



FFY 2015 REQUEST FOR PROPOSALS

Residential Substance Abuse Treatment Formula Grant Program (RSAT)

Funding Available: \$65,200

The Utah Commission on Criminal and Juvenile Justice (CCJJ) is requesting proposals from units of local government and federally-recognized Indian tribal governments in the State of Utah who will provide jail-based substance use disorder treatment services for incarcerated offenders in need.

The funding period for the FFY 2015 RSAT grants is anticipated to be October 1, 2015 through September 30, 2016. Awards will be made on the basis of a competitive application review process. Projects selected for funding will be active until funds are expended, with no guarantee of continuation in future years.

The application forms and instructions are available on the CCJJ website at:
<http://justice.utah.gov/grants.html>

Application Deadline:

Thursday, September 10, 2015 at 4:00 p.m.

at the

Utah Commission on Criminal and Juvenile Justice
Utah State Capitol Complex, Senate Office Building, Suite 330
P.O. Box 142330
Salt Lake City, Utah 84114-2330

No late applications, faxed applications, or e-mailed applications will be accepted.

CCJJ RSAT Contact:

Mary Lou Emerson at 801-538-1921 or memerson@utah.gov

FFY 2015

RSAT Grant Application Instructions

Introduction

These instructions provide program requirements and application guidelines for the **FFY 2015 Residential Substance Abuse Treatment Formula Grant Program (RSAT)** managed by the Utah Commission on Criminal and Juvenile Justice (CCJJ).

The goal of the RSAT Program is to break the cycle of drugs and violence by reducing the demand for, use, and trafficking of illegal drugs. RSAT enhances the capability of states and units of local and tribal governments to provide residential substance use disorder treatment for incarcerated inmates; prepares offenders for their reintegration into the communities from which they came by incorporating reentry planning activities into treatment programs; and assists offenders and their communities through the reentry process through the delivery of community-based treatment and other broad-based aftercare services. Treatment practices/services must be evidence-based. Evidence-based programs/practices are based on research findings and expert or consensus opinion about available evidence, and are expected to produce a specific clinical outcome (measurable change in client status). Examples of evidence-based interventions include cognitive behavioral therapy, motivational enhancement, and medication assisted treatment.

Funding Available

CCJJ has determined the FFY 2015 RSAT funds will be used to fund jail-based substance use disorder treatment programs only. CCJJ will award up to **\$65,200** in FFY 2015 RSAT funds for one or more **jail-based** RSAT program(s). It is anticipated the successful applicant(s) will begin their RSAT program(s) by October 1, 2015.

Program Contact

The CCJJ Program Contact for the RSAT Program is **Mary Lou Emerson**, 801-538-1921 or memerson@utah.gov.

Application Due Date: Thursday, September 10, 2015 at 4:00 p.m.

Program Requirements

RSAT funds may be used to implement jail-based substance use disorder treatment programs. Only programs that meet the following criteria will be eligible for funding:

Jail-Based Programs

- **Engage participants for at least 3 months.**
- **Focus on the inmate's substance use diagnosis and addiction related needs.**
- **Develop the inmate's cognitive, behavioral, social, vocational, and other skills to solve the substance use disorder and related problems.**
- **Require urinalysis or other proven reliable forms of testing, including both periodic and random testing: (1) of an individual before the individual enters the jail-based substance use disorder treatment program; (2) during the period in which the individual participates in the treatment program; and (3) of an individual released from a residential substance use disorder treatment program if the individual remains in custody.**
- **Program design must be based on effective, scientific practices (evidence-based).**
- **Jail-based programs should separate the treatment population from the general correctional population, if possible.**

Aftercare Programs

To be eligible for RSAT funds, a subgrantee shall ensure that individuals who participate in the substance use disorder treatment program established or implemented with RSAT funds will be provided with aftercare/recovery support services. Aftercare services must be paid for with a non-RSAT funding source, and must involve coordination between the correctional treatment program and other social service and rehabilitation programs, such as: case management services, education and job training, correctional supervision, housing, self-help, peer support, and other non-clinical services. To qualify as an aftercare program, the head of the substance use disorder treatment program must work in conjunction with state and local authorities and organizations involved in substance use disorder treatment to assist in the placement of program participants into community substance use disorder treatment programs/facilities and/or recovery support services upon release.

Match Requirement

A grant awarded under this program may not cover more than 75 percent of the total costs of the project being funded. The applicant must identify the source of the 25 percent non-federal portion of the budget and how match funds will be used. Applicants may satisfy this match requirement with **either cash or in-kind services**.

