs, one serves adult females only, and another serves juveniles (both male and female). Six programs serve adult males and females. Only one aftercare program is connected with a prison population; the 10 are linked to local jails or community corrections. This is likely due to the greater ease that jails have in establishing relationships with community providers and the greater likelihood that individuals released from jail will stay in the same geographic area. We crossed the locations of these aftercare programs with the information from the state PoC survey and found that four of the programs are in states that dedicate some RSAT funds to aftercare, and the remaining seven are in states that reported that they require funded RSAT programs to include aftercare, even if it is not funded by RSAT.

There are several ways in which participants are identified and recruited for RSAT-funded aftercare programs. Seven programs link directly to a correctional facility-based RSAT program.[6] Five of these programs use in-reach to participants for program recruitment, and the remaining two programs are a step-down phase of the program. Among the four programs not linked to a correctional facility-based RSAT program, two provide step-down treatment for individuals participating in correctional treatment funded by other sources, and two identify individuals leaving jails with substance use disorder needs.

Table IV-24: Identification/Referral Processes for RSAT-Funded Post-Facility Programs (n=11)

Aftercare Participants Identified/Referred by…	% (n)
Links directly to an RSAT program	64% (7)
In-reach/outreach to facility (not specific to RSAT)	36% (4)
Step-down treatment phase	36% (4)

The settings for RSAT aftercare services are a mix of outpatient and residential treatment. Four programs use residential treatment for their aftercare program; the length of stay ranges from 30 days to 12 months. The other seven programs use community-based outpatient treatment, and all seven have a case manager position that assists in coordination of treatment services. All aftercare programs reported that they provide treatment planning; nine respondents indicated that they develop a unique plan from the correctional-based services, and two reported that they continue to use the institutional plan.

Respondents were asked about the types of services provided to participants in their RSAT aftercare program and the approximate percentages of participants that receive each service. Similar to facility based treatment programs (Table IV-13), there is a gap between the number of programs that reported providing a service, and the programs reporting that 76%–100% receive the service. Table V-25 presents the types of services provided arrayed by the most common service to the least common service. As illustrated in the table, the vast majority of programs provided case management services to the majority of their clients, whereas all programs provide social skills training to fewer clients. All but one program offers group therapy and individual counseling; however, only 64% of programs reported that most or all of their clients receive these services. Case management, social skills training, group therapy and individual counseling for substance use disorders are also the most common treatment services provided in the RSAT-funded correctional treatment programs.

[6] Three programs reported referrals from "RSAT" programs, which may not have been funded by BJA resources and were not reported in BJA performance measures (PMT) data, and thus were not included in the subgrantee sample frame.

Table IV-25: Types of Treatment Services Provided by RSAT-Funded Post-Facility Programs (n=11) -

General Treatment Services for Aftercare Programs	% Programs Providing Service	% Programs Providing Service to 76% 100% RSAT Participants (n)*
Case management	100% (11)	82% (9)
Social skills development	100% (11)	64% (7)
Individual counseling sessions for substance use disorder treatment	91% (10)	64% (7)
Group therapy substance use disorder treatment	91% (10)	64% (7)
12-step meetings	82% (9)	46% (5)
Family therapy/counseling	82% (9)	27% (3)
Role playing	82% (9)	55% (6)
Trauma services	73% (8)	27% (3)
Parenting classes	64% (7)	9% (1)
Substance use disorder education	55% (6)	46% (5)
Peer mentor services	55% (6)	18% (2)
Spiritual programming/ services	46% (5)	0
Alternative therapies (e.g., yoga, meditation)	36% (4)	18% (2)
Therapeutic community	27% (3)	9% (1)
Batterer services	18% (2)	0
Detoxification for substances	18% (2)	0

*Percentages may vary due to missing data.

In terms of differences in services provided in correctional treatment settings compared to funded aftercare program settings, more aftercare settings provide family therapy/counseling (82%, n=9) than correctional-based treatment programs (43%, n=23); the same is true for 12-step meetings (82%, n=9) vs. 70%, n=37). The lower proportion of programs providing therapeutic community-related services is expected (72%, n=38 of correctional-based programs, compared with 27%, n=3 of aftercare programs) because five of the aftercare programs are in outpatient treatment settings.

Respondents were also asked about the provision of EBPs in their aftercare programs (Table IV-26). All programs reported providing at least one EBP. As with the correctional programs, the majority of programs provided both CBT and MI (73%, n=8). Consistent with the prior facility-based treatment programs, the study did not include questions about training and fidelity assessment activities to support EBP implementation.

Table IV-26: Types of EBPs Provided by RSAT-Funded Post-Facility Programs (n=11) -

Evidence Based Services/Practices for Aftercare/Post Programs	% Providing EBP to 76% 100% RSAT Participants*
Motivational enhancement therapies (METs)/ Motivational Interviewing (MI)	82% (9)
Cognitive Behavioral Therapy (CBT)	73% (8)
Seeking Safety	18% (2)
Hazelden Model/Series	9% (1)
Co-occurring treatment/integrated mental health and substance use disorder services	9% (1)
The Matrix Model	9% (1)
Moral Reconation Therapy (MRT)	9% (1)

Respondents were asked to identify other types of services that RSAT aftercare participants typically receive. As illustrated in Table IV-27, the largest proportion of programs (73%) reported that participants receive vocational and educational services. However, only three programs reported that most or all of the participants receive these services. Among the four programs that reported access to medication-assisted treatment, all identified Naltrexone as a treatment; one program indicated that all participants receive it; two programs indicated that 1%–25% of participants receive it, and the remaining program did not know the percentage.

Table IV-27: Other Types of Services for Aftercare Participants (n=11)

Services for Aftercare Programs	% Programs Where Participants Typically Receive Service (n)	% Programs Where Service Received by 76% 100% Participants
Vocational services	73% (8)	18% (2)
Educational services	73% (8)	27% (3)
Medical services	64% (7)	9% (1)
Pharmacotherapies	36% (4)	9% (1)
Childcare	36% (4)	0
Legal assistance	27% (3)	0

Facilitators and Challenges to Aftercare Program Implementation

Respondents were asked to identify factors that facilitate implementation of their programs. All aftercare programs reported that partnerships with community providers and/or corrections were important to successful implementation of their programs, and many indicated that these collaborations were one of the main strengths of the programs. More than half of programs reported involvement in a community reentry initiative or workgroup. Similarly, almost all of the programs reported collaboration with community-based behavioral health providers, as well as providers such as the local housing authority, employment programs, and faith-based organizations. As one respondent reported, no agency sees themselves as “owning” the client, but instead, they work together to get the client the most appropriate services. Several programs reported that treatment providers that contract with RSAT leveraged additional services for participants through internal referrals or collaborative networks.

The majority of respondents indicated that, although there are few challenges in enrolling participants in aftercare programs, the real challenge is getting them to show up to services in the community and keeping them engaged in treatment. However, several programs reported that the timing of releases can make sustained engagement difficult. Individuals may be released from jail or prison with little notice, leaving little or no time to introduce them to aftercare services. Respondents indicated that engaging with participants early is important. Several programs reported that they have the aftercare counselor/case manager meet with participants well before they are released, so that when they are in the community, they are meeting with a familiar face. For this reason, other programs reported that they use the same staff to provide services both inside and outside the facility to ensure program engagement. One program reported that they use "ex-offenders" who have successfully completed the program to engage with participants to "sell" them on the program. They reported that it is meaningful to have someone who has been there speak on behalf of the program.

The most frequently identified challenge was the shortage of funding and limited services for aftercare. The majority of respondents indicated that there are not enough services in the community to support individuals transitioning from correctional programming and that there are many treatment gaps (e.g., pharmacotherapies). The one aftercare program focused on youth reported there were virtually no treatment resources for juveniles in their community. In addition to limited programming, several respondents reported that services are not long enough, especially for individuals with heroin or methamphetamine addiction that are a longer-term struggle. A little over half of the programs reported that housing and transportation represent significant barriers to successful participation in aftercare. Participants' inability to access safe housing often means they return to unhealthy situations where they are likely to relapse. In addition to a general lack of services, programs reported challenges for participants related to the stigma of criminal justice involvement, which makes it harder for participants to access limited services. Several respondents reported that programs in their community will not serve convicted felons, not understanding that felonies do not necessarily mean someone is dangerous or violent. These programs reported efforts to provide outreach and education to change attitudinal barriers. Additional programmatic challenges mentioned by respondents included locating clients or re-engaging with them after a relapse, and accessing Medicaid benefits to support treatment.

Strategies and Strengths

All programs identified strategies for engaging and retaining participants in aftercare services. As previously discussed, consistency in staffing and pre-release engagement is important for program retention; more than half of programs reported using this strategy. Another important strategy is collaboration between treatment and community corrections. One program described a collaboration in which, with the appropriate releases, probation can share information with clinical staff on any issues participants may have meeting requirements, and clinicians keep probation in the loop on treatment. This can mean the difference between violating a probationer with a dirty drug screen and the opportunity to intensify treatment and supports. Several programs reported that they have routine meetings with probation, and two programs reported that their offices are located in the same building, creating opportunities for informal communication and a better understanding of the needs of program participants.

Other strengths and innovations of RSAT aftercare programs included the services/evidence-based practices implemented through the program. For some programs, there was a specific practice, such as Motivational Interviewing; another program is using RSAT funds for medication-assisted treatment (MAT), which filled a gap in their community services. One program identified its specific focus on linking participants with housing during aftercare as a strength and contribution of the RSAT program. They reported that they applied a lesson they learned from their SAMHSA Access to Recovery (ATR)[7] grant- that clients often can find housing but need first month's rent or utilities to secure it- and they put aside resources for RSAT participants for these purposes.

2. Non-RSAT-Funded Aftercare

To help understand the types of aftercare provided to RSAT program participants, we also asked respondents whose programs *did not* have RSAT funded aftercare about the types of support and services available to program participants. Among the 49 programs completing this section of the interview, only about half, 49% (n=24), reported that participants received aftercare services that were specifically targeted to individuals transitioning from correctional facilities to communities. Notably, there is a large gap in the number of programs that reported aftercare is included in treatment planning activities, 73%, n=43 (Table 5.10) and the number of programs that actually reported connection to aftercare programs. This suggests that aftercare planning for some programs may focus only on referrals to treatment services.

RSAT participants are linked to the non-RSAT-funded aftercare programs in the following ways: programs that have aftercare services available for anyone released from jail/prison facility (46%, n=11); programs that only provide services to individuals who successfully completed correctional-based RSAT program (46%, n=11); and programs that identify potential participants from anyone who was enrolled in correctional-based RSAT (13%, n=3). Table IV-28 presents information on the settings for aftercare services. About half of the programs reported that the settings for aftercare services were in community corrections centers (50%) and outpatient substance use disorder facilities (46%).

