

RESIDENTIAL SUBSTANCE ABUSE TREATMENT (RSAT)

Training and Technical Assistance

Promising Practices Guidelines for Residential Substance Abuse Treatment



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Promising Practices Guidelines for Residential Substance Abuse Treatment

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Promising Practices Guidelines for Residential Substance Abuse Treatment

Introduction

The Residential Substance Abuse Treatment (RSAT) for State Prisoners Program (42 U.S.C. § 3796ff et. seq.) assists states and local governments in the development and implementation of substance use disorder treatment programs in state, local, and tribal correctional and detention facilities. Funds are also provided to create and maintain community-based aftercare services for individuals after they are released from incarceration. As of October 2016, there were approximately 41 RSAT jail awards, 34 state prison or juvenile awards, and 9 aftercare awards in all but two states, in total serving almost 9,000 incarcerated individuals.¹

Congress has set limited basic requirements for all RSAT programs based upon the Residential State Abuse Treatment (RSAT) for State Prisoners (42 U.S.C. § 3796ff et. seq.). This statute includes the following requirements for the development of substance abuse treatment programs in local, state, and tribal corrections facilities:²

- Programs in state correctional facilities must be at least six months in length, and participants must be physically separated from the general population.
- Jail-based programs must be at least three months in length, and participants must be physically separated from the general population if the facility permits. (In some jurisdictions, this physical separation is called a treatment unit or “treatment pod.”)
- RSAT participants are required to be tested for illicit drugs at admission into the program and at random during the program.
- RSAT programs, if possible, should be limited to participants who have 6 to 12 months remaining in their confinement. This ensures that the person can be released directly from the treatment unit in the correctional facility to the community instead of being returned to the general population after completing the treatment program.

When funding RSAT programs, states are also required to give preference to programs that provide aftercare services. This includes coordination between the correctional treatment program and other human service and rehabilitation programs, such as education and job training, probation or parole supervision, halfway houses, and self-help and peer groups, which may help rehabilitate offenders.

RSAT enhances the capabilities of states and units of local and tribal governments to provide residential substance use disorders treatment for incarcerated individuals; prepares individuals for reintegration into their communities by incorporating reentry planning activities into treatment programs; and assists individuals and their communities through the reentry process through the delivery of community-based treatment and other broad-based aftercare services.

RSAT programs are based on the therapeutic community model, for which a considerable body of research supports the effectiveness of therapeutic community treatment for offenders, particularly in a

continuum of care that involves prison treatment followed by community treatment.³ Therapeutic communities have a history of treating clients involved in the criminal justice system, and the therapeutic community focus on treating the whole person (as opposed to drug problems exclusively) is particularly appropriate for RSAT populations.

Therapeutic communities using CBT are the most supported model. Key components of this include having counselor- and peer-led groups; providing a process for participants to increase his or her role; using the group to establish norms to socialize the group; having individuals reward others; creating an environment that supports change; having separate housing units; instilling a sense of unity and pride; and including family treatment to develop a social support network.

Available Research on RSAT Programs

The National Institute of Justice's CrimeSolutions.gov registry only lists four studies of RSAT programs that have been rated "promising," meaning the programs show some evidence to indicate that they achieve their intended outcomes. None received enough study for a rating beyond "promising." (Programs rated as "effective," the highest rating, have strong evidence to indicate they achieve their intended outcomes when implemented with fidelity.) However, CrimeSolutions.gov makes it clear that the resource is not intended "to replace or supersede informed judgment and/or innovation ... Rigorous evaluation evidence is one of several factors to consider in justice programming, policy, and funding decisions. We also recognize the importance of encouraging and supporting innovative approaches that may not yet have extensive evidence of effectiveness."⁴

The four RSAT programs recognized as "promising" are:

- **The Minnesota Department of Corrections Prison-Based Chemical Dependency Treatment**, based on the therapeutic community model;⁵
- **The Forever Free Program at the California Institute for Women**, which follows a cognitive-behavioral curriculum that stresses relapse prevention;^{6,7}
- **The Amity In-Prison Therapeutic Community**, located in a medium-security prison in San Diego that uses workbooks, teacher's guides, and videotapes as well as psychodrama groups and "lifer mentors"—highly committed individuals with criminal histories who are recovering substance users;⁸ and
- **The Delaware Department of Correction KEY/Crest programs**, which begin with a prison-based therapeutic community and continues with post-release treatment in the community.⁹

These four programs vary considerably, reflecting the wide diversity of RSAT programs around the country and U.S. territories. The Minnesota RSAT provides 15–25 hours per week of programming for participants, with a staff to participant ratio of 1:15. The state DOC abandoned its 90-day program after it was found to be less effective than two longer-term programs: One that lasted 180 days, and the other that lasted a full year. The 180-day program proved to be the most effective in reducing recidivism.¹⁰

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

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

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

The Delaware RSAT program includes 12–18 months in the KEY program, which is a prison-based therapeutic community treatment program. It includes constant staff oversight and treatment programming seven days a week, with group sessions twice per week. Aftercare includes six months at a Crest Outreach Center, which are residential work release centers based on the therapeutic community model. The last 3 months of Crest include daily work release. While KEY/Crest programs were found to be effective in general, findings were mixed in the KEY component—some studies found the prison-based component effective and others did not.

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

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

Goal of this Paper

Promising Practice Guidelines for Residential Substance Abuse Treatment is intended to assist correctional administrators and practitioners at the state and county level to establish and maintain RSAT programs that adhere to the promising practices suggested by existing research and related standards developed for substance use disorders treatment and criminal justice programming.

READING THE GUIDELINES

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

Promising Practices Guidelines for Residential Substance Abuse Treatment

I. Intake, Screening, and Assessment

Across correctional facilities, the decision-making authority for determining which individuals are referred to and placed in RSAT programming varies across staff. Correctional facilities should therefore have clearly defined criteria for program eligibility.

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

The primary criteria for an individual's admission into an RSAT program should be the existence of a moderate to severe substance use disorder based on diagnostic criteria and an evidence-based assessment that indicates a medium to high criminogenic risk (the likelihood of reoffending).

Research shows that, in general:

- People with substance use disorders despite even long periods of abstinence while incarcerated still are at risk for relapse and reoffending¹¹; and
- Criminogenic needs important to reducing offender not only include substance use, but also antisocial cognition, antisocial associates, family and marital relations, employment, and leisure and recreational activities.¹²

In addition, there is evidence to support that people with substance use disorders leaving correctional facilities face an increased risk of death from an opioid overdose after release, especially in the first two weeks.¹³ Individuals showing a medium to high criminogenic risk would thus benefit most from cognitive and skill-building interventions designed to address their criminogenic needs.

Correctional facilities should have protocols in place to screen and assess for these substance use disorders and for criminogenic risk. There are multiple validated screening and assessment instruments available for use.* The results of these screens and assessments should guide decision-making about eligibility criteria for RSAT programs.

* See SAMHSA's report that reviews different screening and assessment instruments for co-occurring disorders, *Screening and Assessment of Co-Occurring Disorders in the Justice System* (2016), at <https://store.samhsa.gov/product/SMA15-4930>.