Quarterly Reporting Requirements

Applicants who are awarded RSAT funding will be required to submit quarterly Progress Reports and Financial Status Reports to the Utah Commission on Criminal and Juvenile Justice (CCJJ). The quarterly Progress Reports must provide information and data related to narrative and numerical performance measures developed by the federal Bureau of Justice Assistance (BJA). In addition, RSAT subgrantees will be required to develop objectives and “targets” in conjunction with the Governor’s SUCCESS initiative, and to submit quarterly data for these measures as well.

Federally Required Performance Measures

Applicants who receive RSAT funding must provide data that measures the results of their work. The federally required narrative and numerical performance measures developed by the Bureau of Justice Assistance (BJA) are as follows:¹

JAIL-BASED PROGRAMS		
PERFORMANCE MEASURES: NARRATIVE DATA		
Please provide a narrative response to the following questions:		
1. What were your accomplishments within this reporting period?		
2. What goals were accomplished, as they relate to your grant application?		
3. What problems/barriers did you encounter, if any, within the reporting period that prevented you from reaching your goals or milestones?		
4. Is there any assistance that CCJJ or the Bureau of Justice Assistance (BJA) can provide to address any problems/barriers identified in question #3? YES or NO. If YES, please explain.		
5. Are you on track to fiscally and programmatically complete your program as outlined in your grant application? (Please answer YES or NO. If NO, please explain.)		
6. What major activities are planned for the next 6 months?		
7. Based on your knowledge of the criminal justice field, are there any innovative programs/ accomplishments that you would like to share with CCJJ or the Bureau of Justice Assistance (BJA)?		
PERFORMANCE MEASURES: NUMERICAL DATA		Reporting Period (Fill in Dates)
AWARD ADMINISTRATION		
Is this the last time reporting to CCJJ before closing out this award? If “yes,” you must complete the Court and Criminal Involvement questions (Questions 29 and 30).		
	A.	Yes
	B.	No
GENERAL AWARD INFORMATION		
1.	Was there grant activity during the reporting period? Grant activity is defined as any proposed activity	

¹ These performance measures are subject to periodic change by the federal Bureau of Justice Assistance. The measures included here reflect the latest changes and are current as of September 2013.

	in the CCJJ-approved grant application that is implemented or executed with RSAT grant funds.	
	A.	Yes
	B.	No
	C.	If no, please explain
2.	Has the RSAT program admitted participants?	
	A.	Yes
	B.	No
ACTIVITY TYPE		
3.	What type of services do you provide to participants in your RSAT program? Select the services that best reflect the program design.	
	A.	Jail-based treatment services
	B.	Aftercare services
PROGRAM CHARACTERISTICS		
4.	Does your RSAT program use evidence-based treatment services? Evidence-based programs and practices are those demonstrated by the research literature to be effective at reducing substance use among court-involved individuals (e.g., see SAMHSA link at http://www.samhsa.gov/ebpwebguide/).	
	A.	Yes
	B.	No
	C.	If yes, please describe the evidence-based treatment services.
	Description:	
4a.	If yes, please enter the number of evidence-based treatment services provided by your program based on the following three crimesolutions.gov rating categories:	
	A.	Effective treatment services
	B.	Promising treatment services
	C.	No effect
5.	Please enter the number of treatment staff who work directly with participants in the RSAT program. When answering 'A', please count all treatment staff regardless of funding source. Staff would be all treatment employees, including but not limited to program managers, case managers, and clinicians. Do NOT count the number of mentors, volunteers or interns.	
	A.	Number of treatment staff
	B.	Of those reported in 'A', how many are paid for at least partially using RSAT program funds, including matching funds?
6.	Please enter the amount of funding from all sources (in dollars) spent in your RSAT program during the reporting period for the following areas:	
	Funds Spent During Reporting Period	RSAT Funds
	Non-RSAT Funds (All Other Sources)	
	A.	Personnel
	B.	Fringe benefits
	C.	Supplies
	D.	Equipment
	E.	Contract/Consultant fees
	F.	Construction
	G.	Indirect costs
	H.	Other
JAIL-BASED PROGRAMS		
7.	During the reporting period, using RSAT program funds including matching funds, did you pay for training for treatment staff to be cross trained in the jail-based portion of the RSAT program?	
	A.	Yes