Table IV-28: Aftercare Non-RSAT-Funded Provided for Correctional-Based Treatment (n=24)

Setting for Post Release Services	% (n)
Community corrections center	50% (12)
Outpatient substance use disorder treatment	46% (11)
Mental health setting	33% (8)
Halfway house	33% (8)
Residential substance use disorder treatment	29% (7)
Educational setting	21% (5)
Vocational setting	17% (4)

[7] Access to Recovery is a federally funded program that provides access to services for individuals who have substance use disorders or are in the early stages of recovery.

Table IV-29 presents the types of post-release services available to RSAT participants in the 24 programs. As presented in the table, substance use disorder treatment was available for the largest proportion of programs (88%, n=21) and legal assistance was available to the fewest (29%, n=7), followed by pharmacotherapies (28%, n=9).

Table IV-29: Types of Post-Release Aftercare Services Available (n=24)*

Types of Post Release Aftercare Services Available*	% (n)
Substance use disorder treatment	88% (21)
Mental health treatment	83% (20)
Case management	79% (19)
Education/GED	67% (16)
Medical care	63% (15)
Vocational services	54% (13)
Pharmacotherapies	38% (9)
Legal assistance	29% (7)

*Percentages may vary due to missing data.

Although the study was able to provide some information on the types of services individuals are linked to post-release, we did not ask respondents if they follow-up with programs to see if individuals actually receive any of these services.

Major Gaps and Challenges for Post-Release Services

The programs without RSAT-funded aftercare identified many of the same service gaps and treatment issues as the RSAT-funded group. Among the 20 respondents providing feedback on this issue, the majority of responses (n=16) centered on contextual barriers and gaps for aftercare. These included limited availability of transportation to treatment services, the lack of affordable housing, and limited employment opportunities, which prevent full engagement in post-release treatment. Eight programs also reported that their communities have limited aftercare services/supports available for RSAT participants. Several respondents commented that, without coordination support from a case manager, RSAT participants have difficulty obtaining identification to access existing treatment (e.g., IDs to obtain Medicaid). Additionally, several programs reported that service providers' rules about criminal justice backgrounds made it difficult for RSAT participants to gain access to treatment. Five programs reported that client motivation was a major barrier to participation in aftercare, and one program reported that it was often difficult for RSAT participants to find support for maintaining their sobriety among their peers once they are in the community.

I. RSAT Participant Data

Subgrantee respondents were also asked about the types of participant data that they maintained in a Management Information System (MIS). The types of data collected most frequently by programs are the elements required for BJA performance measures reporting, such as program completion status and reason for discharge (Table IV-30). Although not required by BJA, 70% of programs reported that demographic information on RSAT participants is available. Relatively few programs maintain client assessment data. Notably, only 15 programs reported that they maintained data on RSAT recidivism, an important indicator of whether RSAT programs are succeeding in their ultimate goals of post-release sobriety and lawful behavior.

Table IV-30: Types of Data Maintained in MIS (n=56)

Data Elements	% (n)
Program completion status	71% (40)
Demographic	71% (40)
Criminal history	66% (37)
Reason for discharge	63% (35)
Treatment participation	55% (31)
Substance use disorder assessment	52% (29)
Recidivism—arrests/incarceration (n=37)	41% (15)
Risk assessment	39% (22)
Mental health assessment	32% (18)

VI. Conclusions and Implications

The purpose of this study was to describe the types of treatment and aftercare services provided under the BJA RSAT program. The study involved two key elements: a web-based survey of BJA state Points of Contact (PoCs) to understand how RSAT programming is targeted from the top down and a telephone interview with RSAT-funded programs (active in the July–September 2014 quarter) to gather details on services and practices. This section highlights the main study findings, including how the states make decisions about funding RSAT programs, the range and types of treatment services supported by RSAT, and the aftercare services supported by RSAT, as well as the key facilitators and challenges to delivering these services.

A. States' Approaches to Funding and Involvement with Programs

A little more than half of the states have adopted a funding mechanism process that makes RSAT funding widely available to applicants on a competitive basis. For many states, the monies are not sufficient to fully fund robust programming, and resources must be leveraged from additional sources to support RSAT programs. In some states, it appears that RSAT resources are used as seed money to launch or enhance programming. Several of the aftercare services funded under RSAT were used to fill a specific programmatic gap in a community and enhance existing treatment services. However, other respondents reported that limited RSAT resources prevented them from implementing programs in local communities.

Across states, there is a great deal of variability in the roles and authority of the BJA PoC responsible for RSAT oversight. Although most state PoCs report reviewing quarterly PMT data, very few are actively involved in the treatment quality or client eligibility issues; this suggests that RSAT programs across the country lack a consistent official responsible for the uniform oversight of the program's essential treatment activity. Further, most state PoCs did not report significant involvement with state policy issues related to substance use disorder treatment and corrections. As a result, they play no role in shaping overall correctional department policies to ensure that they are consistent with or supportive of RSAT programs. Additionally, state PoCs may not be knowledgeable about issues relevant to RSAT programs, potentially missing opportunities to support and leverage resources for programming.

B. Treatment Services Supported by RSAT

Most RSAT funds are used to support treatment services provided in correctional settings (85%, n=53). Forty percent (n=22) of these programs have received RSAT funds for 2 to5 years, and 27% (n=16) have received RSAT funds for more than 10 years. In terms of science-based treatment services, most programs reported providing at least one EBP and many provide two or more. Notably, criminogenic interventions, included in the NIDA drug treatment principles for criminal justice populations, was reported by fewer than half of the programs. The fact that this principle was not highly endorsed, even among programs that endorse most of the NIDA principles suggests that this may be an area of needed technical support for programs. Other areas that may benefit from technical assistance include screening and assessment practices. The reported utilization of valid screening/assessment instruments for substance use disorders was low in jail-based treatment programs. Additionally, fewer than one-third of the programs report the use of valid mental health screening/assessment instruments, even though the overlap between substance use disorders and

mental health problems is well-documented. Although almost all facility-based programs reported providing transitional planning services to RSAT participants prior to release, at least half are missing the connection to community-based aftercare programs that can provide recovery supports that help prevent relapse or re-offense.

Some of the key challenges to implementing facility-based programs identified by respondents included philosophical differences between corrections and treatment staff and the rotation of correctional officers in facilities. This is not surprising when considering that a minority of programs reported training correctional officers with RSAT resources and only 12% of programs reported they had correctional officers dedicated to the RSAT unit. It is generally recognized that successful RSAT programming requires close collaboration between correctional and clinical staffs. Although clinical staff may be available during working hours, the correctional officers are with participants 24/7 and their interactions can either advance treatment or undermine it. Motivational interventions, therapeutic communities, and other evidence-based programming require a united front from both clinical and correctional staffs. Programs should be encouraged to support cross-training to maximize the program's impact.

C. Aftercare Services Supported by RSAT: Facilitators and Challenges

Less than one-fifth of RSAT-funded programs provide step-down treatment or aftercare services. Although the recent lifting of the 10% funding restriction (2013) for community-based services may partially account for the small number of aftercare programs, it is more likely that states have chosen to focus on correctional-based treatment services because of the limited funding available for the RSAT program. As described in Chapter III, PoC respondents reported that the need for treatment services is high and that it is challenging to determine the most effective use of limited funds. Several state PoCs explicitly stated that all RSAT funds are needed to support facility-based programming in their state. Further, only about half of the correctional-based RSAT programs (49%, n=24) not using funds for aftercare reported that aftercare services funded by other sources were available to RSAT participants.

Factors facilitating aftercare identified by respondents focus on the collaboration and relationships with other community reentry initiatives, treatment providers, and community corrections. In some states, all released individuals are under some form of correctional supervision that can incorporate post-release treatment and other conditions. However, in others, unless individuals are sentenced to a post-release probationary period or are paroled before their sentences expire, a large proportion of individuals released from jail or prison are not under correctional supervision, increasing the need for community collaboration. Several of the RSAT aftercare programs reported that this was one of the reasons they were involved in community reentry initiatives. Aftercare is totally voluntary for individuals released from corrections; therefore, building relationships before release is important to ensure that the individual makes it to a treatment appointment. Close collaboration is required between the RSAT programs and parole and probation agents, as well as between RSAT programs and the community programs to which individuals are referred.

Many of the challenges identified by respondents are contextual/community problems that reduce motivation or create barriers to program participation. Respondents from both RSAT-funded

and non-RSAT-funded aftercare indicated that limited transportation, lack of safe/affordable housing, lack of employment opportunities, and the stigma of a criminal record are the reentry pressures that may trigger a relapse. Gaps in the availability of treatment and support services were also identified as a major challenge for aftercare services, even among communities with existing aftercare programs. It is difficult to help formerly incarcerated individuals maintain recovery if there are not enough services to support them. Contextual barriers and limited programmatic resources are problems that one program cannot solve alone. Engagement in community initiatives and coalition-building are necessary to develop solutions to the challenges that prevent full community reintegration and long-term recovery supports. Future research should examine the mechanisms and processes communities use to address these challenges to provide a road map for other jurisdictions.

D. Study Strengths and Limitations

This study had several strengths and limitations. This research fills a knowledge gap about the BJA RSAT supported treatment services and program approaches. Additionally, the study provides some understanding about states' approaches to RSAT funding and the activities conducted by state PoCs. A limitation of the study is that the evaluators' decision to focus data collection on a telephone interview of a single quarter of funded programs serving 10 or more participants resulted in missing some RSAT programs. However, we believe this method enhanced the quality of the data and resulted in a higher response rate. Another limitation is that not all respondents were knowledgeable about all the components of their programs, which contributed to missing data. Although the evaluation provided a detailed list of the types of questions in advance of the interview and respondents were invited to include additional individuals in interviews, there are several sections of the interview that were difficult for some respondents to complete (e.g., funding amounts, names of screening/assessment instruments, community aftercare resources). Where appropriate, the evaluation engaged in follow-up to complete missing data. Although some missing data remains throughout the interview, we believe that this rate would have been higher if it had been conducted as a web survey.

Another limitation of the study is that it cannot provide information on the *quality* of treatment services implemented by the program or whether EBPs are implemented with fidelity. Although the study collected information on the number and type of staff, it did not collect information on the training, education, or experience of clinical staff. Further, the study cannot comment on the staff's level of training/experience with EBPs or the nature of supervision or fidelity assessment activities to support EBPs. Finally, although information on participant criminal justice outcomes (e.g., recidivism, substance use) would provide valuable information about the impact of the RSAT programs, collecting this type of data was outside the scope of this study. We recommend that future research on RSAT programming address these issues of quality and outcomes.

