The RSAT Subgrantee Program Inventory is a semi-structured interview administered via telephone to all RSAT-funded programs reporting active programs that served 10 or more individuals during the July–September 2014 reporting quarter. The interview was designed to capture information about services provided in traditional RSAT-funded correctional programs and services provided in aftercare programs. The Subgrantee Inventory includes questions on the RSAT program: funding; staffing and enrollment criteria; screening and assessment procedures; program enrollment and completion rates; and types of general treatment, wraparound, and evidence-based practices and transitional services provided to clients. There is also a range of open-ended questions that ask respondents to reflect on the strengths of their programs and facilitators related to implementing aftercare services, as well as questions that ask respondents to reflect on aftercare service gaps and challenges to providing aftercare services. A total of 77 programs met the criteria for the sample and 60 completed the interview (78% response rate).

## D. FINDINGS[2]

### 1. State's Approaches to Funding RSAT Programs

*About two-thirds of states (64%, n=30) use a competitive application process to make decisions about the types of programs that are funded through RSAT*.

- Among the 17 states that do not have a competitive process, the Department of Corrections is responsible for distributing funds in 11 states (23%), and the remaining six states reported that they typically fund the same programs every year.
- In some states, RSAT resources are used as seed money to launch or enhance programming. Several of the aftercare programs reported that they used RSAT resources to fill a specific programmatic gap in their community or to enhance existing treatment services.

*For half of the states (51%, n=24), RSAT funds are not sufficient to fully fund robust programming and resources are leveraged from additional sources*.

- Overwhelmingly, respondents reported that declining RSAT appropriations make it difficult to determine the most effective use of resources; limited funds also make it difficult for states to establish a comprehensive service model.
- A little more than half (51%, n=24) of the state PoCs reported that their programs use funds from other sources to help support the RSAT programs and most of these funds come from state resources (67%, n=16).
- Regardless of whether states leveraged additional funds, more than half (53%, n=25) reported that they encourage RSAT subgrantees to collaborate with other BJA-funded programs, including other SCA programs (n=10) and Adult Drug Court Discretionary Grant Program grantees (n=4).

*Despite the BJA requirement that RSAT-funded programs assure connections to aftercare services, only 55% (n=23) of POCs reported that they require RSAT subgrantees to provide aftercare services, and even fewer report using RSAT funds specifically for aftercare (29%, n=12).*

[2] The percentages reported throughout this summary and the report may vary due to missing data.

- Given the limited RSAT funding, as well as general funding gaps for aftercare, it is challenging for states to require these services. Several respondents explicitly stated that all RSAT funds are necessary to support facility-based programming in their state.
- The most frequently reported rationale for not requiring aftercare was that there are existing state aftercare services available to RSAT participants, implying that the requirement is not necessary.

*Only a small percentage of state PoCs are actively involved in treatment quality or client eligibility issues (Exhibit 2).* This finding suggests that RSAT programs across the country lack a consistent official who is responsible for uniform oversight of the program's essential treatment activity.

**Exhibit 2. RSAT State Point of Contact Activities (n=45)***

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

*Percentages may vary due to missing data.

*Most state PoCs do not report significant involvement with state policy issues related to substance use treatment and corrections*.

- Although 83% (n=38) are highly involved in decisions with how RSAT funds are distributed, only 22% (n=8) report "quite a bit" of involvement in state policy issues related to substance use treatment and corrections. This suggests they play no role in shaping overall correctional department policies to ensure that they are consistent with or supportive of RSAT programs. Additionally, state PoCs may not be knowledgeable about issues relevant to RSAT programs, potentially missing opportunities to support and leverage resources for programming.

## 2. RSAT-Funded Treatment Programs and Related Services

*Most programs use RSAT funds to support treatment services in correctional settings (85%, n=53).*

- The types of services provided in these programs to all or most participants include group substance use disorder therapy (98%, n=52), substance use disorder education (91%, n=48),

[3] PMT are performance measures required by BJA for all RSAT-funded programs.

case management services (81%, n=43), social skills development (77%, n=41), and individual substance use disorder counseling (70%, n=37).