	B.	No (go to Question 9)	
8.	Please enter the number of treatment staff members who were cross trained in the jail-based portion of the RSAT program. <i>This information should be based on the number of treatment staff who received training in the implementation of assessment instruments, motivational interviewing (MI) techniques, accountability training, or addiction-related trainings, as well as the number of treatment staff who received officer training and other security training sessions.</i>		
	A.	Number of treatment staff cross trained	
9.	During the reporting period, using RSAT program funds including matching funds, did you pay for training for custody staff to be cross trained in the jail-based portion of your RSAT program?		
	A.	Yes	
	B.	No (go to next section/question 11)	
10.	Please enter the number of custody staff members who were cross trained in the jail-based portion of the RSAT program. <i>This information should be based on the number of uniformed officers who received training in the implementation of assessment instruments, motivational interviewing (MI) techniques, accountability training, or addiction-related trainings, as well as the number of custody staff who received officer training and other security training sessions.</i>		
	A.	Number of custody staff cross trained	
Risk Assessment and Treatment Planning			
11.	Of those who entered the jail/prison-based portion of the RSAT program during the reporting period, please enter the number of jail/prison-based participants who were administered a risk and/or needs assessment. <i>A risk and needs assessment is an instrument to help identify factors that may lead a participant to reoffend. It pinpoints needed services to minimize those risks. Only include those individuals who have been admitted to the RSAT program.</i>		
	A.	Number of jail-based participants administered a risk and/or needs assessment	
12.	Please name the risk assessment instrument(s) that is used to assess risk/needs.		
	Instrument(s):		
13.	Of those who entered the jail-based portion of the RSAT program during the reporting period, please enter the number of such individuals who were identified as having high criminogenic risks and/or high substance abuse treatment needs.		
	A.	Number of jail/prison-based participants with high criminogenic risks and/or high substance abuse treatment needs	
14.	Of those who entered the jail-based portion of the RSAT program during the reporting period, please enter the number with an individualized substance abuse treatment plan. <i>The number entered should be equal to or less than the number of participants currently enrolled and should be based on an unduplicated count of participants with an individualized treatment plan. Participants with updated individualized treatment plans should be counted only once.</i>		
	A.	Number of jail-based participants with an individualized substance abuse treatment plan	
Number of Participants Receiving Services			
15.	Please enter the total number of jail-based participants enrolled in the RSAT program as of the last day of the reporting period.		
	A.	Total number of jail-based participants enrolled as of the last day of the reporting period	
16.	Please enter the number of NEW jail-based participants admitted during the reporting period.		
	A.	Number of NEW jail-based participants admitted	
Services Provided			
17.	Please enter the number of jail-based participants who were provided services during the reporting		

	period with RSAT program funds, including matching funds, through the following treatment components:	
	A.	Substance abuse and treatment services
	B.	Cognitive and behavioral services (<i>cognitive behavioral services include interventions that address criminal thinking and antisocial behavior</i>)
	C.	Employment services
	D.	Housing services
	E.	Mental health services
	F.	Other services
	G.	Please explain other services
	Explanation of other services:	
18.	Please enter the number of jail-based participants who were provided with transitional planning services with RSAT program funds, including matching funds , during the reporting period. <i>To provide transitional planning services, the RSAT program must work with clients to develop individualized post-release plans that address each client's needs in terms of housing, employment/financial support, and ongoing therapeutic needs. These include enrollment in Medicaid or subsidized insurance programs, where available. They also include prerelease engagement with the community correctional agency that will be providing post-release supervision of the client, where relevant. Note: Blanket referrals to community self-help programs do not constitute "transitional planning services."</i>	
	A.	Number of jail-based participants receiving transitional planning services
Program Completion		
19.	Please enter the number of participants who successfully completed all requirements of the jail-based portion of your RSAT program during the reporting period. <i>The number entered should represent only those participants who successfully completed all the requirements of the RSAT program during the reporting period.</i>	
	A.	Number of jail-based successful completers
20.	Of those jail-based participants who successfully completed all program requirements, please enter the number who were released to the community during the reporting period.	
	A.	Number of jail-based successful completers released to the community
	B.	Of those reported in 'A', how many individuals were released under correctional supervision?
	C.	Of the number of successful completers released to the community, how many individuals were referred to an aftercare program? <i>Aftercare programs are defined in 42 U.S.C. 3796ff-1(c)</i>
21.	Of those jail/prison-based program completers released to the community, please enter the number with a continuity of care arrangement or reentry or transitional plan . <i>The number should be based on the number of participants with active treatment plans that continue in the community and on participants who receive referrals for services after their release into the community.</i>	
	A.	Number of jail-based successful completers with confirmed continuity of care arrangements
22.	Please enter the number of individuals who did not complete the jail/prison-based portion of the RSAT program for the categories below. <i>Participants should not fit in more than one category, so please choose the option that best represents why these individuals did not complete the program.</i>	
	Jail/Prison-Based Incompletes	
		Measure
		Number
	A.	Number of participants no longer in the program due to termination for a new charge