B. Programs should screen and assess individuals for co-occurring mental disorders.¹⁴

The overlap between substance use disorders and mental illness, including trauma, has shown to be substantial. Studies have found that up to 59 percent of state prisoners with mental illness have co-occurring substance use disorders.¹⁵ As part of screening and assessment protocols, RSAT programs should screen for co-occurring mental illness among individuals who have a substance use disorder.[†] Just as with substance use, there are several mental health screening instruments that are in the public domain and have been validated on people who are incarcerated.[‡] A clinical assessment for mental illness should be conducted for those who screen positive for signs of mental illness. RSAT programs should be structured in a way that responds to the treatment needs of individuals with substance use and co-occurring mental disorders, making special considerations for medications and counseling for mental illness in addition to the cognitive-based interventions and other services that are offered.¹⁶

Principles of Co-Occurring Integrated Treatment

Recovery is an individualized process—informed by levels of severity, needs, strengths and preferences of each client. Increased coordination translates into more realistic expectations that recognize there is no point when one treatment should end and the other begins. Experts agree on the following integrated treatment principles: 1) co-occurring disorders are the expectation; clinical services should incorporate this assumption into screening, assessment, and treatment planning; 2) within the treatment context, both disorders are considered primary; 3) empathy, respect, and a belief in the individual's capacity for recovery are fundamental provider attitudes; 4) treatment should be individualized to accommodate the unique needs and personal goals of individuals at different stages of their recovery; and 5) the role of an individual's community in treatment, post-release reintegration and aftercare is a major factor in recovery.¹⁷

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

Once screened for admission into RSAT, individuals should be more comprehensively assessed for substance use disorders, criminogenic risk and need, and responsivity factors such as trauma, mental health, physical health, literacy, and any other factor that will affect their ability to remain abstinent from substance use and not recidivate. According to the National Institute on Drug Abuse's Principles of Drug Abuse Treatment for Criminal Justice Populations, assessment is the first step in treatment.¹⁸

Individuals differ in terms of age, gender, ethnicity and culture, substance use disorder severity, readiness to change, recovery stage, and level of required supervision. Individuals also respond differently to different treatment approaches and treatment providers. In general, alcohol and substance use treatment should address issues of motivation, problem solving, and skill building for resisting alcohol, substance use, and criminal behavior. Lessons aimed at supplanting alcohol and substance use and criminal activities with prosocial activities, and at understanding the consequences of one's thoughts and actions, are also important to include. Tailored treatment interventions can facilitate the

[†] Under Section 14012 of the 21st Century Cures Act, RSAT grant funds may be used for programs for state prison inmates with co-occurring substance use and mental disorders.

[‡] *Ibid.*

development of healthy interpersonal relationships and improve the participant's ability to interact with family, peers, and others in the community.

Although the more limited duration of many jail RSAT programs may also limit the ability of the programs to provide intensive individualized treatment programming, completing individualized assessments may allow programs to at least define subgroups of participants with similar needs so that programming can better meet their specific demands.

Programs should create policies and procedures that include information on what is included in the comprehensive assessment. A good guidance document on what constitutes comprehensive assessment was developed by The American Society of Addiction Medicine (ASAM outlines the following:¹⁹

- A physical exam
- A mental status exam
- Medical and psychiatric history
- A detailed past and present substance use history, including assessment of withdrawal potential
- A history of the pathological pursuit of reward or relief through engagement in addictive behaviors such as gambling or exercise
- Substance use disorder and addictive disorder treatment history and response to previous treatment, including history of use of pharmacotherapies and response to such interventions
- Family medical, psychiatric, substance use, addictive behavior and addiction treatment history
- Allergies
- Current medications
- Social history
- Consultation with appropriate collateral sources of information
- A summary of the patient's readiness to engage in treatment, potential to continue unhealthy use or return to unhealthy engagement in substance use or addictive behaviors, and the recovery environment that can support or impede recovery
- Diagnostic formulation(s)

- Identification of facilitators and barriers to treatment engagement including patient motivational level and recovery environment

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

Research suggests that substance use disorder treatment does not need to be voluntary to be effective. However, individuals should not be referred to RSAT based on rewards or consequences for institutional behavior or plea/sentencing agreements that are antithetical to eligibility for RSAT programming.

RSAT staff should assess potential participants’ readiness to change and adapt programming to match their stage of readiness. After admission, the RSAT program should provide motivational enhancement therapies that help participants to address their substance use disorders and commit to treatment.

II. Core Program Components and Structure

REQUIRED BY THE AUTHORIZING STATUTE (42 U.S.C. § 3796ff et. seq.):²¹

Treatment practices/services should be, to the extent possible, evidence-based and should develop participants’ cognitive, behavioral, social, vocational, and other skills to facilitate recovery for the substance use disorders and related problems.

A. Treatment should target factors associated with criminal behavior in addition to substance use disorders.

“Criminal thinking” is understood as a combination of attitudes and beliefs that support a criminal lifestyle and criminal behavior, such as feeling entitled to have things one’s own way, feeling that one’s

STATE DEPARTMENT OF CORRECTION PROTOCOL

The Hawaii Department of Public Safety’s Corrections Division maintains the following protocol:

“All patients with a drug or alcohol history shall be referred to a provider for a physical examination, including:

1. An assessment of their current medical condition;
2. Documentation on the medical record regarding health care findings;
3. Prescription of condition-specific medications, as needed;
4. Referral to mental health services for documented assessments and follow-up; and
5. The ordering of appropriate diagnostic tests to evaluate for the occurrence of associated disorders such as liver disease.”²⁰

criminal behavior is justified, failing to accept responsibility for one’s actions, and consistently failing to anticipate or appreciate the consequences of one’s behavior. Treatment that provides specific cognitive skills training to help individuals recognize patterns of thinking that lead to alcohol and substance use and criminal behavior may improve outcomes.

B. RSAT programs should offer treatment interventions that are evidence-based or based on promising practices.

Almost all the evidence-based substance use disorder treatment programs have been implemented in the community, as opposed to in correctional settings. Implementation science suggests that, to be successful, interventions must be evidence-based and delivered in a way that mirrors the original design or maintains fidelity to the intervention in complex settings.²² The research also shows that implementing an intervention with fidelity to the original model increases the likelihood of achieving positive outcomes, while not doing so can undermine the effectiveness of the intervention and may even produce harmful effects from the intervention.

As noted in the CrimeSolutions.gov registry of evidence-based correctional programs, however, innovation requires experimentation; trying new approaches; and building on evidence-based programming to both meet the evolving needs of RSAT participants as well as the evolving implications of research. Thus, in the absence of specific evidence-based substance use disorder treatment programs in prison or jail, RSAT programs should implement treatment interventions that are known to be evidence-based for justice populations in the community. RSAT staff must then determine that:

- The intervention is transferable to an institutional correctional setting;
- The intervention would serve a similar target population (including age, gender, ethnicity and race, special needs, culture, and so on);
- The intervention can be implemented with reasonable fidelity;
- There exists the resources and capacity to implement the program; and that
- Staff implementing the intervention have the qualifications necessary to deliver it.

Implementation of the evidence-based intervention should be aligned with existing process and procedures within the prison or jail, while maintaining fidelity to the original intervention as much as possible. Administrators of RSAT programs should ensure that the interventions chosen for the target population are delivered with accuracy at different stages of the implementation process, including during the period of exploration and adaptation; program installation; initial implementation; and full implementation, as well as in the time afterward.²³

Research has identified six core drivers of implementation, including (1) staff selection; (2) pre-service and in-service training; (3) ongoing consultation and coaching; (4) staff and program evaluation; (5) facilitative administrative support; and (6) systems interventions.²⁴ There are multiple checkpoints that RSAT programs can put in place to ensure that staff receive the necessary training and coaching to deliver interventions to participants.

C. Medications should be considered part of the contemporary standard of care for the treatment of individuals with alcohol and opioid use disorders and also for individuals with co-occurring mental illness.