*Eighty-five percent of programs provided at least one evidence-based practice (EBP).*

- Most programs provided Cognitive Behavioral Therapy (CBT) with another type of EBP (64%, n=34), typically a criminal thinking EBP or another type of targeted intervention (e.g., TREM, MATRIX, Seeking Safety).

*Most correctional facility-based RSAT programs reported that participants have a written pre-release plan (98%, n=50) and case management staff who facilitate the transition to the community (94%, n=48).*

- Although almost all programs reported that RSAT participants are connected to substance use disorder treatment and other services at release, the majority made these connections through referrals. Research indicates that individuals who were formerly incarcerated are more likely to follow through with appointments if in-person contact is made prior to release (CSAT, 1998), but less than half of programs (43%, n=21) provide this type of connection to community-based substance use disorder treatment.

*There were some differences in programmatic practices between prisons and jails, including the following:*

- Reported utilization of valid screening/assessment instruments for substance use problems was low in jail-based treatment programs (63%, n=12) compared to prison-based programs (95%, n=20).
- Almost all prison programs (91%, n=19) provide segregated housing and treatment in accordance with BJA RSAT guidelines; only 54% (n=11) of jail programs meet this requirement.
- Twice as many jail programs use a personal appointment for connecting RSAT participants to community-based substance use treatment prior to release than do prison programs (54%, n=12 vs. 29%, n=6).

*Fewer than half of respondents (43%, n=26) reported that their program was not at maximum capacity in 2014, principally because of participant turnover as individuals are released, transferred, or moved to different security levels.*

- Notably, several jail programs reported challenges enrolling participants because the pool of eligible individuals was not as large as previous years, which respondents attributed to the implementation of the diversion and alternatives to incarceration programs in their communities that draw against the eligible pool of RSAT participants.

*Some of the key challenges implementing facility-based programs were philosophical differences between corrections and treatment staff and the rotation of correctional officers in facilities.*

- It is generally recognized that successful RSAT programming requires close collaboration between correctional and clinical staffs. Although clinical staff may be available during working hours, the correctional officers are with participants 24/7, and their interactions can either advance treatment or undermine it. However, only 12% (n=7) of programs

reported that they have correctional officers dedicated to the RSAT unit and only 9% (n=5) reported using RSAT funds to train correctional officers.

*Only a small percentage of facility-based programs (13%, n=7) endorsed most or all the 11 NIDA drug use treatment principles for criminal justice populations measured in the study.*

- A sizable majority of RSAT programs incorporated basic treatment principles, such as drug testing (100%, n=53), treatment planning and transitional planning (87%, n=46), and screening/assessment for substance use disorders (79%, n=42), whereas they were least likely to provide connections to medical services (36%, n=19) or linkages to medication-assisted treatment (MAT) post-program (23%, n=12).

## 3. RSAT-Funded Aftercare Programs and Linkage to Aftercare Funded by Other Sources

*Less than one-fifth of programs use RSAT funds to support step-down treatment or aftercare services (18%, n=11)*.

- Seven of the RSAT-funded aftercare programs link directly to a facility-based RSAT-funded treatment program.
- The settings for these aftercare programs are outpatient settings (n=7) and residential facilities (n=4).
- Case management services are a critical component for six of the RSAT aftercare programs, providing the initial program in-reach and transitional planning while the individual is incarcerated and then coordinating services after the individual is released to the community.
- Ten of the aftercare programs reported providing individual therapy and group counseling to RSAT participants and 10 programs reported providing at least one evidence-based psychosocial intervention, principally Motivational Interviewing (MI) or Cognitive Behavioral Therapy (CBT), but a range of other EBPs were also reported, including trauma-specific EBPs.

*Several respondents reported that RSAT resources allowed them to fill community service gaps and offer innovative services.* Some examples include the following:

- One program provides medication assisted treatment (MAT) to individuals transitioning from their jails, a service that would not be available in the community without RSAT BJA funds.
- Another program reported that RSAT helped fill a programmatic gap for a correctional-based residential program by providing step-down services and community-based support following treatment.
- RSAT funds helped fill a transitional service gap in correctional facilities by supporting a case management position that begins to work with individuals several months before release.