	B.	Number of participants no longer in the program due to release or transfer to another correctional facility	
	C.	Number of participants no longer in the program due to death or serious illness	
	D.	Number of participants no longer in the program due to voluntary drop out	
	E.	Number of participants no longer in the program due to failure to meet program requirements	
	F.	Number of participants no longer in the program due to violation of institutional rules	
	G.	Number of participants who did not complete the program for other reasons (please specify below)	
Other reasons:			
23.	Of those jail-based participants who left the RSAT program successfully , please enter the number who completed the program during the following timeframes. <i>The sum of all of these categories should be equal to the number in question 19. If not, please check for data entry errors.</i>		
	A.	0 to 3 months	
	B.	4 to 6 months	
	C.	7 to 9 months	
	D.	10 months or more	
24.	Of those jail-based participants who left the RSAT program unsuccessfully or did not complete the program , please enter the number who left the program during the following timeframes. <i>The sum of all of these categories should be equal to the number in question 22. If not, please check for data entry errors.</i>		
	A.	0 to 3 months	
	B.	4 to 6 months	
	C.	7 to 9 months	
	D.	10 months or more	
Alcohol and Substance Involvement			
25.	Please enter the number of jail-based participants who were administered an alcohol/drug test (e.g., urinalysis test) before admission into your RSAT program. <i>As a requirement, grantees must agree to implement or continue to require urinalysis or other proven reliable forms of testing, including both periodic and random testing (1) of an individual before the individual enters an RSAT program and during the period in which the individual participates in the treatment program; and (2) of an individual released from an RSAT program if the individual remains in the custody of the state.</i>		
	A.	Number of jail-based participants tested before admission	
26.	Of those enrolled in the jail-based portion of the RSAT program, please enter the total number of participants tested for alcohol or illegal substances during the reporting period. <i>This should represent the total number of RSAT participants who were given alcohol/drug tests. The number entered should be an unduplicated count only of participants who were tested for alcohol or illegal substances, and it should be equal to or greater than the number of participants who tested positive. If not, please check for data entry error.</i>		
	A.	Total number of jail/prison-based participants tested for alcohol or illegal substances	
27.	Of those enrolled in the jail-based portion of the RSAT program, please enter the number of participants who tested positive for the presence of alcohol or illegal substances during the reporting period. <i>The number entered should be an unduplicated count only of participants who tested positive for alcohol or illegal substances, and it should be equal to or less than the total number of participants tested. If not, please check for data entry error. Alcohol and substance use information should be</i>		

	<i>based on documented tests rather than self-reported information from program participants. Include all participants who received services during the reporting period, regardless of whether they successfully completed the RSAT program, left without completing it, or are currently enrolled.</i>		
	A.	Number of jail-based participants who tested positive for alcohol or illegal substances	
28.	During the reporting period, please enter the number of participants who were administered an alcohol/drug test (e.g., urinalysis test) within 30 days after successfully completing your RSAT program and are still under supervision of the program.		
	A.	Number of jail-based participants tested after program completion	
	B.	Of that number, how many tested positive for alcohol or illegal substances after program completion?	
COURT AND CRIMINAL INVOLVEMENT: JAIL-BASED			
The next set of questions is about court and criminal involvement for offenders who have ever participated in your RSAT jail-based program. This section is to be completed at the close of the grant.			
29.	Since the start of the RSAT award , how many jail-based participants:		
	A.	Are still participating in the jail-based RSAT program?	
	B.	Have successfully completed the jail-based RSAT program and released into the community?	
	C.	Did not complete the jail-based RSAT program and released into the community?	
	D.	Were released into a mandated aftercare program? <i>Aftercare programs are defined in 42 U.S.C. 3796ff-1(c).</i>	
30.	Since the start of the RSAT award, enter the total number of jail-based participants released into the community who successfully completed and unsuccessfully exited and were reincarcerated:		
	Court and Criminal Involvement Since the Start of the RSAT Award for Individuals Who Received Aftercare Services		
		Measure	Reincarcerated based on a New Criminal Charge
		Reincarcerated based on a Revocation for a Technical Violation	
	A.	Participants released into the community (excluding mandated aftercare programs) who successfully completed the jail-based program	
	B.	Participants released into the community (excluding mandated aftercare programs) who participated but unsuccessfully exited the program	