E. Conclusion

The RSAT program represents an important funding source for substance use disorder treatment for justice-involved individuals. Many states rely on these funds to fill treatment gaps in their correctional systems, which is why the reductions in RSAT funding in the past decade have been acutely felt by state and subgrantee respondents. Although BJA's removal of the 10% limitation for community treatment has allowed some communities to creatively use RSAT funds for aftercare

services, the study suggests that, for many states, the RSAT resources are not sufficient to take on new aftercare programming activities. Treatment and resource gaps in communities prevent many RSAT-funded programs from fulfilling the legislative mandate to provide aftercare. Further, the "semi-active" role that many state PoCs play in program implementation means that aftercare and pre-release activities are not likely to receive priority attention. Active leadership in states and increased resources are necessary to ensure the continuity of care for individuals leaving correctional-based treatment; without these efforts, the positive impacts of RSAT program services provided in correctional facilities are likely to be lost to the pressures of post-release community reintegration.

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Appendix A: RSAT State Coordinator Survey

Study of the Use of Residential Substance Abuse Treatment for State Prisoners (RSAT) funds in Aftercare Services

RSAT State Coordinator Program Inventory

Purpose

This survey is part of a larger study of the use of Bureau of Justice Assistance (BJA) Residential Substance Abuse Treatment (RSAT) Program Funds on Aftercare Services. The purpose of this study is to understand how States/Territories and Subgrantees use BJA RSAT funds for treatment and aftercare for offenders transitioning to the community and to describe the specific substance use disorder treatment and aftercare services that are provided. The National Institute of Justice (NIJ) is funding Advocates for Human Potential, Inc., (AHP) a Massachusetts-based technical assistance and evaluation firm, to conduct this study as part of a federal grant award (Award # 2013-MU-CX-0057).

Procedures

AHP is asking all RSAT State/Territory Coordinators to participate in this brief survey to help NIJ and BJA obtain a better understanding of how States and Territory's make decisions around RSAT funding. The RSAT Program Inventory will include questions about how much RSAT funds a State received; your role with respect to Subgrantees and your role in administering RSAT funds within your State/Territory.

This survey will take 15-20 minutes to complete. The survey will be conducted between May 2014 and July 2014. Once you complete and submit the survey, your participation in the study ends. If you are interested in receiving reports on the research findings, you will be able to access the reports provided by the researchers.

Confidentiality

The information you provide will be kept confidential. You will not be identified in any reports on the study and your responses will be kept confidential by researchers. Codes will be used on the survey forms in place of your name. You may complete the survey in a private location of your choice. Only AHP research staff will be able to access your survey responses. You will not be identified in any report and the name of your agency or the state in which it is located will not be identified in any report. **Published materials will not identify a particular state, correctional facility, RSAT Program, or individual respondent**. All information collected will be stored in secure computerized files that are accessible only to designated AHP researchers. At the end of the study, the de-identified data will with be archived with the National Archive of Criminal Justice Data (NACJD). The quantitative datasets submitted to NACJD will be completely de-identified and will not contain any direct identifiers, thus ensuring the confidentiality of the study subjects.

Risk

There is minimal risk involved in participating in this study. In answering the survey, you may provide information or opinions that are critical of federal or state agencies. The research staff will implement procedures to reduce these risks, as outlined in the confidentiality section of this form. It is highly unlikely that survey questions will cause distress. You can refuse to answer any questions and may cease completing the survey at any point during administration. No other risks are anticipated.

Benefits and Freedom to Withdraw

The results of this survey may lead to improvements in access to substance use disorder treatment and aftercare for offenders. You may elect not to participate in the survey without any impact on your standing in this agency or any other penalty. You are free to withdraw from the study at any time. Questions about the survey can be addressed at any time by calling Cassandra Carter at 518-729-1241.

Contact Information of Principal Investigator

Kristin Stainbrook, Ph.D., Advocates for Human Potential, Inc., 41 State Street, Ste. 500, Albany, NY, 12207; (518) 729-1241; kstainbrook@ahpnet.com.

Contact Information of Institutional Review Board Chair

An Institutional Review Board (IRB) is a committee designed to approve, monitor, and review human subjects research to ensure rights are protected. If you have any questions about your rights as an evaluation participant, please leave a message for Al Volo, Ph.D., AHP IRB Chair, with Sylvie Casserly at (800)-220-8397 ext. 260 and Dr. Volo will return your call.

ELECTRONIC CONSENT: Please select your choice below.

Clicking on the "agree" button below indicates that:
- **you have ready the above information**
- **you voluntarily agree to participate**
- **you are at least 18 years of age**

If you do not wish to participate in the research study, please decline participation by clicking on the "disagree" button.

◉ Agree

○ Disagree

Respondent ID: ___ ___ ___ ___

I. Respondent Information

1. - What is the title of your position? _____

2. - How long have you been your state's Residential Substance Abuse Treatment (RSAT) - Coordinator/Point of Contact? _____(years) -

(If you have been your state's RSAT Coordinator for less than 1 year please enter 1)

II. RSAT Funding Allocation

3. Does your state provide Bureau of Justice Assistance (BJA) RSAT funds to prison programs?

☐ Yes

☐ No [Skip to Q5]

4. - Are these funds dispersed to: (Check all that apply)

☐ Adult programs

☐ Juvenile programs

5. - Does your state provide BJA RSAT funds to county or local corrections programs?

☐ Yes

☐ No [Skip to Q7]

6. - Are these funds dispersed to: (Check all that apply)

☐ Adult programs

☐ Juvenile programs

7. What percentage of BJA RSAT funds is provided to state and county/local jurisdictions?

_____% state -

_____% county -

100 % TOTAL

8. - How does your state determine what percentage of BJA RSAT funds are allocated to state vs. county/local programs?

_____

_____

_____

9. - Are BJA RSAT funds distributed in your state through a competitive application process where programs must apply for funding?

☐ Yes

☐ No [Skip to Q9b]

☐ Other, specify: _____

☐ Don't Know [Skip to Q9b]

a. - If yes, how often do you release a Request for Proposal (RFP)?

☐ Annually [Skip to Q10]

☐ Other, specify: _____ [Skip to Q10]

b. - If you do not have a formal competitive process, do you: [check one]

☐ Fund the same programs each year

☐ Provide RSAT funding to the Department of Corrections (DOC) to decide how the funding is allocated

☐ Provide RSAT funding to some other agency to decide how the funding is allocated

Specify agency: _____

☐ None of the above, please describe your process for allocating BJA RSAT funds:

_____
_____
_____
_____

10. Does your state use other funding to support RSAT programs?

☐ Yes

☐ No [Skip to Q13]

☐ Don't know [Skip to Q13]

11. Please identify the additional federal or state funding sources used to support RSAT - programs. -

_____

_____

_____

12. What were the total additional funds provided to RSAT programs in 2014? -

$ _____ -

☐ Don't know

13. Does your state require RSAT programs to dedicate a specific amount of funding to - aftercare services? -

By aftercare services we mean: Services to facilitate the coordination between the correctional treatment program and other social service and rehabilitation programs- such as education and job training, parole supervision, halfway houses, self-help, and peer group programs- in a community setting.

☐ Yes

☐ No [Skip to Q15]

☐ Don't know [Skip to Q15]

14. What percentage of RSAT funds must be dedicated to aftercare services? -

_____ % -

☐ Don't know

15. Does your state require RSAT programs to provide aftercare, *even if aftercare is not funded by RSAT dollars*?

☐ Yes [Skip to Q17]

☐ No

☐ Don't know

16. Please indicate if there are any specific reasons why aftercare services are not required.

_____

_____

_____

17. For RSAT participants released from jail/prison into parole/probation, is pre-release planning coordination with parole/probation required?

    ☐ Yes

    ☐ No [Skip to Q19]

    ☐ Don't know [Skip to Q19]

    ☐ Not applicable [Skip to Q19]

18. Is there a formal Memorandum of Understanding (MOU) or protocol in place to support coordination between the RSAT participant and parole/probation?

    ☐ Yes

    ☐ No

    ☐ Don't know

19. Please describe any challenges associated with distributing and/or using RSAT funds.

    _____
    _____
    _____
    _____

A. III. Role of RSAT State Administrator/Coordinator

20. In your role as RSAT Coordinator, how involved are you in the following Subgrantee activities?

	Not at all	Sometimes	Frequently	N/A
a. Monitoring the RSAT Subgrantee(s) contract	☐	☐	☐	☐
b. Monitoring RSAT Subgrantee program implementation	☐	☐	☐	☐
c. Working with RSAT Subgrantee(s) on client eligibility	☐	☐	☐	☐
d. Working with the RSAT Subgrantee(s) on treatment quality	☐	☐	☐	☐
e. Working with RSAT Subgrantee(s) on quality improvement issues	☐	☐	☐	☐
f. Reviewing Quarterly RSAT Performance Management Tool (PMT) data	☐	☐	☐	☐
g. Conducting monitoring visits to RSAT Subgrantee program(s)	☐	☐	☐	☐

21. As RSAT Coordinator, do you require or encourage other BJA-funded programs (such as Second Chance or Drug Courts) to collaborate with RSAT programs?

☐ Yes

☐ No [Skip to Q23]

☐ Don't know [Skip to Q23]

22. Please indicate which programs and describe how they collaborate.

_____
_____
_____
_____

23. Are RSAT Subgrantees required to submit any reports *in addition to* the quarterly BJA Performance Management Tool (PMT) reports?

☐ Yes

☐ No [Skip to Q25]

☐ Don't Know [Skip to Q25]

24. Please describe any additional reporting required of RSAT Subgrantees.

_____

_____

_____

25. In your role as RSAT Coordinator, how involved are you in the following activities?

	Not at all	A little Bit	Quite A Bit	N/A
a. Work on State Policy issues related to substance use disorder treatment and corrections	☐	☐	☐	☐
b. Work with my State/Territory's Department of Corrections around health policy	☐	☐	☐	☐
c. Work with my state legislature around issues relevant to RSAT Programming	☐	☐	☐	☐
d. Involved with decisions around distributing RSAT funds	☐	☐	☐	☐

26. Please describe any additional responsibilities/duties you may have as RSAT Coordinator that have not been mentioned.