Medicines used in medication-assisted treatment, such as methadone, buprenorphine, and naltrexone for opioid use disorders, and naltrexone, acamprosate calcium and disulfiram for alcohol use disorders,

should be made available to individuals who could benefit from them.^{25,26} Effective use of medications can also be instrumental in enabling people with co-occurring mental disorders to function successfully in both prison, jail, and the community. If potential RSAT participants are prescribed antipsychotic medication, they should be allowed to continue receiving the medication pending medical and psychiatric assessments. Discontinuing the use of antipsychotic medication has the potential to affect both recidivism and health care costs after release, as well as the severity of symptoms of the mental disorder, overuse of solitary confinement, and suicide within prisons and jails.²⁷

If RSAT participants are prescribed methadone or buprenorphine for opioid disorders, they should be allowed to continue the medication or be given the option of safely tapering off the medication while in the program. Programs should also assist RSAT graduates in obtaining access to appropriate medication(s) upon release if they and their physicians and treatment providers deem it appropriate.

Research shows that medication-assisted treatment that began or continued in prison or jail led to much higher rates of entry in aftercare treatment post-release than for individuals who received in-jail or prison treatment without medication.²⁸

In its 2016 report to help states develop a road map for responding to the growing opioid epidemic in the United States, the National Governors Association called upon state correctional agencies to:

1. Increase access to medication-assisted treatment in prisons and correctional settings;
2. Ensure continued access to medication-assisted treatment upon reentry into the community; and
3. Provide overdose education and naloxone for individuals during their reentry process, when they are most vulnerable to overdose.²⁹

The National Commission on Correctional Health Care also declared in 2015 that correctional staff “undergo training that includes education regarding opioid overdose and its signs; correct technique for administration of naloxone....[and] positioning of the individual; and essential related procedures, including performance of cardiopulmonary resuscitation and emergency transfer of the individual to a facility equipped to treat overdose.”³⁰

RELATED RESEARCH

A randomized clinical trial of prison-initiated buprenorphine provided to male and female individuals who were previously heroin dependent prior to incarceration found that those receiving the medication were significantly more likely to enter community treatment upon release (47.5% vs. 33.7%). However, the researchers noted that, although buprenorphine can facilitate entry into community treatment, concerns remain with in-prison treatment due to attempted diversion of medication.³¹

A study at Riker’s Island jail in New York City found the use of injectable naltrexone decreased illicit opioid use by more than 50 percent following release.³²

And in a Baltimore prison, men who received methadone maintenance treatment and counseling with treatment continuing upon release were reported to show a much lower rate of illicit opioid use compared to those who received counseling only.³³

Note: More detailed and specific guidelines on medication-assisted treatment please refer to the [RSAT TTA publication Prison/Jail Medication Assisted Treatment Manual](#).³⁴

D. RSAT length requirements should be considered minimum, and RSAT programming should be offered in phases.

Similar to the treatment that is offered through specialty court programs, RSAT should be structured in different phases. The treatment provided by RSAT programs should be considered the first phase of *ongoing* treatment that begins in prison or jail but continues after release. Institutional administrators, paroling authorities, and judges should be advised to allow participants to remain in RSAT programs at least for these minimum lengths. Potential RSAT participants should be advised in advance, however, if RSAT program completion will impact on their eligibility to be considered for early release. [See “Related Research,” below.]

RELATED RESEARCH

Two studies of a jail RSAT program found that those who did not complete their RSAT program, including those who did not complete because they were granted early parole, had significantly higher recidivism rates post release than those who did complete the program.³⁵ Graduation from one phase of the treatment to the next should be based on behavior, and not time elapsed.

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

Similar to the recommendations made by the Adult Drug Court Best Practice Standards committee, RSAT programming should be designed so that participants receive services in phases. The first phase should address orientation to the rules of the RSAT pod and program as well as a participant’s mental health symptoms, substance-related cravings, withdrawal, anhedonia, and readiness to change and motivation. In the next phase, services should address resolution of criminogenic needs, including criminal thinking. In the last phase, services are provided to maintain treatment gains by enhancing RSAT participants’ long-term adaptive functioning.³⁶

F. RSAT programs should be culturally competent.

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

relationships between clients and providers, and treatment retention and outcomes. Cultural competence is an essential ingredient in decreasing disparities in behavioral health.³⁷

Knowledge of a culture's attitudes toward mental illness, substance use, healing, and help-seeking patterns, practices, and beliefs is essential when considering an individual's "presenting problem" (initial symptom or symptoms for which they seek help). It is also essential for developing culturally competent counseling skills and formulating culturally relevant agency policies and procedures. RSAT staff should learn, and understand, how identification with one or more cultural groups influences each client's worldview, beliefs, and traditions surrounding initiation of use, healing, and treatment.^{38§}

STATE DEPARTMENT OF CORRECTION PROTOCOL

The Virginia Department of Corrections provides that its therapeutic community programs for substance use disorders must include, at a minimum, "culturally sensitive treatment objectives, as appropriate."³⁹

G. Positive programming should account for the majority of the participants' day.

Although many RSAT participants will be segregated from the general prison or jail population, negative influences can be further minimized if individuals are involved in positive programming most of the day. For this reason, it is imperative that correctional officers, who spend more direct face time with participants than treatment staff, reinforce behavioral standards and activities promoted by RSAT program staff. It is suggested that cross-training officers and RSAT staff will encourage consistent, positive reinforcement for treatment. Keeping RSAT participants positively engaged is one of the reasons why many RSAT programs employ modified therapeutic communities to address participants' substance use disorders. Some programs use activity logs to track participants' structured activities. Others provide participants with electronic tablets that can be monitored to measure time spent on the specific educational or treatment programming available on the device.

H. Recovery support is a critical component of ongoing recovery success during RSAT and after release.

Connections to safe and supportive peers, other people in addiction recovery, and pro-social networks of support are important components of successful RSAT programs. Often individuals reentering the community who have long histories of substance use have very few contacts who are not connected with drug and alcohol use. Some have no contact with supportive family members; even a good friend who does not use drugs may be a thing of the past. Increasing RSAT participants' connections to pro-social peer support network begins in the treatment setting, and is a key aspect of the therapeutic community approach. Recovering peers have role in treatment settings that is distinct from staff. In RSAT programs, an outside peer recovery presence is desirable; however, peers who have completed treatment and are awaiting release can serve a similar purpose. The unique contributions of peers fall into four categories that complement professional services.

§ SAMHSA has developed a checklist to evaluate cultural competence in treatment programs and organizations, some of which is applicable for RSAT programs. The checklist as well includes acculturation and ethnic identity measures and can be found at <http://store.samhsa.gov/shin/content/SMA14-4849/SMA14-4849.pdf>.

Peers in addiction recovery can:

1. **Promote hope** through positive self-disclosure; assuring others that recovery is possible;
2. **Model recovery thinking**, reentry success, positive parenting, and gainful employment;
3. **Share knowledge**, unwritten rules, resources, and pro-social "street smarts," vital for navigating social services systems; and
4. **Engage others** in informal networks of support that provide an alternative to anti-social companions and activities.