SUCCESS Measurable Objectives and Targets²

SUCCESS Initiative RSAT Program Goal, Measurable Objectives and Targets						
						STATE OF UTAH Commission on Criminal and Juvenile Justice Utah State Capitol Complex Senate Office Building, Suite 330 Salt Lake City, Utah 84114-2330 www.justice.utah.gov
Grantee Agency						RSAT Grant #
Instructions: 1) In the white space below, please state the primary Goal of your RSAT program. 2) In the white space after each Measurable Objective , provide a quantitative performance measure that will track your progress in meeting your goal. You must provide a minimum of three (3) measurable objectives. You are welcome to expand this form if you want to provide more than three measurable objectives. 3) In the white space after FY 2016 Targets , indicate the numerical target you expect to achieve for each measurable objective at the end of each quarter and for the year. Be sure to set your quarterly and annual targets for each measurable objective at a level you can be reasonably certain to meet.						
RSAT Program Goal:						
Measurable Objective 1:						
FY 2015 Totals	Quarter	Oct - Dec 2015	Jan - Mar 2016	Apr - June 2016	Jul - Sept 2016	FY 2016 Total
	FY 2016 Targets					
	FY 2016 Actual					
Measurable Objective 2:						
FY 2015 Totals	Quarter	Oct - Dec 2015	Jan - Mar 2016	Apr - June 2016	Jul - Sept 2016	FY 2016 Total
	FY 2016 Targets					
	FY 2016 Actual					
Measurable Objective 3:						
FY 2015 Totals	Quarter	Oct - Dec 2015	Jan - Mar 2016	Apr - June 2016	Jul - Sept 2016	FY 2016 Total
	FY 2016 Targets					
	FY 2016 Actual					

² See Attachment 1 for an overview of the SUCCESS initiative.

Application Guidelines

1. The completed grant application, with original signatures and appendices, must be submitted to the Utah Commission on Criminal and Juvenile Justice, Utah State Capitol Complex, Senate Office Building, Suite 330, P.O. Box 142330, Salt Lake City, Utah, 84114-2330, Attention: Mary Lou Emerson. **The deadline for submitting applications is Thursday, September 10, 2015 at 4:00 p.m.** No late, faxed, or e-mailed applications will be accepted. No copies of the application are required, only the original application with original signatures and appendices.
2. The application may be single or double-spaced, using a standard 12-point font, with 1-inch margins. **The pages of the application must be numbered.** The application must include the following sections:
 - A. **Cover Sheet**

The **authorized official** who is to sign the cover sheet and the grant assurances/conditions/certifications is a county council or commission member, or tribal executive. The **program director** may be a Sheriff, agency director, tribal official, or their designee.
 - B. **Current Jail-Based Substance Use Disorder Treatment Services**

If you currently have substance use disorder treatment services available for inmates in your jail, please provide a detailed description of these services, including the following information if it is available: number of beds/slots in the program, number of clients, by gender, admitted to the program; number who have successfully completed the program; percentage that remained drug-free during the program; number of clients that remained drug-free and arrest-free following release from jail; and source of funding for the services/program.
 - C. **Program Design and Implementation**

Please provide detailed information for each of the following components of your RSAT program:

 1. Goals, Objectives and Performance Measures

List your program goals and corresponding objectives. Identify how you will gather data and measure program effectiveness. Subgrantees are required to submit quarterly Progress Reports (containing narrative and numerical performance measures data required by BJA) and Financial Status Reports within 25 days of the end of each quarter (on January 25, April 25, July 25, and October 25).

Since subgrantees will be required to establish a program goal, at least three objectives, and “targets” in conjunction with the Governor’s SUCCESS initiative, it is suggested the SUCCESS measures should be included in the goals, objectives and performance measures described in this section of the application.