_____

_____

_____

_____

Thank you for taking the time to complete the RSAT State Coordinator Program Inventory

Study of the Use of Residential Substance Abuse Treatment for State Prisoners (RSAT) funds in Aftercare Services

RSAT Subgrantee Program Inventory

Appendix B: RSAT Subgrantee Program Inventory

Introduction

THANK YOU FOR AGREEING TO PARTICIPATE IN THE RSAT PROGRAM INVENTORY

As my email explained, the purpose of this interview is to understand how programs use BJA RSAT funds for treatment and aftercare services. This interview will ask about the program setting and enrollment criteria for your RSAT program; the screening and assessment procedures; program staffing; program enrollment and completion rates; the types of services funded by RSAT provided in facility and/or in community settings, any exemplary practices; barriers and facilitators to aftercare; and lessons learned.

This interview is part of a larger study of the use of Bureau of Justice Assistance (BJA) Residential Substance Abuse Treatment (RSAT) Program Funds on Aftercare Services. The National Institute of Justice (NIJ) is funding Advocates for Human Potential, Inc., (AHP) a Massachusetts-based technical assistance and evaluation firm, to conduct this study as part of a federal grant award (Award #2013-MU-CX-0057).

This interview will take 60-90 minutes to complete.

Consent

*[**Interviewer**- confirm that the respondent has reviewed and understands the consent form, and has submitted a copy. If **yes**- you may begin the interview.]*

Obtain Verbal Consent if the Respondent has <u>not</u> submitted a consent form.

Confidentiality

The information you provide will be kept confidential. You will not be identified in any reports on the study and your responses will be kept confidential by researchers. A researcher will be taking notes on the conversation, but codes will be used on the data collected from the interview in place of your name. We will also be audio recording the interview to supplement our notes and ensure that we do not miss any information. Your name will not be attached to this audio file. Only AHP research staff will be able to access the notes and audio from your interview. You will not be identified in any report, nor will the name of your agency. **Published materials will not identify a particular correctional facility, RSAT Program, or individual respondent**. All information collected will be stored in secure computerized files that are accessible only to designated AHP researchers.

Risk

There is minimal risk involved in participating in this study. In answering the interview questions, you may provide information or opinions that are critical of RSAT processes. The research staff will implement procedures to reduce these risks, as outlined in the confidentiality section of this form. It is highly unlikely that interview questions will cause distress. You can refuse to answer any questions and may end the interview at any point during administration. No other risks are anticipated.

Benefits and Freedom to Withdraw

Your participation in the interview is voluntary. You may elect not to participate in the interview without any impact on your standing in this agency or any other penalty. You are free to withdraw from the study at any time.

Do you acknowledge that you understand the consent form and voluntarily agree to participate in a Telephone Meeting with an evaluation team from Advocates for Human Potential, Inc.? Do you affirm that you are at least 18 years old?

_____

Signature of Evaluator

Do you consent to the interview being audio recorded for the sole purpose of ensuring the notes from this meeting are accurate and facilitating accurate data collection and analysis? The audio files will be deleted at the end of the study.

_____

Signature of Evaluator

_____

Date

Administrative Data

Program ID	
Respondent Name(s)	
RSAT Program State/Territory	
RSAT Program County/City /Facility	
Type of RSAT Funded Program	
Date of Interview	
Name of Interviewer	

RESPONDENT INFORMATION

The following section asks about your professional background and the facility/agency in which you work.

1. What is your title and role in the RSAT Program? How many years have you been in this role? (If more than one respondent is on the call, record for everyone)

	RSAT Title	RSAT Role	Number of Years in current RSAT role
a.			
b.			
c.			
d.			

2. Do you oversee more than one RSAT program?

☐ Yes ☐ No (Skip to Q2c)

a. - If yes, how many? _____

b. - Do all of the programs use the same treatment service model? That is, do they have the same general enrollment criteria, treatment services, etc.?

☐ Yes ☐ No

c. - Please indicate the name of the program that serves the largest number of individuals. Please use this program to answers the questions in this interview.

_____

I. RSAT Funding

The following section asks general questions about RSAT Program funding. If you are not able to answer these questions- we can send them to you and you may have someone to assist you in completing them.

3. How many years has this RSAT Program(s) received BJA/RSAT funding? _____ (years)

4. How much funding did your RSAT Program(s) have in 2014? This includes BJA RSAT grant dollars, match dollars and funding from other sources. -

$_____ Amount BJA RSAT dollars used for program in 2014 -

$_____ Match dollars in 2014 (if applicable) -

$_____ Other funds/resources in 2014, specify: -

_____

5. Of the total amount of BJA/RSAT dollars the RSAT Program received for 2014, what percent of those dollars are for: (1) RSAT treatment services provided in facility (jail/prison/juvenile detention center), (2) transitional programming provided in facility, and (3) post-release activities/services provided in the community?

Please provide your best estimate. Should total 100%.

Facility treatment refers to treatment services (e.g., SA, MH, COD, trauma, etc.) provided to a participant in jail/prison/juvenile detention center. Transitional services/programming take place in the jail/prison/juvenile detention center to help bridge offenders from the correctional facility to the community. Post release activities/services refer to services provided to an offender when he/she is released from jail/prison/juvenile detention center; post release activities take place in the community.

% of RSAT Funds dedicated to:

____ treatment services provided in facility

____ transitional programming provided in facility

____ post-release activities/services not located in a jail/prison

100% TOTAL

6. - RSAT Program Staffing- Please estimate the number of full-time equivalent (FTE) staff currently employed in your RSAT Program column (a), how those staff positions are funded columns (b) and (c), if funded by other sources specify the funding source in column (d), if the position is filled by contracted staff column (e), and where services are provided column (f).

Columns (b) and (c) should add up to 100%. Match dollars should go in column (c), other funds.

Type of RSAT Staff	(a) # RSAT Program FTEs (1.0, 0.25, etc.)	(b) % Supported by BJA RSAT funds (0 100%)	(c) % Supported by other funds (0 100%) *if >0 go to d; if <0 go to e*	(d) Specify Funding Source	(e) Contracted 1 Yes 2 No	(f) Category of services provided by Staff code all that apply: 1 Facility Tx; 2 Transitional svcs in facility; 3 Post Release svcs	(g) Notes
a. RSAT Program Manager							
b. Substance use disorder Clinician(s)							
c. Correctional officer(s) (only include if they are dedicated to the unit)							
d. Other Clinical staff (social workers, vocational or mental health counselors, etc.)							
e. Case manager(s)							
f. Peer Supports							
g. Aftercare/Transitional Coordinator							
h. Administrator(s)							
i. Other (specify) _____							
j. Other (specify) _____							
k. Other (specify) _____							

7. Are all of your RSAT Program staff positions currently filled?

☐ Yes (Skip to Q9) ☐ No

8. If no, why not?

_____

_____

9. Does your program use BJA RSAT funds for any of the following non-staff program expenses?

Type of Expense	Yes	No	Specify where funds spent 1 Facility TX; 2 Transitional svcs in facility; 3 Post release svcs (Choose all that apply)
a. Facility maintenance			
b. Training of clinical staff			
c. Training of correctional staff			
h. Drug testing			
i. Videos or workbooks and other materials for groups			
j. Other, specify: _____			
k. Other, specify: _____			

II. RSAT Program Criteria

The following section asks details about the RSAT Program target population.

10. What is the name of the RSAT Program?

    _____

11. What population does the RSAT Program serve? (Check all that apply)

    ☐ Adults

    ☐ Juveniles

    ☐ Males

    ☐ Females

12. Indicate the primary setting(s) of the RSAT Program: (Check all that apply)

    ☐ State Prison

    ☐ Jail

    ☐ Juvenile Facility

    ☐ Corrections Operated Community-Based Facility/Agency (e.g., halfway house, work release, residential, etc.)

    ☐ Non-Corrections Operated Community-Based Facility/Agency (e.g., halfway house)

    ☐Residential facility

    ☐Outpatient SUD treatment facility

    ☐Vocational training program

    ☐School/education setting

    ☐ Other (*specify*) _____

13. Does the RSAT Program have eligibility criteria for program enrollment?

    ☐ Yes ☐ No [Skip to Next Section]

14. If yes, what are the eligibility criteria for the RSAT Program? (*Codes are on following page. Probe for: length of sentence, time to release; screened to meet DSM IV or V criteria for substance dependence, risk level, etc.)*

    _____

    _____

    _____

15. Please describe any specific exclusion criteria.
(*Probe for: no mental health diagnosis, no history of violence, etc.)*

_____
_____
_____
_____

Interviewer will code responses after the interview is complete. Place a check next to the appropriate code(s). (Please note, these codes are both treatment and aftercare programs, and for eligibility and exclusion criteria.)

√	Code List	
☐	01.	Individual must be within a certain number of months of release. Specify # months: _____
☐	02.	Individual is court ordered or mandated to RSAT program
☐	03.	Individual must have a prior drug charge or offense
☐	04.	Individual must be motivated to participate; willing to work on SUD issues
☐	05.	Individual must be willing to participate in aftercare post-release
☐	06.	Individual must meet a certain score on a SUD Instrument.
☐	07.	Individual must have a history of drug or alcohol use
☐	08.	Individual must be screened on a valid risk assessment instrument
☐	09.	Individual must be screened on a valid risk assessment instrument, and have high score
☐	010.	Individual must have a history of drug offenses
☐	011.	Individual must have a specific drug of choice.
☐	012.	Individual must have successfully complete RSAT program while incarcerated.
☐	013.	Individual must have participated in RSAT program while incarcerated, regardless of whether they successfully completed it.
☐	014.	Any individual released from jail/prisons with confirmed SUD (aftercare)
☐	015.	Individual CANNOT have medical problems
☐	016.	Individual CANNOT have a mental health diagnosis

☐	017.	Individual CANNOT have a history of trauma
☐	018.	Individual CANNOT have a history of violence
☐	019.	Individual CANNOT have a sex crime conviction
☐	020.	Other, specify:
☐	021.	Other, specify:
☐	022.	Other, specify:
☐	023.	Other, specify:
☐	024.	Other, specify:
☐	025.	Other, specify:

III. RSAT Screening and Assessment

This section asks about the RSAT Programs' screening and assessment procedures.

16. Are RSAT participants screened/ assessed for substance use disorders?

☐ Yes ☐ No (Skip to Q17)

Reception/Diagnostic center. Location where sentenced individuals are received and processed into the correctional system before being sent to the facility where they will serve their sentence.

Facility intake. Intake and screening activities that take place at the jail/prison/juvenile detention center where the individual will reside for his/her sentence.