Recovery coaching, mentoring, attendance at recovery support groups, and connections to local recovery community resources are examples of peer-led elements of successful RSAT programs. Multiple studies have verified the effectiveness of peer support programs— in addition to treatment— for adolescents in the juvenile justice system, female offenders, justice-involved veterans, and adult offenders.⁴⁰

I. There should be more rewards than sanctions to encourage pro-social behavior and treatment participation.

When providing correctional supervision of individuals participating in substance use disorder treatment, it is important to reinforce positive behavior. Non-monetary "social reinforcers," such as recognition for progress or sincere effort, can be effective, as can graduated sanctions that are consistent, predictable, and clear responses to noncompliant behavior. Generally, less punitive responses are used for early and less serious noncompliance, with increasingly severe sanctions issuing for continued problem behavior. Rewards and sanctions are most likely to have the desired effect when they are perceived as fair and when they swiftly follow the targeted behavior. Consequences for participants' behavior should be administered in accordance with evidence-based principles of effective behavior modification. Moreover, confrontation should focus on negative behavior and attitudes, and not on the individual.

RELATED RESEARCH

As summarized by the National Institute on Drug Abuse, research has demonstrated the effectiveness of treatment approaches using contingency management (CM) principles, which involve giving patients tangible rewards to reinforce positive behaviors such as abstinence. Studies conducted in both methadone programs and psychosocial counseling treatment programs demonstrate that incentive-based interventions are highly effective in increasing treatment retention and promoting abstinence from drugs.⁴¹ Research shows that implementing a higher number of incentives to sanctions, particularly in a ratio of four or more rewards for every sanction, achieves the best outcomes for people on community supervision.⁴²

STATE DEPARTMENT OF CORRECTION PROTOCOL

The Michigan Department of Corrections provides in its policy directive on substance use programming and testing that a "prisoner's refusal to actively participate in required programming may be considered in determining whether to grant special good time or special disciplinary credits, as set forth in 'Good Time Credits' or 'Disciplinary Credits/Drug Law Credits,' as appropriate."⁴³

III. Staffing and Training

A. In group activities, the ratio of RSAT participants to staff should be no more than 20 to 1.⁴⁴

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

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

Both treatment staff and correctional officers should understand RSAT standards, philosophy, benchmarks, and objectives. Both should be expected to attend and participate in relevant program activities, including daily or weekly meetings as well as community meetings with RSAT participants. Both should be involved in discipline and performance reviews—including whether participants should advance to the next phase of treatment—along with assessments and clinical supervision. Treatment staff and correctional officers should be involved in cross training—including implementation of assessment instruments—motivational interviewing techniques, accountability training, and addiction-related trainings.

Treatment staff should attend correctional officer training and security-related training, and correctional officers should be exposed to treatment training. In addition to initial training, all staff should be required to complete a regimen of in-service training to keep up with latest evidence-based treatment. Whether the primary modality of treatment is a modified therapeutic community or not, counselors and correctional officers should be trained appropriately and work as a team.

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

To be effective, substance use disorder treatment programming should take up 40–70 percent of an individual's time.⁴⁵ This requires a collaborative effort between correctional officers and treatment staff so that RSAT participants are involved in the program beyond the limited hours counselors are available in the institution. In turn, this means that correctional officers must understand RSAT programming and be as committed to treatment as RSAT counselors and administrators.

D. Treatment and correctional officers should be represented in program administration.

Treatment providers and correctional officers, whether the former is contracted in- or out-of-house, should be centrally involved in RSAT program administration, operation, and direction. The most promising RSAT programs represent collaboration among treatment staff, correctional officers and prison/jail administrators, where each recognizes the needs of the others.

IV. Treatment and Service Interventions

A. RSAT programming should be responsive to a diverse population; include both group and individual counseling delivered in a way that supports and reinforces the acquisition of skills that aid and sustain recovery; and be periodically reviewed to ensure adopted methods are the best fit for participants.

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

- Cognitive behavioral therapy (CBT)
- Therapeutic communities (TC)
- Contingency management (CM) interventions/motivational incentives
- Community reinforcement approach (CRA), plus vouchers
- Motivational enhancement therapy (MET)
- The Matrix Model
- Twelve-step facilitation therapy
- Family behavior therapy (FBT)
- Behavioral therapies, including multisystemic therapy (MST)⁴⁶

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

Many evidence-based behavioral therapies are focused on particular substances and have been studied primarily in community settings. Thus, their use in correctional settings requires adjustments and modifications. Once implemented, it is imperative that RSAT programs evaluate whether they have maintained fidelity to the essential elements of the treatment and that the program, as modified and implemented, achieves commensurate results as that found in the research.

RSAT programs have also found evidence-based, manualized treatment interventions (those that are implemented according to instruction manuals) to be effective, offering structure and consistency. They are also easy to use and can help focus sessions, although they can be restrictive and counselors need to incorporate personal style and creativity in their use.⁴⁷ The quality of the interpersonal relationships between staff and the participants, along with the skills of the staff, are as important to risk reduction as the specific programs in which offenders participate.⁴⁸

In addition to behavioral therapies, NIDA also lists the use of pharmacotherapies deemed helpful. For opioid addiction, it lists methadone, buprenorphine, and naltrexone. For alcohol addiction it lists naltrexone, acamprosate, disulfiram, and topiramate.

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

Cognitive behavioral interventions (CBI) are designed to directly address the risk factors that are directly related to the likelihood of an individual committing future crime.

For instance, “distorted cognition” is a characteristic very often found in people with criminal offenses. This can include self-justificatory thinking, misinterpretation of social cues, feelings of dominance and entitlement, and a lack of moral reasoning. The use of CBI for people involved in the justice system is based on the idea that an individual’s cognitive deficits and criminal-thinking patterns are learned, and not inherited, behavior. Therefore, CBIs typically use a set of structured techniques that attempt to build cognitive skills in areas in which individuals show deficits. CBIs can also help “restructure” cognition in areas where people show biased or distorted thinking. They are designed so that a well-trained non-clinician could provide the intervention to clients. Examples of such programs include Thinking for a Change; Reasoning and Rehabilitation; and Good Intentions, Bad Choices.**

Cognitive behavioral therapy (CBT) is a problem-focused set of therapeutic approaches provided by a clinical professional. It helps people identify and change dysfunctional beliefs, thoughts, and patterns of behavior that contribute to their problem behaviors, criminal and otherwise. CBT programs emphasize individual accountability and attempt to help adult offenders to understand their thinking processes and the choices they make.⁴⁹ Examples of CBT include rational emotive behavior therapy; cognitive therapy; and dialectical behavioral therapy.

To help reinforce this approach, RSAT staff, officers, and treatment staff should teach participants to become aware of their thinking, verbalize their thoughts, and stop reacting to automatic thoughts; and understand how their thoughts and beliefs can trigger criminal and addictive behaviors. Staff should provide skills training and opportunities for modeling and behavior rehearsal. All RSAT staff should understand the program’s basic CBT approach and key terms. CBT sessions should be monitored periodically to assure that proper techniques are employed; principles or skills are being reinforced outside of CBT sessions; other treatment tools and program rules are consistent with CBT principles; and that participants are held accountable.⁵⁰

RELATED RESEARCH

Aggregating the results from 32 studies to examine the impact of CBI and CBT on crimes committed by moderate- and high-risk adult offenders, researchers found a significant effect size (-0.14) favoring the treatment group, meaning that moderate- and high-risk adult offenders who received CBT were significantly less likely to commit a crime, compared with adult offenders who did not receive intervention.⁵¹

** SAMHSA’s National Registry of Evidence-based Programs and Practices lists more than 20 CBT-based programs. See <http://nrepp.samhsa.gov/AdvancedSearch.aspx>. The CrimeSolutions.gov registry also finds CBI to be “promising” for moderate and high-risk adult offenders.