*Among the 49 correctional-based RSAT programs that do not link to RSAT-funded aftercare, only about half (49%, n=24) reported that RSAT participants are connected to other aftercare services.*

- The 24 programs fall into three groups: programs that connect anyone released from the correctional facility to aftercare (46%, n=11), programs that connect only individuals who

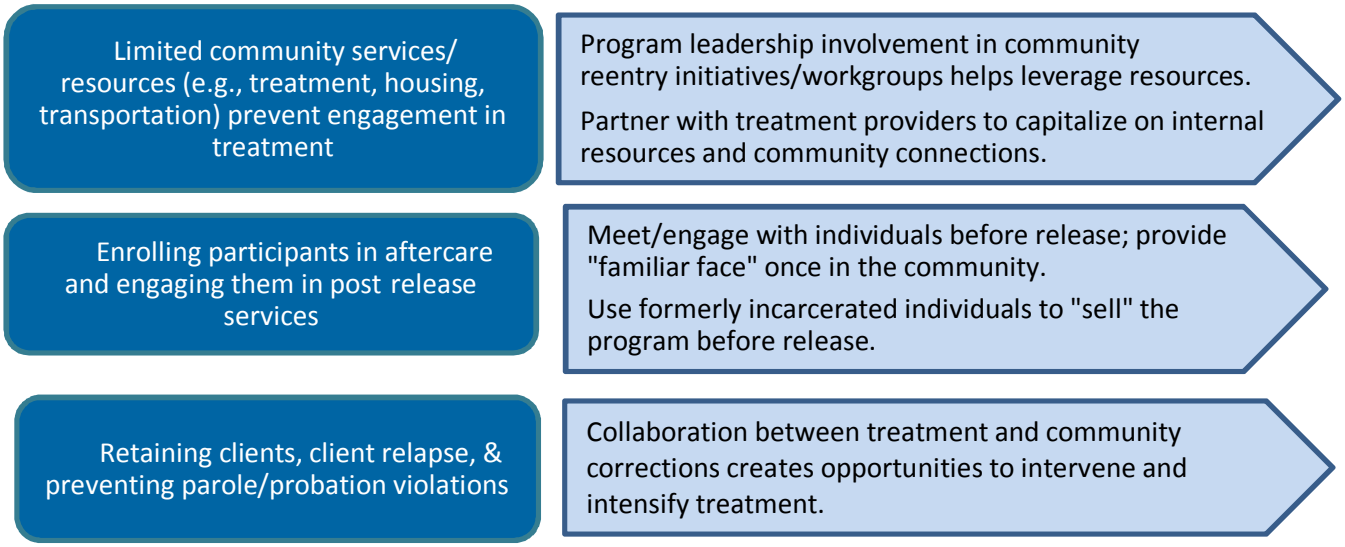
successfully complete RSAT (46%, n=11), and programs that connect anyone who was enrolled in RSAT, regardless of whether they completed the program (13%, n=3).

- The most common settings for post-release aftercare are community corrections centers (50%, n=12) and outpatient substance use disorder treatment providers (46%, n=11).

*All aftercare programs identified challenges to serving clients and many offered programmatic strategies they used to address these challenges.*

As presented in Exhibit 3, the major challenges reported by respondents include a general shortage of treatment and services to support individuals transitioning from correctional programming to the community, difficulty engaging individuals in the aftercare services once they are in the community, and the barriers to retaining clients in the program.

**Exhibit 3. Common Challenges and Strategies for Implementing Aftercare Programs**




The strategies used by RSAT-funded aftercare programs to facilitate program services include developing a wide range of community provider partnerships and active involvement in community reentry initiatives/workgroups, which help leverage resources and develop open communication around program participants. Respondents also reported that these relationships, in particular with community corrections, can mean the difference between violating an individual on probation because of a positive drug screen or using it as an opportunity to intensify treatment. Finally, pre-release engagement with staff who will work with them after release is important because individuals are more likely to show up for the first post-release appointment with someone they already know. Additionally, using individuals who have successfully completed the aftercare program to engage participants helps facilitate program buy-in.