If yes, please indicate what instrument(s) is/are used (if known). **Substance use disorder Instruments**	When do participants receive the screening/ assessment? (Check all that apply)				Instrument Not Used
	At Reception/ Diagnostic Center	At Intake to Facility	Just prior to starting RSAT	Don't know when	
a. Addiction Severity Index (ASI)	☐	☐	☐	☐	☐
b. Alcohol Dependence Scale (ADS)	☐	☐	☐	☐	☐
c. Drug Abuse Screening Tool (DAST)	☐	☐	☐	☐	☐

d. Michigan Alcohol Screening Tool (MAST)	☐	☐	☐	☐	☐
e. Substance Abuse Subtle Screening Inventory (SASSI)	☐	☐	☐	☐	☐
f. TCU Drug Screening	☐	☐	☐	☐	☐
g. CAGE Substance Abuse Screening Tool	☐	☐	☐	☐	☐
h. Own SUD tool	☐	☐	☐	☐	☐
i. Other standardized instrument (*specify*) _____	☐	☐	☐	☐	☐
DON'T KNOW NAME OF INSTRUMENT USED	☐	☐	☐	☐	

17. Are RSAT participants screened/ assessed for <u>mental health disorders</u>?

☐ Yes ☐ No (Skip to Q18)

If yes, please indicate what instrument (s) is/are used (if known). **Mental Health Instruments**	When do participants receive the screening/ assessment? (Check all that apply)				Instrument Not Used
	At Reception/ Diagnostic Center	At Intake to Facility	Just prior to starting RSAT	Don't know	
a. Becks Depression Inventory (BDI)	☐	☐	☐	☐	☐
b. Structured Clinical Interview of Diagnosis (SCID)	☐	☐	☐	☐	☐
c. Diagnostic Interview Scale (DIS)	☐	☐	☐	☐	☐
d. Symptoms Checklist-90 Revised (SCL-90R)	☐	☐	☐	☐	☐
e. Other standardized instrument (*specify*) _____	☐	☐	☐	☐	☐
DON'T KNOW NAME OF INSTRUMENT USED	☐	☐	☐	☐	

18. Are RSAT participants given a risk and needs assessment using a valid instrument or screened/assessed for any other needs with a valid instrument?

☐ Yes ☐ No (Skip to Q19)

If yes, please indicate what instrument(s) is/are used (if known). **Risk/ level of need Instruments**	When do participants receive the screening/ assessment? (Check all that apply)				Instrument Not Used
	At Reception/ Diagnostic Center	At Intake to Facility	Just prior to starting RSAT	Don't know	
a. Wisconsin Needs and Risks (original or modified version)	☐	☐	☐	☐	☐
b. Correctional Offender Management Profiling for Alternative Sanctions (COMPAS)	☐	☐	☐	☐	☐
c. Static Risk and Offender Needs Guide (STRONG)	☐	☐	☐	☐	☐
d. Level of Service Inventory Revised (LSI-R)	☐	☐	☐	☐	☐
e. Level of Service / Case Management Inventory (LS/CMI)	☐	☐	☐	☐	☐
f. Criminal Sentiments	☐	☐	☐	☐	☐
g. TCU Criminal Thinking Scales	☐	☐	☐	☐	☐
h. PCLR (psychopathic checklist)	☐	☐	☐	☐	☐
i. Ohio Risk Assessment System (ORAS) or some instrument based on ORAS	☐	☐	☐	☐	☐
j. Correctional Assessment Instrument System (CAIS)	☐	☐	☐	☐	☐
k. Global Assessment of Individual Needs (GAIN)	☐	☐	☐	☐	☐
l. Youth Level of Service /Case Management Inventory (YLS/CMI)	☐	☐	☐	☐	☐

m. Other: _____	☐	☐	☐	☐	☐
DON'T KNOW NAME OF INSTRUMENT USED	☐	☐	☐	☐	

19. Are RSAT participants screened/assessed for <u>trauma</u> using with a valid instrument?

☐ Yes ☐ No (Skip to Q20)

If yes, please indicate what instrument (s) is/are used (if known). **Trauma Instruments**	When do participants receive the screening/ assessment? (Check all that apply)				Instrument Not Used
	At Reception/ Diagnostic Center	At Intake to Facility	Just prior to starting RSAT	Don't know	
a. Brief Trauma Questionnaire (BTQ)	☐	☐	☐	☐	☐
b. Life Stressor Checklist – Revised (LSC-R)	☐	☐	☐	☐	☐
c. Posttraumatic Diagnostic Scale (PDS)	☐	☐	☐	☐	☐
d. Short Form of the PTSD Checklist - Civilian Version	☐	☐	☐	☐	☐
e. Traumatic Life Events Questionnaire (TLEQ)	☐	☐	☐	☐	☐
f. Other standardized trauma instrument (*specify*) _____	☐	☐	☐	☐	☐
DON'T KNOW NAME OF INSTRUMENT USED	☐	☐	☐	☐	

20. Are RSAT participants screened for eligibility for the following benefits? (*read list)*

	Yes	No	Don t know	**If Yes**, when do participants receiving the screening/ assessment? (Check all that apply)			
				At Reception/ Diagnostic Center	At Intake to Facility	In the RSAT program	Don't know when
a. Supplemental Security Income (SSI)	☐	☐	☐	☐	☐	☐	☐
b. Social Security Disability Income (SSDI)	☐	☐	☐	☐	☐	☐	☐
c. Medicaid	☐	☐	☐	☐	☐	☐	☐
d. Veteran Benefits	☐	☐	☐	☐	☐	☐	☐
e. Affordable Care Act (ACA)	☐	☐	☐	☐	☐	☐	☐
f. Other: _____	☐	☐	☐	☐	☐	☐	☐

IV. RSAT Treatment Planning

The following questions ask about treatment planning for RSAT participants while they are enrolled in the RSAT Program.

21. Approximately what proportion of RSAT participants have a *written* individual treatment plan developed by RSAT in facility clinical staff?

☐ All

☐ More than half

☐ Less than half but more than a third

☐ Less than a third

☐ None (Skip to Q30)

☐ Don't Know

22. Do RSAT participants have an opportunity to review and provide input on the written plan?

☐ Yes ☐ No ☐ Don't Know

23. Are screening/assessments results tied into the treatment plan? If yes, describe how treatment matching is accomplished.

_____
_____
_____
_____
_____
_____

24. Are RSAT program participants reassessed using any of the standardized instruments identified above (for SUD, MH or other needs).

☐ Yes ☐ No (Skip to Q27)

25. If yes, specify instrument type and specific time point.

Specify type of Reassessment 1 Substance Use 2 Mental Health (not including trauma) 3 Level of Risk 4 Trauma 5 Other	***Specify time point(s) for reassessment*** 1 After 3 months 2 6 months 3 Discharge 4 No set assessment period 5 Other, specify 6 Don t Know
a.	
b.	
c.	
d.	
e.	

26. If screening/assessment is done at multiple time points, is the treatment plan revised to reflect any changes?

☐ Yes ☐ No ☐ Don't Know

27. Is the treatment plan updated? If so, how frequently?

_____
_____
_____

28. Do family members have an opportunity to participate in treatment planning?

☐ Yes ☐ No ☐ Don't Know

29. Is aftercare included in individual treatment plans?

☐ Yes ☐ No ☐ Don't Know

30. Does your program provide more intensive treatment services (e.g., more individual sessions; different types of treatment) to participants that have higher risk scores or greater treatment needs?

☐ Yes ☐ No ☐ Don't Know

31. Does your program adjust the treatment sessions based on the progress of the individual; that is, if individual is making clinical progress more quickly than others, would his treatment sessions be reduced/modified?

☐ Yes ☐ No ☐ Don't Know

32. Do RSAT participants have access to additional services, such as mental health or trauma services, if they need them?

☐ Yes ☐ No ☐ Don't Know

V. RSAT *Funded* Services Provided in a Jail/Prison/Juvenile Detention Setting

The following section focuses on the RSAT funded services that are provided while an individual is in **a jail, prison, or juvenile detention setting**. Subsections include: (A) an overview of the facility, (B) services provided in the Jail/Prison/Juvenile Detention Setting (Pre-Release), (C) drug testing and compliance management, and (D) pre-release activities.

If no services or staff positions are funded in this setting, skip to Section VII, pg. 28.

A. Overview of the Facility

33. What is the security level/designation of the RSAT population? (This may be different than the security level/designation of the larger facility) (Check all that apply)

☐ Pre-release or work release

☐ Minimum or low security

☐ Medium security

☐ High or maximum security

☐ Unclassified

☐ Special population facility/jail/prison

☐ Designated SUD treatment facility/jail/prison

☐ Don't know

34. In 2014, what was the total number of RSAT participants who enrolled in the program?

_____ (participants) ☐ Don't know

35. What is the maximum capacity (i.e., maximum daily census) of the RSAT Program at any given time? -

_____ (beds/participants) ☐ Don't know -

36. In 2014, on average, how many participants were enrolled in the RSAT Program at any given time? (average daily census) -

_____ (participants) [If # is less than Q34, ask Q36] ☐ Don't know -

37. If your RSAT Program was not at maximum capacity during 2014 please describe why.

_____

_____

_____

IF THE RSAT PROGRAM DOES NOT FUND ANY IN-FACILITY TREATMENT SERVICES BUT DOES FUND IN-FACILITY TRANSITIONAL SERVICES, SKIP TO Page 23 for D. PRE-RELEASE PLANNING SERVICES

38. Which of the following best describes the setting in which RSAT participants reside while in your jail/prison/juvenile detention center?

☐ A segregated housing area (e.g., separate facility/unit) – RSAT participants are segregated from offenders not attending the RSAT Program

☐ A non-segregated housing – RSAT participants are integrated with offenders not attending the RSAT Program

☐ Don't know

39. Which of the following best describes the setting in which RSAT participants receive treatment while in your jail/prison/juvenile detention center?

☐ A segregated area (e.g., separate facility/unit) – RSAT participants are segregated from offenders not attending the RSAT Program

☐ A non-segregated area – RSAT participants are near and with other offenders in programming

☐ Don't know

40. On average, what is the duration (in months) of RSAT Program services?

_____ (months) ☐ Don't know

B. RSAT Services Provided in Jail/Prison/Juvenile Detention Setting (Pre-Release)

The next set of questions focuses on the types of services participants may receive through the RSAT Program while they are in the jail/prison/juvenile detention setting.