C. Therapeutic communities should be adapted to function within a prison or jail without sacrificing the essential components of a therapeutic community.

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

The defining feature of TCs is its emphasis on participation by all members of the program in the overall goal of reducing substance use and recidivism. The TC theory proposes that recovery involves rehabilitation to learn healthy behaviors and “habilitation” to integrate those healthy behaviors into a routine.⁵² TCs differ from other models of treatment by its focus on recovery, overall lifestyle changes, and the use of the “community”—which includes peers and facility staff—as the key instrument for that change.⁵³ TCs use a stepping-stone model, in which participants progress through several levels of treatment. As they progress through each treatment level, their level of responsibility also increases. TCs are implemented in a residential setting to help participant adjust to the idea of a community working together toward a common goal.⁵⁴ Treatment includes aftercare and reentry services as a means of providing continued support and relapse prevention after leaving the community.⁵⁵

Modified therapeutic communities for individuals with co-occurring substance use and mental disorders have also been found to be “promising” in CrimeSolutions’ registry.⁵⁶

The Therapeutic Communities of America, a membership organization of more than 650 substance use disorders and mental health treatment centers, recommends the following for TCs to be most effective:

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

8. The community must adhere to strict behavioral expectations with certain consequences and sanctions applied in a mutual effort by other members and staff.
9. To ensure there is no corruption or programmatic drifting, it is essential to have regular therapeutic community-specific monitoring and training from outside the community.⁵⁷

RELATED RESEARCH

Synthesized results from 30 studies that examined the effectiveness of incarceration-based therapeutic communities for adults indicated that people involved in the treatment group were significantly less likely to recidivate after release than the comparison group after release (odds ratio = 1.38 for the treatment group). This means that if the comparison group had an assumed recidivism rate of 35 percent, the treatment group offenders would have a 28 percent recidivism rate.⁵⁸ Another analysis on the effectiveness of incarceration-based therapeutic communities for adults indicated that treatment group offenders were significantly less likely to recidivate than comparison group offenders (effect size = -0.12).⁵⁹

D. Motivational interviewing for substance use disorders can help strengthen participants' motivation to stop using substances and constitutes an important component of RSAT programming.

Motivational interviewing, which has been rated by CrimeSolutions.gov as “effective,” is a brief client-centered, semi-directive psychological treatment approach that concentrates on improving and strengthening an individual’s motivation to change.⁶⁰ It incorporates four basic principles into treatment: (1) expressing empathy; (2) developing discrepancy; (3) rolling with resistance; and (4) developing self-efficacy. When provided to individuals with substance use disorders, the long-term goal is to help them reduce or stop using drugs and alcohol. The practice can target individuals who are less motivated or ready to change, and who may show more anger, opposition, or ambivalence. The intervention itself is brief; typically an individual will meet with a counselor 1–4 times, for about an hour each session. The delivery setting can vary and consists of aftercare/outpatient clinics, inpatient facilities, correctional facilities, halfway houses, and other community-based settings.

RELATED RESEARCH

Twelve studies looking at the extent of substance use when comparing individuals who received motivational interviewing with individuals who received no treatment showed, at follow-up periods between 6 and 12 months, that those individuals in the motivational interviewing treatment groups significantly reduced their use of substances compared with individuals in the no-treatment control groups. However, the effect size was small (standardized mean difference=0.15).⁶¹

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

The adoption of an evidence-based treatment program does not guarantee the same results found in related research. While RSAT programs should adopt evidence-based practices, definable and measurable outcomes must also exist to assess and determine program effectiveness. In addition, documentation of case information—including formal, valid mechanism(s) for measuring outcomes—

should be required. RSAT programs must routinely assess participants' progress or change in cognitive development and skills, and evaluate the recidivism and relapse rates of program graduates. Also, there should be periodic staff performance evaluations to achieve greater fidelity to the evidence-based program design; service delivery principles; and outcomes. Staff monitoring, measuring, and reinforcing promotes overall cohesiveness and greater support to the program mission.⁶² Feedback is essential for both RSAT participants and staff.⁶³

F. RSAT programs should include compatible treatment and social services.

Although all RSAT participants are engaged in treatment for substance use disorders, other needs must be addressed while they are incarcerated to prepare them for reintegrating into the community. Examples of compatible treatment and services include the following, also identified by drug court researchers⁶⁴:

- clinical case management
- housing assistance (sober/drug-free)
- mental health treatment
- trauma-informed and specific services
- criminal thinking interventions
- family and social support and interpersonal counseling
- recovery community support
- peer recovery support
- pro-social and recreational activities
- vocational and educational services
- medical and dental treatment
- overdose prevention and reversal, including provision of naloxone to individuals, or family members/partners, after they are released

G. RSAT programs should be trauma-informed regardless of whether trauma-specific services are provided.

At least one third of males and two thirds of females in RSAT programs may be experiencing lasting effects of trauma exposure that play a role in their continued use of drugs and alcohol.⁶⁵ As part of the principle of responsivity, RSAT programming should be accessible to participants who have experienced trauma. For this reason, all programming should be trauma-informed as much as possible, given that prisons and jails present challenging settings for trauma-informed approaches. For an individual with post-traumatic stress disorder (PTSD), for example, there may be scores of unavoidable triggers—shackles, overcrowded housing units, lights that are on all night, loud speakers that blare without warning, and severely limited privacy. Pat downs and strip searches, frequent discipline from authority figures, and restricted movement may all mimic certain dynamics of past abuse. All of these factors are likely to aggravate trauma-related behaviors and symptoms that can be difficult for staff to manage.⁶⁶ Some individuals with PTSD may have used alcohol and drugs to cope with trauma responses and triggers, and with the removal of these from the individual's life, trauma-related symptoms may worsen.⁶⁷

Integrating trauma stabilization and coping skills training into an RSAT program will make the substance use disorder treatment more accessible for individuals who have experienced trauma. Trauma-informed programs and cognitive behavioral trauma-specific interventions can help offenders master the skills that will set the stage for engagement in effective recovery programming. Trauma-informed RSAT programs should: have staff who understand trauma and its impact on the addiction and recovery process; services designed to enhance safety, minimize triggers, and prevent re-traumatization; encourage relationships between staff and participants based on equity and healing; and empower trauma survivors with information, hope, and appropriate referrals upon release.

Although there cannot be equity in relationships between staff and RSAT participants, participant councils can be formed to give participants some input into how the RSAT programs or pods operate—and in such a way that does not compromise the security and safety of the institution. Trauma-specific services might include specific groups and interventions aimed at coping with the aftermath of trauma, decreasing symptoms of trauma-related disorders, and increasing knowledge about trauma. Individuals should be empowered with skills and techniques to manage and lessen the effects of trauma in their ongoing recovery.

STATE DEPARTMENT OF CORRECTION PROTOCOL

New York Department of Corrections provides a Female Trauma Recovery Program, which uses the Trauma Recovery Empowerment Model (TREM).⁶⁸ The program also addresses issues around substance use disorders; parenting; health issues; and building interpersonal and resource networks. It is followed by the development of an aftercare plan for participants who have ongoing treatment needs.⁶⁹

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

For many RSAT participants, the justice system may be their first exposure to substance use disorder treatment. Others might have attempted treatment but had their periods of recovery “sabotaged” by untreated mental health issues, resulting in a revolving door of recidivism. Still others may have accessed mental health services while substance use problems went unaddressed, eventually contributing to criminal justice involvement. Co-occurring mental health conditions among individuals with substance use disorders should be considered the rule rather than the exception, as evidence suggests that up to 56 percent of people with the most serious mental illnesses will experience a co-occurring substance use disorder within their lifetime.⁷⁰ Given the frequency of consumers with co-occurring disorders, RSAT programs should establish procedures for collaboration with mental health treatment staff.