## E. Conclusions

According to the study data, the RSAT program has partially met its mandate to provide aftercare services to program participants. A little more than half the RSAT subgrantee correctional-based treatment programs (53%, n=28) reported connections to aftercare treatment or services for RSAT participants. This finding was echoed by the state PoCs; only about half reported that their states require RSAT-funded programs to provide aftercare.

Only a small portion of the RSAT programs (18%, n=11) reported using RSAT funds for aftercare treatment and services. Although BJA removed the 10% limitation for aftercare in 2013, reductions in RSAT funding over the last decade may have made this change moot. As reflected by the state PoC survey, diminishing funding for RSAT over the past decade has been a significant challenge for states. Although respondents acknowledged that RSAT plays an important role in funding treatment services for incarcerated individuals, the resources do not go far enough to meet their treatment needs, much less allow states to take on new aftercare programming activities. This is further underscored by the necessity for programs to secure funds from other sources to support RSAT programming.

Most treatment programs reported providing a wide range of counseling and support services to RSAT participants, including at least one EBP. Service components common to most correctional treatment programs are in line with NIDA drug treatment principles for criminal justice populations, including screening/assessment, treatment planning, sanctions/incentives, and drug testing. Additionally, almost all programs reported providing transitional planning and case management support to RSAT participants prior to release.

Given the limited federal funding available for RSAT institutional or aftercare services, in addition to the limited state and local resources for treatment, the continued existence of RSAT programs in prisons, jails, and in communities represents a huge achievement. For programs to achieve their fullest potential, however, will require not only more resources but also consistent leadership and oversight on a statewide basis to ensure that correctional-based treatment and continuity of care in the community is not only a correctional priority but also a public health priority.

## References

Bahr, S. J., Masters, L., & Taylor, B. M. (2012). What works in substance abuse treatment programs for offenders? *The Prison Journal*, *92*(2), 155–174.

Bureau of Justice Assistance (BJA). (2005). *Residential Substance Abuse Treatment for State Prisoners (RSAT) Program: Program update*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. Retrieved from https://www.ncjrs.gov/pdffiles1/bja/206269.pdf

Butzin, C. A., Martin, S. S., & Inciardi, J. A. (2002). Evaluating component effects of a prison-based treatment continuum. *Journal of Substance Abuse Treatment*, *22*, 63–69.

Center for Substance Abuse Treatment (CSAT) (1998). *Continuity of offender treatment for substance use disorders from institution to community (TIP 30)*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Field, G. (1984). The cornerstone program: A client outcome study. *Federal Probation*, *48*, 50–55.

Field, G. (1989). A study of the effects of intensive treatment on reducing the criminal recidivism of addicted offenders. *Federal Probation*, *53*(10), 51–56.

Mitchell, O., Wilson, D., & MacKenzie, D. (2006). A systematic review of drug court effects on recidivism. *Journal of Experimental Criminology*, *2*, 459–487.

National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2010). *Behind bars II: Substance abuse and America's prison population*. Retrieved from http://www.casacolumbia.org/articlefiles/575-report2010behindbars2.pdf

National Institute on Drug Abuse (NIDA). (2014). *Principles of Drug Abuse Treatment for Criminal Justice Populations - A Research-Based Guide*. Retrieved from https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations-research-based-guide

Pew Center on the States. (2008, December). Putting public safety first: 13 strategies for successful supervision and reentry. *Public Safety Policy Brief, 7*.

Schiraldi, V., & Ziedenberg, J. (2003). *Costs and benefits? The impact of drug imprisonment in New Jersey*. Washington, DC: Justice Policy Institute.

Second Chance Act of 2007 § 42 U.S.C. 3796ff-1(c) (2008).

Wexler, H. K., Falkin, G. P., & Lipton, D. S. (1990). Outcome evaluation of prison therapeutic community for substance abusers. *Criminal Justice and Behavior*, *17*(1), 71–92.