41. Please indicate if the following types of general treatment services provided and the approximate percentage of RSAT participants that receive each service while in your jail/prison/juvenile detention center. *(Interviewer- if service provided check approximate %)*

[Read each row to respondent. If respondent is hesitant to provide percent/number- probe for best response. *For example, "Would you say more than half or less than have received substance use disorder education? If less than half, would you say closer to 15 or 20% or closer to 40 or 45%?" etc.**]***

General Treatment Services	Service not provided	Approximate % receiving service				
		1% 25%	26% 50%	51% 75%	76% 100%	Don t Know %
a. Substance use disorder education	☐	☐	☐	☐	☐	☐
b. Individual counseling sessions for substance use disorder treatment	☐	☐	☐	☐	☐	☐
c. Group therapy substance use disorder treatment	☐	☐	☐	☐	☐	☐
d. Detoxification for substances	☐	☐	☐	☐	☐	☐
e. Therapeutic community	☐	☐	☐	☐	☐	☐
f. Peer mentor services	☐	☐	☐	☐	☐	☐
g. 12-Step Meetings	☐	☐	☐	☐	☐	☐
h. Parenting classes	☐	☐	☐	☐	☐	☐
i. Case management	☐	☐	☐	☐	☐	☐
j. Family therapy/counseling	☐	☐	☐	☐	☐	☐
k. Trauma services	☐	☐	☐	☐	☐	☐
l. Role playing	☐	☐	☐	☐	☐	☐
m. Social skills development	☐	☐	☐	☐	☐	☐
n. Alternative therapies (e.g., yoga, meditation)	☐	☐	☐	☐	☐	☐
o. Batterer services	☐	☐	☐	☐	☐	☐
p. Spiritual programming/ services	☐	☐	☐	☐	☐	☐
q. Other, specify: _____	☐	☐	☐	☐	☐	☐
r. Other, specify: _____	☐	☐	☐	☐	☐	☐

42. Does your RSAT program include any Evidence Based Services/Practices? *By Evidenced-Based Services/Treatment I mean, approaches to treatment that are based in theory and have undergone scientific evaluation, such as Cognitive Behavioral Therapy, Motivational Interviewing, etc.*

☐ Yes

☐ No (Skip to Q44)

☐ Don't Know (Skip to Q44)

43. If yes, please indicate the types of evidence-based treatment services provided to RSAT participants and the approximate percentage of RSAT participants that receive each evidence-based service while in your jail/prison/juvenile detention center? *(Interviewer- if service provided check approximate %)*

[Read each row to respondent. If respondent is hesitant to provide percent/number- probe for best response. *For example, "Would you say more than half or less than receive substance use disorder education? If less than half, would you say closer to 15 or 20% or closer to 40 or 45%?" etc.]*

Evidence Based Services/Practices	Service not provided	Approximate % receiving service				
		1% 25%	26% 50%	51% 75%	76% 100%	Don t Know %
a. Co-Occurring Treatment/Integrated Mental Health and Substance use disorder Services	☐	☐	☐	☐	☐	☐
b. Motivational Enhancement Therapies (MET)/Motivational Interviewing (MI)	☐	☐	☐	☐	☐	☐
c. Cognitive Behavioral Therapy (CBT)	☐	☐	☐	☐	☐	☐
d. Illness Management and Recovery (IMR)	☐	☐	☐	☐	☐	☐
e. Contingency Management	☐	☐	☐	☐	☐	☐
f. The Matrix Model	☐	☐	☐	☐	☐	☐
g. Thinking for a Change (T4C)	☐	☐	☐	☐	☐	☐
h. Moral Reconation Therapy (MRT)	☐	☐	☐	☐	☐	☐
i. Hazelden Model/Series	☐	☐	☐	☐	☐	☐

Evidence Based Services/Practices	Service not provided	Approximate % receiving service				
		1% 25%	26% 50%	51% 75%	76% 100%	Don t Know %
j. Relapse Prevention Therapy (RPT)	☐	☐	☐	☐	☐	☐
k. Trauma Recovery and Empowerment Model (TREM)	☐	☐	☐	☐	☐	☐
l. Seeking Safety	☐	☐	☐	☐	☐	☐
m. Multisystemic Therapies (MST) (for Juveniles)	☐	☐	☐	☐	☐	☐
n. Adolescent Community Reinforcement Approach (A-CRA)	☐	☐	☐	☐	☐	☐
o. Adolescent Relapse Prevention	☐	☐	☐	☐	☐	☐
p. Other, specify: _____	☐	☐	☐	☐	☐	☐
q. Other, specify: _____	☐	☐	☐	☐	☐	☐
r. Other, specify: _____	☐	☐	☐	☐	☐	☐

44. Do RSAT participants receive wraparound services while they are in your RSAT program*? By wraparound services we mean non-clinical supportive services, such as child care, vocational, educational, and transportation services, that are designed to improve the individual's access to treatment and services, and retention in the program.*

☐ Yes

☐ No [Skip to Q46]

45. If yes, please indicate who provides these wraparound services to participants? (Check one for each row)

Wraparound Service	Provided to participant through the RSAT program (using RSAT funds)	Provided to participants through other facility resources/ programs	Provided to participants but don t know how it s funded	Service not Provided while in RSAT
a. Education/ High school equivalency	☐	☐	☐	☐
b. Vocational Services	☐	☐	☐	☐
c. Other, specify: _____	☐	☐	☐	☐
d. Other, specify: _____	☐	☐	☐	☐

46. Are family members able to participate in the RSAT Program?

☐ Yes (Go to next question)

☐ No, we do not have the ability to include family (e.g., lockdown facility only visitation permitted) (Skip to next section)

☐ No, we have not considered how to include family (Skip to next section)

☐ No, we tried to include family in planning, but it was difficult (Skip to next section)

☐ Don't know (Skip to next section)

47. Indicate the ways in which family members may participate in the RSAT Program. (Check all that apply)

☐ Through video conferences

☐ At discharge planning for treatment

☐ At intake

☐ Routine family support sessions (may be via videoconferencing)

☐ Allow RSAT participants to read to children via phone or videoconferencing

☐ Don't know

C. RSAT Drug Testing and Compliance Management in a Jail/Prison/Juvenile Detention Setting (Pre-Release) -

The following questions ask about drug testing and compliance management while RSAT participants are in the jail/prison/juvenile detention setting.

48. Under what circumstances are RSAT participants tested for drug/alcohol use, while in your jail/prison/juvenile detention center? (Check all that apply)

    ☐ Only tested when ordered by court/parole board

    ☐ Tested at random

    ☐ Tested when suspected of drug/alcohol use

    ☐ Tested weekly

    ☐ Other (specify) _____

    ☐ Don't know

49. Does your RSAT Program use sanctions while participants are in your jail/prison/juvenile detention center? *By sanction we mean the imposition of an undesirable consequence in response to an undesirable behavior.*

    ☐ Yes

    ☐ No

    ☐ Don't know

50. Does your RSAT Program use incentives or rewards while participants are in your jail/prison/juvenile detention center? *By incentive/reward we mean a positive consequence that is the result of an individual's positive behavior.*

    ☐ Yes

    ☐ No

    ☐ Don't know

D. RSAT Pre-Release Planning Activities in a Jail/Prison/Juvenile - Detention Setting -

This set of questions asks about pre-release planning activities for RSAT participants.

51. Please indicate if RSAT participants receive the following types of assistance prior to release from jail/prison/juvenile detention. *[Interviewer: If No or DK, skip to next row]*

[Note: a j do not have to be provided with RSAT funds]	Type of assistance received by RSAT participants?			*If yes, are these types of assistance also available to <u>non RSAT</u> participants?*			*If yes, are RSAT participants prioritized?*		
	Yes	No	DK	Yes	No	DK	Yes	No	DK
a. Designated personnel/case management staff who facilitate the RSAT participant's transition from the correctional facility to the community.	☐	☐	☐	☐	☐	☐	☐	☐	☐
b. A written pre-release plan.	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. If not previously enrolled in mainstream benefits, assistance applying for and securing benefits (SSI, SSDI, Medicaid) prior to release.	☐	☐	☐	☐	☐	☐	☐	☐	☐
d. Assistance applying for and securing Affordable Care Act (ACA) benefits.	☐	☐	☐	☐	☐	☐	☐	☐	☐
e. If previously enrolled in mainstream benefits, assistance having benefits (SSI, SSDI, Medicaid) reinstated prior to release.	☐	☐	☐	☐	☐	☐	☐	☐	☐
f. A HIPAA form is provided to share information with <u>treatment provider(s)</u>.	☐	☐	☐	☐	☐	☐	☐	☐	☐
g. A HIPAA form is provided to share information with a <u>supervision agency</u>.	☐	☐	☐	☐	☐	☐	☐	☐	☐
h. A HIPAA form is provided to share information with <u>health provider(s)</u>.	☐	☐	☐	☐	☐	☐	☐	☐	☐
i. Other, specify_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
j. Other, specify_____	☐	☐	☐	☐	☐	☐	☐	☐	☐

The next questions focus on how RSAT participants are connected to services in the community – *The types of ways include: (1) Through referral (no pre-arranged appointment; participant is provided with the name and contact information for a recommended service agency only) (2) by pre-arranged appointment (a date and time for an appointment/intake is scheduled before the participants leaves the facility), or (3) personal contact (the participant has contact face-to-face or via video conferencing with a representative from the agency).*

52. Please indicate is RSAT participants connected to the following community-based services as part of their pre-release activities, and the ways in which they linked to these services.

Type of Service	Connection provided?			*If yes,* how is it provided? (Check all that apply)				*If yes,* are these services also provided for non RSAT offenders?		
	Yes	No	DK	By referral	By pre-arranged appointment	By personal contact	DK	Yes	No	DK
a. Substance use disorder treatment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
b. Vocational or educational services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. Housing services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
d. Mental health treatment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
e. Parole or probation agent who will be supervising the individual in the community	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
f. Other, specify: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

53. Please indicate if any of these other services are provided to RSAT participant as part of pre-release activities.

Type of Service	Service provided?			*If yes,* are these services also provided to non RSAT offenders?		
	Yes	No	DK	Yes	No	DK
a. A supply of medication to last until his/her appointment for service	☐	☐	☐	☐	☐	☐
b. A state approved identification card (for Medicaid purposes)	☐	☐	☐	☐	☐	☐
c. Clothing	☐	☐	☐	☐	☐	☐
d. Name and contact information of a 12-step sponsor/community sponsor	☐	☐	☐	☐	☐	☐
e. Housing arrangements are already established upon release	☐	☐	☐	☐	☐	☐
f. Other, specify: _____	☐	☐	☐	☐	☐	☐

54. Approximately what percentage of RSAT participants are under community supervision either by a probation or parole agency after release?