RSAT staff should receive training on the signs and symptoms of mental health disorders and information on how the presence of one disorder can impact treatment and recovery of another. Although program participants may have already been screened for mental health disorders, symptoms can emerge or develop during the course of substance use disorder treatment. Therefore, RSAT staff should know how to identify those who may require further screening and assessment by a qualified mental health professional.

There are different strategies RSAT programs can employ in dealing with individuals with co-occurring disorders. Some RSAT programs may be geared specifically to the needs of individuals with both mental

health and substance use disorders, offering integrated treatment. Other programs work with mental health staff to provide parallel treatment to RSAT participants who have mental health issues. In some cases, services may be delivered sequentially, with RSAT participants completing a required course of mental health treatment to stabilize and manage their symptoms prior to their admission into addiction treatment.

According to the National Institutes of Health and SAMHSA, both substance use and mental health disorders are brain conditions that respond better to integrated approaches that combine elements helpful to both mental health and addiction recovery into a comprehensive treatment program. The challenge for RSAT staff is to understand how these conditions interact to provide RSAT participants with tools to manage recovery from both and ensure that pre-release planning facilitates connections to the full range of required services and supports. Fortunately, there are a number of evidence-based approaches that have proven effective for both substance use and mental health disorders, including pharmacotherapies; motivational approaches such as motivational interviewing, motivational enhancement therapy, and contingency management; and illness management and recovery. The latter refers to a set of practices that teach people with mental illness how to manage their disorder and how to work with treatment providers and friends and family to help sustain recovery. These strategies align with current substance use disorder treatment principles, which impart information, tools, and resources that empower people to effectively manage ongoing recovery.

SAMHSA has developed the following practice principles for integrated treatment:

- Mental and substance use disorders treatment are integrated to meet the needs of people with co-occurring disorders;
- Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses;
- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages;
- Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage;
- Substance use disorders counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages;
- Multiple formats for services are available, including individual, group, self-help, and family; and
- Medication services are integrated and coordinated with psychosocial services.⁷¹

Research shows that people in integrated treatment programs show more improvement in the following areas than those in non-integrated programs: reduced substance use; improvement in psychiatric symptoms and functioning; decreased hospitalization; increased housing stability; fewer arrests; and improved quality of life.^{72, 73}

State Department of Correction Protocol

The Georgia Department of Corrections opened two integrated treatment facilities in 2012. The program is nine months in length, highly structured, and actively combines interventions intended to address both mental health and substance use disorder issues in people with co-occurring disorders. The intent is to treat both disorders, related problems, and the whole person effectively in a

residential therapeutic community that includes a balance of individual and group sessions. Elements of the program include screening and assessment to include risk-need responsivity; individualized treatment; ongoing monitoring of mental health symptoms; cognitive behavioral treatment; illness management; trauma-focused treatment; psychoeducational therapy; medication assisted therapy; problem-solving skills; and a reentry plan that includes a Wellness Recovery Action Plan (WRAP); among other elements.⁷⁴

Similarly, the New York Department of Corrections provides for “Integrated Dual Disorder Treatment” where “substance abuse services are co-facilitated by trained substance use treatment staff and mental health professionals.”⁷⁵

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

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

V. Drug-Free Environments

REQUIRED BY THE AUTHORIZING STATUTE:

A state must also agree to implement or continue to require urinalysis or other proven forms of testing, including both periodic and random testing of (1) an individual before the individual enters an RSAT program and during the period in which the individual participates in the treatment program; and (2) an individual released from an RSAT program if the individual remains in the custody of the state.

A. Urine testing should be supervised, periodic, and random. In addition, it should be done to ensure abstinence for participants who will be provided medication-assisted treatment prior to their release.

Participants should be carefully monitored for alcohol and substance use during treatment in the correctional facility. Those trying to recover from alcohol and drug addiction may experience a relapse, and return to drug use. Triggers for relapse are varied, but common ones include mental stress; associations with antisocial peers; and social situations linked to drug use. An undetected relapse can progress to more serious issues with substance use, but detected use can present opportunities for therapeutic intervention. Monitoring alcohol and substance use through urinalysis or other objective methods as part of treatment or criminal justice supervision provides a basis for assessing and providing feedback on the participant’s treatment progress. It also provides opportunities to intervene to change unconstructive behavior—for example, determining rewards and sanctions to facilitate change and modifying treatment plans according to progress. In jails that do not have the facilities to

separate RSAT participants from the general population, alcohol and other drug testing should be more prevalent.

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

VI. Transition and Aftercare Planning

REQUIRED BY THE AUTHORIZING STATUTE:

States must give preference to subgrant applicants who will provide aftercare services to program participants. Such services must involve coordination between the correctional treatment program and other human service and rehabilitation programs, such as those providing education and job training, parole supervision, halfway houses, and self-help and peer groups, which may help in rehabilitating offenders.

In 2003, the National Institute of Justice published findings from the only national evaluation of the RSAT program, which included summaries of evaluations of 12 local RSAT programs.⁷⁶ The report found that less than half of programs included an aftercare component. (Aftercare generally included work release, halfway houses, or parole-supervised treatment.)

For many years, RSAT funding for aftercare was limited to 10 percent of the grants provided. This was altered in fiscal year 2013. RSAT programs should help participants connect to community resources, mobilize family and pro-social peers, and help them develop a pro-social peer network by encouraging peer-to-peer learning, peer reentry liaison, and engagement in twelve step/mutual help/faith networks. All of this should occur in addition to specific treatment and service referrals.

Effective aftercare requires transition planning and programming, prerelease planning, and a “warm handoff” to a community-based treatment provider for substance use disorder and mental illness treatment; physical and behavioral case management; referrals for employment/education; and first dose of medication where appropriate. Effective aftercare also requires coordination with parole/probation.

STATE DEPARTMENT OF CORRECTION PROTOCOL

The Massachusetts Department of Correction mandates under “Continuity of Care” for individuals releasing from correctional custody that “follow up shall be conducted in a manner consistent with the recommendations of the treatment plan.... Upon impending discharge, parole, or transfer to pre-release, staff shall update the personalized program plan and develop aftercare plans. The aftercare plan is a separate plan that shall be incorporated into the personalized program plan. The plan shall be based upon the completed substance abuse-specific assessment; input from program staff; the participant; community based treatment program staff; and the institution parole officer, if applicable. All referrals and placements shall be entered in the designated (record) screen.”⁷⁷

A. Continuity of care is essential for people with substance use disorders who are reentering the community.

People who complete prison-based treatment and continue with treatment in the community typically show the best outcomes.⁷⁸ Research shows how providing aftercare can result in better outcomes than when aftercare is not provided.⁷⁹ Continuing substance use disorders treatment can also help individuals who are recently released deal with issues that become relevant at that time, such as learning to handle situations that could lead to relapse; learning how to live drug-free in the community; and developing a drug-free peer support network. Treatment in prison or jail can begin a process of therapeutic change, helping lead to reduced drug use and a reduction of criminal behavior post-incarceration. Continuing drug treatment in the community is essential to sustain these gains. To facilitate connections between in-custody treatment and community-based treatment, information-sharing protocols must be established between both treatment and security staff in correctional facilities and with post-release case managers and treatment staff in the community. This is important to ensure seamless transfer of information about an individual's behavioral health conditions, progress in treatment while incarcerated, and treatment needs that should be addressed in the community.