☐ 1%-25%

☐ 26%-50%

☐ 51%-75%

☐ 76%-100%

☐ Don't know

55. If known, what is the typical length of community supervision?

_____ (months)

☐ Don't know

E. Program Completion for RSAT Services provided in a Jail/Prison/Juvenile Detention Setting -

The following questions are about RSAT Program completion and reasons for termination.

56. What are the criteria for completing the RSAT Program in your jail/prison/juvenile detention facility? (Check all that apply)

☐ Length in program; specify months: _____

☐ Completing all required components

☐ Not testing positive for 3 months (for community-based RSAT Programs)

☐ Becoming a facilitator or team leader

☐ Making clinical progress, meeting individual goals

☐ Agreeing to participate in aftercare (for prison/jail-based RSAT Programs)

☐ Not making trouble in groups

☐ Other, specify: _____

☐ Don't know

57. Please indicate what percentage of participants successfully completed the RSAT Program provided in your jai/prison/juvenile detention facility in 2014: (Check one)

☐ 1%-25%

☐ 26%-50%

☐ 51%-75%

☐ 76%-100%

☐ Don't know

58. In 2014, about what percent of participants did not complete the RSAT Program for the following reasons: -

_____% Voluntarily left/dropped out of the program -

_____% involuntary discharge (kicked-out, asked to leave by program staff, violation of rules)

_____% transferred to another facility before completing program

_____% sentence was up, released from facility

_____% other, specify: _____

☐ Don't know

59. Are there any specific features of your RSAT program that you feel are unique or represent a specific strength?

_____
_____
_____
_____
_____
_____
_____

60. Please describe any challenges or barriers to implementing your RSAT Program and any strategies you have used to overcome these barriers, if applicable.

_____
_____
_____
_____
_____
_____
_____
_____

If the program does not use any RSAT dollars for post-release aftercare services, SKIP TO SECTION VIII, pg. 42

VI. RSAT *Funded* Post-Release Aftercare Services Provided in Community Setting (corrections or non-corrections operated setting)

The following section focuses on RSAT-funded services that are provided in a community setting (post-release). This may include community corrections operated halfway houses, work release programs, residential treatment, etc. and non-corrections operated halfway houses, residential treatment, aftercare programs, etc.

If RSAT does not fund post-release services, skip to Section VIII, pg. 41.

61. How are potential participants identified or referred to RSAT post-release aftercare - services? (Check all that apply) -

☐ Outreach directly to in-facility RSAT participants (i.e., describe the program, its requirements, benefits of participation etc.)

☐ Outreach to in-facility RSAT staff to identify individuals who may be eligible for aftercare

☐ Outreach to other facility staff to identify individuals who may be eligible for aftercare

☐ Outreach to family members to encourage potential participant's involvement in aftercare

☐ Outreach to other justice system personnel (i.e., judges, attorneys, probation, parole etc.) (specify)_____

☐ Other, specify: _____

62. In 2014, what was the total number of individuals who enrolled in the RSAT Aftercare program? -

_____ (participants) ☐ Don't know -

63. What is the maximum capacity (i.e., maximum daily census) of the RSAT Aftercare Program at any given time? -

_____ (participants) ☐ Don't know -

64. In 2014, on average, how many participants were enrolled in the RSAT Aftercare Program at any given time? (i.e. Average daily census) -

_____ (participants) ☐ Don't know -

65. If the RSAT Aftercare Program was not at maximum capacity during 2014 please describe why.

_____
_____
_____
_____
_____
_____

66. What percentage of RSAT participants are under community supervision either by a probation or parole agency after release?

☐ 1%-25%

☐ 26%-50%

☐ 51%-75%

☐ 76%-100%

☐ Don't know

67. If known, what is the typical length of community supervision?

_____ (months)

☐ Don't know

68. What are the major challenges to enrolling participants in RSAT post-release aftercare services?

_____
_____
_____
_____
_____
_____
_____

69. Have you developed any effective strategies for maximizing participant enrollment in RSAT post-release aftercare services? If yes, please describe.

_____
_____
_____
_____

B. RSAT Post-Release Aftercare Services: Treatment Planning

70. Is there a separate/unique post-release treatment plan different from the treatment plan developed in the correction institution/facility?

    ☐ Yes – Who is responsible for overseeing its implementation?

    _____

    ☐ No – Plan is the same as developed in-facility

71. What strategies, if any, are in place for post-release two-way communication and case planning between inside and outside facility staff? (Probe for innovation)

    _____
    _____
    _____
    _____
    _____
    _____

72. What are the major challenges to treatment planning with a post-release population? Please detail.

    _____
    _____
    _____
    _____
    _____
    _____
    _____

C. RSAT Post-Release Aftercare Services: Partnerships/ - Networks and Collaboration -

73. What types of partnerships/service networks have you developed to help implement your RSAT post-release aftercare program? (Probe for the types of systems they represent versus the names of the partners)

_____
_____
_____
_____
_____

74. Are partnerships formalized and in what ways? (Probe for MOUs; formal network meetings; interagency teams) Describe approach to formalization (Probe for innovation)

_____
_____
_____
_____
_____

75. Is your RSAT post-release aftercare program involved with other community efforts (local reentry taskforce, Homeless Coalition) that meet to coordinate services for reentering offenders? If yes, please describe.

_____
_____
_____
_____
_____

76. What are the major challenges to developing community partnerships to serve post-release aftercare clients?

_____
_____
_____
_____
_____

D. RSAT Post-Release Aftercare Services

The next set of questions focuses on services offered as part of your aftercare program.

77. Please provide a brief overview of your RSAT funded post-release aftercare program.

[Probe for a way to characterize the program (i.e., continuing care or recovery or both). Does it focus on connecting individuals with community services (referral model staffed by case manager or referral hotline)? Offer relapse supports through connection with AA or other peer support program? Provide direct treatment in residential, step-down, or day treatment programs? Other approach?]

_____
_____
_____
_____
_____
_____
_____
_____

78. Please indicate if the following types of <u>general treatment services</u> are provided and the approximate percentage of RSAT participants that receive each service (corrections or non-corrections operated setting). *(Interviewer- if service provided check approximate %)*

[Read each row to respondent. If respondent is hesitant to provide percent/number, probe for best response. *For example, "Would you say more than half or less than have received substance use disorder education? If less than half, would you say closer to 15 or 20% or closer to 40 or 45%?" etc.**]***

General Treatment Services	Service not provided	Approximate % receiving service				
		1% 25%	26% 50%	51% 75%	76% 100%	Don t Know %
a. Substance use disorder education	☐	☐	☐	☐	☐	☐
b. Individual counseling sessions for substance use disorder treatment	☐	☐	☐	☐	☐	☐
c. Group therapy substance use disorder treatment	☐	☐	☐	☐	☐	☐
d. Detoxification for substances	☐	☐	☐	☐	☐	☐
e. Therapeutic community	☐	☐	☐	☐	☐	☐
f. Peer support services	☐	☐	☐	☐	☐	☐
g. 12-Step Meetings	☐	☐	☐	☐	☐	☐
h. Parenting classes	☐	☐	☐	☐	☐	☐
i. Case management	☐	☐	☐	☐	☐	☐
j. Family therapy/counseling	☐	☐	☐	☐	☐	☐
k. Trauma services	☐	☐	☐	☐	☐	☐
l. Role playing	☐	☐	☐	☐	☐	☐
m. Social skills development	☐	☐	☐	☐	☐	☐
n. Alternative therapies (e.g., yoga, meditation)	☐	☐	☐	☐	☐	☐
o. Batterer services	☐	☐	☐	☐	☐	☐
p. Spiritual programming/ services	☐	☐	☐	☐	☐	☐
q. Other, specify: _____	☐	☐	☐	☐	☐	☐
r. Other, specify: _____	☐	☐	☐	☐	☐	☐

79. Does your RSAT program include any Evidence Based Services/Practices*? By Evidenced Based Services/Treatment I mean, approaches to treatment that are based in theory and have undergone scientific evaluation, such as Cognitive Behavioral Therapy, Motivational Interviewing, etc.*

☐ Yes

☐ No (Skip to Q81)

☐ Don't Know (Skip to Q81)

80. If yes, please identify any evidence-based treatment services provided to RSAT participants and the approximate percentage of RSAT participants that receive each evidence-based service. *(Interviewer- if service provided check approximate %)*

[If respondent is hesitant to provide percent/number, probe for response.** For example, "Would you say more than half or less than receive substance use disorder education? If less than half, would you say closer to 15 or 20% or closer to 40 or 45%?" etc.**]

Evidence Based Services/Practices	Service not provided	Approximate % receiving EBP				
		1% 25%	26% 50%	51% 75%	76% 100%	Don t Know %
a. Co-Occurring Treatment/Integrated Mental Health and Substance use disorder Services	☐	☐	☐	☐	☐	☐
b. Motivational Enhancement Therapies (MET)/Motivational Interviewing (MI)	☐	☐	☐	☐	☐	☐
c. Cognitive Behavioral Therapy (CBT)	☐	☐	☐	☐	☐	☐
d. Illness Management and Recovery (IMR)	☐	☐	☐	☐	☐	☐
e. Contingency Management	☐	☐	☐	☐	☐	☐
f. The Matrix Model	☐	☐	☐	☐	☐	☐
g. Thinking for a Change (T4C)	☐	☐	☐	☐	☐	☐
h. Moral Reconation Therapy (MRT)	☐	☐	☐	☐	☐	☐
i. Hazelden Model/Series	☐	☐	☐	☐	☐	☐
j. Relapse Prevention Therapy (RPT)	☐	☐	☐	☐	☐	☐

Evidence Based Services/Practices	Service not provided	Approximate % receiving EBP				
		1% 25%	26% 50%	51% 75%	76% 100%	Don t Know %
k. Trauma Recovery and Empowerment Model (TREM)	☐	☐	☐	☐	☐	☐
l. Seeking Safety	☐	☐	☐	☐	☐	☐
m. Multisystemic Therapies (MST) (for Juveniles)	☐	☐	☐	☐	☐	☐
n. Adolescent Community Reinforcement Approach (A-CRA)	☐	☐	☐	☐	☐	☐
o. Adolescent Relapse Prevention	☐	☐	☐	☐	☐	☐
p. Other, specify: _____	☐	☐	☐	☐	☐	☐
q. Other, specify: _____	☐	☐	☐	☐	☐	☐

81. [If the respondent indicates "don't know" for Q80, explore the challenges to documenting the use of evidence based practices in the community.]

_____

_____

_____

_____

82. Does your RSAT Aftercare Program provide/fund wraparound services while participants are in a community setting (corrections or non-corrections operated setting)? *By wraparound services we mean non-clinical supportive services, such as child care, vocational, educational, and transportation services, that are designed to improve the individual's access to treatment and services, and retention in the program.*

☐ Yes

☐ No (Skip to Q84)

83. Please indicate if the following types of wraparound services are provided to RSAT participants and the approximate percentage of RSAT participants that receive each service in a community setting (corrections or non-corrections operated setting). (Check one for each row)

[Read each row to respondent. If respondent is hesitant to provide percent/number, probe for best response. *For example, "Would you say more than half or less than have received substance use disorder education? If less than half, would you say closer to 15 or 20% or closer to 40 or 45%?" etc.**]***

Wraparound Services	Service not provided	Approximate % receiving service				
		1% 25%	26% 50%	51% 75%	76% 100%	Don t Know %
a. Education/GED	☐	☐	☐	☐	☐	☐
b. Vocational Services	☐	☐	☐	☐	☐	☐
c. Medical Care	☐	☐	☐	☐	☐	☐
d. Legal Assistance	☐	☐	☐	☐	☐	☐
e. Child care	☐	☐	☐	☐	☐	☐
f. Other, specify: _____	☐	☐	☐	☐	☐	☐

84. Does your RSAT Aftercare Program use pharmacotherapies?

☐ Yes ☐ No (Skip to Q86)

85. Please indicate if any of the following pharmacotherapies are used for RSAT participants and the approximate percentage of RSAT participants that receive it <u>in a community setting</u> (corrections or non-corrections operated setting). (Check one for each row)

[If respondent is hesitant to provide percent/number, probe for response. *For example, "Would you say more than half or less than have received substance use disorder education? If less than half, would you say closer to 15 or 20% or closer to 40 or 45%?" etc.**]***

Pharmacotherapies	Service not provided	Approximate % receiving service				
		1% 25%	26% 50%	51% 75%	76% 100%	DK %
a. Naltrexone (e.g., ReVia®, Vivitrol®, Depade®)	☐	☐	☐	☐	☐	☐
b. Disulfiram (e.g.,Antabuse®)	☐	☐	☐	☐	☐	☐
c. Acamprosate Calcium (e.g., Campral®)	☐	☐	☐	☐	☐	☐
d. Methadone	☐	☐	☐	☐	☐	☐
e. Buprenorphine (e.g., Suboxone®, Subutex®)	☐	☐	☐	☐	☐	☐

86. What efforts are in place to maximize post-release supports? When and to what extent are family members involved?

_____
_____
_____
_____
_____
_____
_____

87. What strategies and innovations have you developed for the delivery of treatment and wrap-around services in community settings?

_____
_____
_____
_____
_____
_____

88. What major challenges have you encountered in providing treatment services to RSAT participants in the community (e.g., availability of community resources, funding, staffing, stigma attached to serving this population etc.)?

_____
_____
_____
_____
_____
_____
_____

E. RSAT Post-Release Aftercare Services: Drug Testing and Compliance Management (corrections or non-corrections operated setting)

The following questions ask about drug testing and compliance management while RSAT participants are in a community setting (corrections or non-corrections operated setting).

89. Under what circumstances are RSAT participants tested for drug/alcohol use while in a community setting (corrections or non-corrections operated setting)? (Check all that apply)

☐ Not tested

☐ Only tested when ordered by court/parole board

☐ Tested at random

☐ Tested when suspected of drug/alcohol use

☐ Tested weekly

☐ Other (*specify*) _____

☐ Don't know

90. Does your RSAT Aftercare Program use sanctions? (corrections or non-corrections operated setting)? *By sanction we mean the imposition of an undesirable consequence in response to an undesirable behavior.*

☐ Yes

☐ No

☐ Don't know

91. Does your RSAT Aftercare Program use incentives or rewards? *By incentive/reward we mean a positive consequence that is the result of an offender's positive behavior.*

☐ Yes

☐ No

☐ Don't know

F. RSAT Post-Release Aftercare Services: Program Completion

The following questions are about RSAT Aftercare Program completion for post-release/community based services.

92. What are the criteria for completing RSAT post-release aftercare services? (Check all that apply)

☐ Length in program; specify months: _____

☐ Not testing positive for 3 months (for community-based RSAT Programs)

☐ Make clinical progress, remain drug free

☐ Do not make trouble in groups

☐ Other, specify: _____

☐ Don't know

93. Please indicate what percentage of RSAT participants successfully completed the RSAT Aftercare Program in 2014: (Check one)

☐ 1%-25%

☐ 26%-50%

☐ 51%-75%

☐ 76%-100%

☐ Don't know

94. In 2014, about what percentage of RSAT participants did not complete the RSAT Aftercare Program for the following reasons: -

_____% Voluntarily left/dropped out of the program -

_____% involuntary discharge -

(kicked-out, asked to leave by program staff, violation of rules)

_____% transferred to another facility before completing program

_____% sentence was up, released from facility

_____% other, specify: _____

☐ Don't know

95. Are there particular strategies or innovations you have developed to improve retention in RSAT post-release aftercare services? (Refer back to the answer Q93 if successful completion is especially high)

_____
_____
_____
_____
_____
_____
_____

96. What are the challenges to retaining RSAT participants in post-release aftercare services? (Refer back to the answer for Q93 if completion is low)

_____
_____
_____
_____
_____
_____
_____

G. RSAT Post-Release Aftercare Services: Wrap-up on Aftercare - Practices, Barriers and Facilitators -

To wrap up, we have already touched on some practices you identified as innovative or exemplary as well as barriers to implementing RSAT post-release aftercare services. We want to make sure we captured everything important in this area.

97. Are there any other aspects of your RSAT post-release aftercare program you consider especially strong? Please explain.

_____
_____
_____
_____
_____
_____
_____

98. Have there been any other major barriers to developing and implementing continuing care and recovery models for RSAT participants transitioning to the community?

_____
_____
_____
_____
_____
_____
_____

99. What has helped most in developing and implementing your RSAT post-release aftercare program (e.g., ACA or other changes in laws and regulation, technology, collaborative relationships, etc.)

_____
_____
_____
_____
_____
_____
_____
_____

SKIP TO SECTION IX, pg. 44.

VIII. *Non-RSAT-Funded* Post-Release Aftercare Services Provided in Community Setting (corrections or non-corrections operated setting)

The following section focuses on post-release aftercare services that are **not funded by RSAT**.

100. Do RSAT participants receive any post-release aftercare services, by aftercare services I mean programs that are specifically targeted to offenders transitioning from correctional facilities to communities?

☐ Yes

☐ No (Skip to next Section)

☐ Don't know (Skip to next Section)

101. How are potential participants identified/ selected for these post-release aftercare services? (Check all that apply)

☐ Potential participants successfully complete a RSAT Program while incarcerated.

☐ Potential participants include anyone who participated in a RSAT Program while incarcerated regardless of whether they successfully completed the program.

☐ Potential participants include anyone recently released from jail/prison.

☐ Other, specify:

_____

_____

_____

102. In what settings are these post-release aftercare services provided? (Check all that apply)

☐ Residential SUD treatment facility (including therapeutic community)

☐ Outpatient SUD treatment facility

☐ Halfway House

☐ Community Corrections Center

☐ School/educational setting

☐ Vocational training program/setting

☐ Mental health program/setting

☐ Other, specify: _____

☐ Don't know

103. Which of the following types of post-release aftercare services do RSAT participants typically receive? **[Read each row to respondent]**

	Yes	No	Don t know
a. Substance use disorder Treatment	☐	☐	☐
b. Pharmacotherapies	☐	☐	☐
c. Mental Health Treatment	☐	☐	☐
d. Case Management	☐	☐	☐
e. Education/GED	☐	☐	☐
f. Vocational Services	☐	☐	☐
g. Medical Care	☐	☐	☐
h. Legal Assistance	☐	☐	☐
h. Other, specify: _____	☐	☐	☐

104. If Yes to any services above, what are the funding sources for these services?

☐ Don't know

☐ Specify sources:

_____

_____

_____

_____

105. Approximately what percentage of RSAT participants participate in post-release aftercare services (corrections or community based)? (Check one)

☐ 1%-25%

☐ 26%-50%

☐ 51%-75%

☐ 76%-100%

☐ Don't know

106. In your opinion, what are the major service gaps for post-release aftercare services?

_____
_____
_____
_____
_____
_____
_____
_____

107. In your opinion, what are the challenges to facilitating participant access and engagement in post-release aftercare services?

_____
_____
_____
_____
_____
_____
_____
_____

IX. RSAT Evaluation/Quality Assurance/Participant Data

The following section asks about the types of the data is that are available on RSAT participants.

108. For each type of data, please indicate if is available for your RSAT participants, if it is maintained in a Management Information System (MIS) and if the program receives routine reports on these data.

	Is this data collected/available on RSAT participants in your program?			Is it maintained in a MIS?		Do you receive routine reports?	
	Yes	**No (SKIP to next row)**	**Don't Know (SKIP to next row)**	**Yes**	**No**	**Yes**	**No**
a. Demographics (e.g. age, race, education)	☐	☐	☐	☐	☐	☐	☐
b. Criminal History (e.g. arrests, incarceration data)	☐	☐	☐	☐	☐	☐	☐
c. Standardized Substance Use Disorder Assessment data (e.g. SASSI; ASI)	☐	☐	☐	☐	☐	☐	☐
d. Standardized Risk Assessment data (e.g. LSI-R)	☐	☐	☐	☐	☐	☐	☐
e. Standardized Mental Health Assessment Data (e.g. BDI, DIS, SCL-90R)	☐	☐	☐	☐	☐	☐	☐
f. Treatment participation/utilization data (e.g. types and amount of services received)	☐	☐	☐	☐	☐	☐	☐
g. Ancillary Service Utilization data (e.g. vocational; educational, medical) *Specify*: _____	☐	☐	☐	☐	☐	☐	☐
h. Graduated Sanctions (e.g. infractions)	☐	☐	☐	☐	☐	☐	☐
i. Incentives (e.g.	☐	☐	☐	☐	☐	☐	☐
j. Program Completion Status	☐	☐	☐	☐	☐	☐	☐

k. Reasons for Program Discharge	☐	☐	☐	☐	☐	☐	☐
l. Recidivism	☐	☐	☐	☐	☐	☐	☐
m. Other Program Data *Specify:* _____	☐	☐	☐	☐	☐	☐	☐

Provide the respondent with a gracious thank you in your own words.

Interviewer Comments:

This is a place for the interviewer to provide narrative comments on the interview/program that are not captured by the questions.