Regardless of intervention type, positive outcomes from prison-based drug treatment programs are most likely to persist when people participate in post-release community treatment. The success of a continuing care model, in which prison treatment is followed by community treatment, is contingent on whether the released individual appears for admission to the community treatment program and continues to attend it. Unfortunately, many individuals upon release do not do so, even in states where post-release treatment is a condition of release, parole, or probation. Fortunately, efforts by various correctional departments have demonstrated that improving the process of reentry referral can result in most entering aftercare.⁸⁰

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

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

- Making aftercare appointments prior to release
- Having multidisciplinary meetings at regular intervals during treatment
- Reassessing criminogenic needs at regular intervals
- Collaborating with community corrections and community-based treatment staff to ensure continuity of treatment and other services, including the transfer of treatment records

If individuals will not be under correctional supervision after release, RSAT programs must motivate graduates to continue treatment on their own and help them put together a plan to get the supports they need to assist them in remaining drug-free after release.

Drug addiction is a serious problem that can be treated and managed throughout its course. Effective substance use disorder treatment engages participants in a therapeutic process, retains them in treatment for an appropriate length of time, and helps them learn to maintain abstinence. Multiple episodes of treatment may be required. Treatment providers, social service agencies, and community supervision agencies can play a role in improving outcomes for people with substance use disorders in the community by monitoring drug use and by encouraging continued participation in treatment.

C. RSAT programs should work with their correctional systems to encourage state Medicaid managed care contract provisions that require plans to provide care coordination services to individuals upon release from jail or prison and recommend that eligible participants enroll in them.

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

The state of Florida requires Medicaid managed care plans “make every effort...to provide medically necessary community-based services for health plan enrollees who have justice system involvement.” Among other things, these plans must: (1) provide psychiatric services to enrollees and likely enrollees within 24 hours after release from a correctional facility; (2) ensure that enrollees are linked to services and receive routine care within 7 days after release; (3) conduct outreach to populations of enrollees at risk of justice system involvement, as well as “Health Plan enrollees currently involved in this system, to assure that services are accessible and provided when necessary.” In addition, behavioral health organizations must work to develop agreements with correctional facilities that will enable plans to anticipate the release of individuals who were enrolled prior to incarceration.⁸¹

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

RSAT personnel should work with participants’ post-release supervisors to plan for the participants’ transition to community-based treatment and links to appropriate post-release services to improve the success of drug treatment and reentry. Abstinence requirements may necessitate a rapid clinical response, such as more counseling, targeted intervention, or increased medication to prevent relapse. Ongoing coordination between corrections and treatment providers is important in addressing the complex needs of those reentering the community.

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

The rates of infectious diseases, such as hepatitis, tuberculosis, and HIV/AIDS, are higher among individuals with substance use disorders, incarcerated offenders, and individuals under community supervision than in the general population.⁸² Consistent with federal and state laws, drug-involved offenders should be offered testing for infectious diseases and receive counseling on their health status and ways to modify risky behaviors. Released RSAT graduates should be linked with appropriate health care services; encouraged to comply with medical treatment; and reestablish their eligibility for public health services (e.g., Medicaid, county health department services) before release from prison or jail. RSAT participants and their families should be informed on the availability of naloxone and its use to prevent overdose deaths. Where available, they should be encouraged to have the medication on hand in case of emergency.

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

Any gains in substance use disorders treatment obtained in RSAT may dissipate upon release, especially if RSAT graduates return to the same environments and peers that contributed to their drug activity. RSAT should be considered preliminary, or the first phase of, treatment for long-term recovery. Insurance or access to free care is essential for the necessary continued treatment in the community.

In addition to substance use disorders, many RSAT participants are likely to have other significant physical and behavioral health care needs that require regular access to care after release.^{83,84} Without access to health services immediately upon release, the physical and mental health conditions of recently released individuals may deteriorate. In fact, research shows that people face a markedly increased risk of death—more than 12 times that of other individuals—during the first two weeks after release and for drug overdose deaths, the risk of death is 129 times more likely.⁸⁵ Research suggests that providing access to Medicaid upon release can promote more timely access to care, which may reduce that risk, particularly for individuals with chronic physical or mental health conditions.⁸⁶ In addition, continuous access to health care immediately after release may reduce the risk of rearrest and reincarceration.⁸⁷

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

^{††} States that have elected to be Medicaid “expansion” states have broadened Medicaid eligibility criteria to include adults who make less than 133 percent of the federal poverty level, thus increasing the amount of people eligible for coverage.

Correctional facilities should identify people eligible for Medicaid and begin the enrollment process before release. Enrollment is just the first step. The second is appropriate utilization of the treatment and services covered.

In 2016, the Bureau of Justice Assistance and the American Correctional Association released *Health Care Reform: A Practical Guide for Corrections and Criminal Justice Professionals*, which outlines enrollment strategies, structure for delivery of Medicaid services within states, and, specifically, a section on reentry from jails and prisons to the community.⁸⁸ The latter section describes important linkages to community health services, including Federally Qualified Health Centers and Medicaid health home referrals, as well as the need to establish processes for transmitting prison and jail health records to community providers. Other innovative linkages for justice-involved populations are described in *Coordinating Access to Services for Justice Involved Populations*, released by the Milbank Memorial Fund in August 2016.⁸⁹ In 2017, the Council of State Governments Justice Center’s National Reentry Resource Center released *Critical Connections: Getting People Leaving Prison and Jail the Mental Health Care and Substance Use Treatment They Need*, a discussion paper that identifies key questions and issues every policymaker should consider when seeking to help people leaving prison and jail connect to needed mental health and substance use treatment. All states, regardless of the scope of their Medicaid coverage, can use this paper to ensure prisons and jails are positioned as effective hubs for helping eligible people get public health care coverage, Social Security, and veterans benefits. This assistance can help facilitate easier access to treatment and help reduce recidivism as part of a comprehensive reentry effort.⁹⁰

VII. Measuring Results

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

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

How an individual performs in a RSAT program, otherwise known as “program outputs,” does not reveal how well they will do once released. To determine program effectiveness, RSAT programs should follow “program outcomes”—how program graduates do after they are released. The most easily obtained outcome measures are recidivism, including new arrests and reincarcerations. Other important outcomes are measures of substance use disorders relapse, generally associated with length of time in treatment. The most critical relapse outcomes that should be measured are death from overdoses and emergency room treatment for overdoses.

STATE DEPARTMENT OF CORRECTION PROTOCOL

The Vermont Department of Corrections has reviewed its Intensive Substance Abuse Program since 1998. A recent review demonstrated a statistically significant reduction in recidivism, with the rate of recidivism for program graduates after one year at 10 percent, compared to 21 percent for non-completers. After three years, the rates were 30 percent compared to 21 percent for non-completers. For people incarcerated with at least three prior convictions, the recidivism reduction was even greater: Program completers showed a 22 percent recidivism rate, compared to 42 percent for non-completers. According to the Vermont DOC, the results “demonstrate a positive treatment outcome, affirming the hypothesis that the program achieves desired results with the population it serves.”⁹¹

B. RSAT programs should encourage independent evaluations to determine how the outcome measures compare to participants involved in other correctional programs or no programming. Programs should also monitor fidelity of service implementation.

It is difficult to evaluate a program’s effectiveness without a random comparison group of like individuals. Generally, sophisticated evaluative research requires an independent research effort where there is no conflict of interest between the program and the researcher. It is important, however, that the researcher has a full understanding of the program, the population studied, and the criminal justice context, and allows program officials to comment on the findings to ensure that the research has adequately interpreted the data found. For example, given the subjects involved, some RSAT program graduates may be reincarcerated following their release, but for charges that arose prior to their RSAT participation. Researchers must know how to read criminal records to decipher such circumstances.

To ensure that the RSAT program works as well for members of historically disadvantaged groups as non-disadvantaged groups, for example, the outputs and outcomes of the former should be compared against those of the latter. Differences may reveal a programmatic bias that is not obvious or may require more investigation to diagnose.

Independent evaluations should include all individuals initially referred to the RSAT program, including those who may drop out or be terminated before completing the program. Although an RSAT program might boast a perfect record among those who successfully complete the program, it might be because the vast majority of individuals who entered the program never completed it. Furthermore, an analysis of non-completers might reveal that the completers are only those with the lowest risk/need scores of those admitted into the program, or are disproportionately represented by one racial or ethnic background over another, suggesting that the program lacks the cultural competence to respond to diverse populations. An intention-to-treat analysis^{##} will inform the program whether it should limit its admission to those it is most effective for, or change its program to accommodate more diverse participants.

In addition, the shorter the follow up in regard to evaluation, the more successful the program is likely to appear. Many criminal justice interventions appear to be successful in terms of recidivism at six

^{##} A type of study design in which every subject is included in the randomization, regardless of the intervention received or adherence to the intervention.

months. If the time period is lengthened, the success rates may decline dramatically. Generally speaking, follow up measures should be for at least a year or more out.

For monitoring fidelity of service implementation, the program evaluation should include key measures based in implementation science.⁹²

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

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

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

Conclusion

The RSAT for State Prisoners Program enables state and local governments to provide residential substance use treatment for people in prison and jails and maintain community-based treatment and aftercare services following a person's release from the correctional facility. The goal of RSAT is to reduce drug use, demand, trafficking, and drug violence through the provision of substance use treatment and associated supports to prepare people for their return to the community. This document outlines the first promising practice guidelines for RSAT programs based upon available research as well as information on current and past programs. The guidelines are designed based upon promising practices available for criminal justice and substance use disorder treatment in order to assist program administrators and practitioners. When possible, examples of model programs have been provided.

These RSAT programs have a vast reach, from jails to state prison to juvenile facilities to aftercare programs. Considering this influence on multiple correctional settings, it is recommended that these guidelines are consulted to help state and local governments both set policies and procedures and develop program manuals that follow the recommended promising practices.

Postscript and Additional Resources

This collection of promising practices guidelines is designed to be a living document. As more research is completed and as more feedback is received from RSAT programs across the nation and U.S. territories, these guidelines will be updated and revised. They are, of course, intended to complement the work already being accomplished among frontline staff, as research has found that the quality of the interpersonal relationship between staff and offender, along with the skills of the staff, is as or more important to reducing risk than the specific programs in which individuals participate.⁹³ In short, there will never be a substitute for the work of dedicated counselors, correctional officers and other program staff who make up prison and jail RSAT programs.

To learn of the latest research establishing evidence-based substance use disorders and correctional treatment programming, a few of the resources of particular value include:

The CrimeSolutions registry

National Institute of Justice, U.S. Department of Justice

www.crimesolutions.gov

Evidence-Based Practices Web Guide

The Substance Abuse and Mental Health Services Administration

www.samhsa.gov/ebp-web-guide

Principles of Drug Addiction Treatment: A Research-Related Guide, Third Edition

National Institute on Drug Abuse

www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment

Adult Drug Court Best Practice Standards

National Association of Drug Court Professionals

www.nadcp.org/Standards

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

Belenko, S., & Taxman, F. (2012). *Implementing Evidence-Based Practices in Community Corrections and Addiction Treatment*. Springer Series on Evidence-Based Crime Policy.

Taxman, F., & Boufford, J. (2001). *Residential Substance Abuse Treatment (RSAT) in Jail: Comparison of Six Sites in Virginia*. U.S. Justice Department, Office of Justice Programs, National Institute of Justice.

Taxman, F., Silverman, R., & Bouffard, J. (2001). *Residential Substance Abuse Treatment (RSAT) in Prison: Evaluation of the Maryland RSAT Program*. U.S. Justice Department, Office of Justice Programs, National Institute of Justice.

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

Appendix A: RSAT Promising Practices Guidelines Roundtable Attendees

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Appendix B: Description of Evidence-Based Programs

NATIONAL INSTITUTE ON DRUG ABUSE/COGNITIVE BEHAVIORAL THERAPY

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

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

CONTINGENCY MANAGEMENT INTERVENTIONS/MOTIVATIONAL INCENTIVES

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

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

COMMUNITY REINFORCEMENT APPROACH PLUS VOUCHERS

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

For more information, see www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-1.

MOTIVATIONAL ENHANCEMENT THERAPY

Motivational Enhancement Therapy, or MET, promotes rapid and internally motivated change among patients through a counseling approach that helps individuals resolve their uncertainty about taking part in treatment and stopping their drug use. In general, MET is most effective with adults who are addicted or dependent on alcohol and marijuana. It is seen as an effective method for engaging individuals in treatment, rather than as a way to produce changes in their drug use.

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

THE MATRIX MODEL

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

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

TWELVE-STEP FACILITATION THERAPY

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

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

FAMILY BEHAVIOR THERAPY

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

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

BEHAVIORAL THERAPIES FOR ADOLESCENTS/MULTISYSTEMIC THERAPY

One adaptation of behavioral therapy for drug-using adolescents is multisystemic therapy (MST). MST examines the factors associated with antisocial behavior in children and adolescents and typically provides its treatment in natural environments—such as home or school—addressing factors such as the child’s characteristics, family, peers, school, and their neighborhood, in an effort to reduce drug use and incarceration.

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

CREATING LASTING FAMILY CONNECTIONS FATHERHOOD PROGRAM

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

For more information, see SAMHSA.gov.

FOREVER FREE

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

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

HELPING WOMEN RECOVER & BEYOND TRAUMA

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

For more information, see www.cebc4cw.org/program/helping-women-recover-beyond-trauma-hwr-bt/.

INTERACTIVE JOURNALING

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

For more information, see <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=333>.

LIVING IN BALANCE

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

For more information, see <http://www.in.gov/idoc/2966.htm> - living balance.

MORAL RECONATION THERAPY

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

For more information, see www.ncjfcj.org/moral-reconation-therapy-mrt.

MAPPING-ENHANCED COUNSELING

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

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

CORRECTIONAL THERAPEUTIC COMMUNITY

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

For more information, see <https://whatworks.csgjusticecenter.org/intervention/therapeutic-communities>.

Appendix C: Pharmacotherapies

METHADONE

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

BUPRENORPHINE

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

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

NALTREXONE

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

ACAMPROSATE

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

DISULFIRAM

Disulfiram (Antabuse®) interferes with degradation of alcohol, resulting in the accumulation of acetaldehyde, which, in turn, produces a very unpleasant reaction that includes flushing, nausea, and palpitations if a person drinks alcohol. The utility and effectiveness of disulfiram is considered limited because compliance is generally poor. However, among patients who are highly motivated, disulfiram can be effective, and some patients use it episodically for high-risk situations, such as social occasions where alcohol is present. It can also be administered in a monitored fashion, such as in a clinic or by a spouse, improving its efficacy.

TOPIRAMATE

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

Endnotes

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