2. RSAT Client Assessment and Selection
All RSAT participants shall undergo an assessment, including identification of risks and needs. Describe how you will assess a potential participant's substance use disorder and need for jail-based treatment services, including assessment methodology, forms, instruments, etc. Describe how you will identify and select participants who will most likely remain in jail for at least 90 days so they can complete the RSAT program.
3. RSAT Program Location
Describe where the RSAT program will be located in the jail, including how you will separate the treatment population from the general correctional population if possible.
4. RSAT Program Capacity
Identify the number of beds/slots available in your RSAT treatment program, the duration of the program, and the estimated number of participants who will be provided with RSAT-funded treatment services during the grant year. Indicate whether the RSAT program will serve men, women, or both (if both, indicate how many beds will be provided for each).
5. Treatment Program Services
Describe the evidence-based treatment services you will provide, including how you will incorporate the following evidence-based principles into your program:³
 - a. Treatment shall be multi-dimensional. In addition to addressing the substance use disorder of the participant, treatment shall develop the participant's cognitive, behavioral, social, vocational, and other skills to resolve the substance use disorder and related problems.
 - b. Treatment shall target factors that are associated with criminal behavior (e.g., criminogenic risk and need factors).⁴
 - c. Treatment shall be of sufficient dosage/duration to affect stable behavioral change. Dosage shall be based on the client's assessed criminogenic needs and clinical needs (e.g., on the client's risk level and response to services).

³ Applicants can find information on evidence-based treatment practices in the Substance Abuse and Mental Health Services Administration's (SAMHSA) *Guide to Evidence-Based Practices* available at www.samhsa.gov/ebpwebguide, as well as on the Office of Justice Programs' www.crimesolutions.gov website. In addition, the National Institute on Drug Abuse's *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* is included as Attachment 2.

⁴ See Attachment 3 for a description of criminogenic risk and need factors.

- d. Treatment must allow for flexibility to accommodate individual differences in each participant's response to treatment.
- e. Treatment shall include behavioral or cognitive-behavioral interventions that are documented in manuals and have been demonstrated to improve outcomes for persons with substance use disorders who are involved in the criminal justice system.
- f. Treatment providers shall be proficient at delivering the selected interventions and shall be supervised regularly to ensure continuous fidelity to the treatment models.
- g. Treatment providers shall be licensed or certified to deliver substance use disorder treatment and shall have substantial experience working with criminal justice populations.
- h. A balance of rewards and sanctions shall be developed and used to encourage pro-social behavior and treatment participation.
- i. Treatment for persons with co-occurring substance use and mental health disorders shall be conducted using an integrated treatment approach.
- j. All RSAT participants shall be assessed for the use of medication assisted treatment.
- k. Treatment providers shall develop strategies to screen for, prevent, and ensure treatment for serious, chronic medical conditions such as HIV/AIDS, hepatitis B and C, and tuberculosis.
- l. Aftercare/recovery support services shall be made available to all RSAT participants.
- m. RSAT participants' clinical records shall document progress in meeting treatment objectives.

6. Treatment and Jail Staff Training

Describe any training to be provided for treatment and/or jail staff regarding substance use disorder treatment in a correctional setting;

7. "Snapshot" of a Typical Day in Treatment

Provide a detailed "snapshot" of a typical day in your RSAT treatment program (e.g., activities, time devoted to each activity, who conducts the activity, whether an individual or group (size) activity, where the activity is conducted, etc.).

8. Program Failures

Describe how program failures will be identified and processed, including a description of what constitutes a program failure and specific examples.

9. Drug Testing Policy and Procedures

Describe the drug testing policy and procedures for your RSAT program, including testing of participants *prior to admission* to the RSAT program, *during participation* in the RSAT program, and *following completion* of the RSAT program (within 30 days) if the individual remains in custody. Explain any differences in the drug testing protocol for the general jail population.

10. Continuing Care/Recovery Support (Aftercare) Services

Describe your plan for providing continuing care/recovery support services for RSAT participants who have completed the jail-based treatment program, including coordination of the RSAT treatment program with other human service and rehabilitation programs such as educational and job training programs, probation/parole supervision programs, halfway house programs, access to safe and affordable housing, and participation in self-help and peer group programs that may aid in the rehabilitation of individuals in the substance use disorder treatment program. Describe how and with which State and/or local substance abuse agencies⁵ you will work to place program participants in appropriate community-based substance use disorder treatment programs when appropriate. Describe the aftercare services that will be provided, how you will ensure providers furnishing aftercare services are approved by the appropriate State or local agency, and are licensed, if necessary, to provide medical treatment or other health services. Please attach any written agreement(s) between your agency and the community substance use disorder treatment/recovery support agencies that will ensure and facilitate coordination and service delivery. Attach these agreements to your application as Appendix 2.

11. Staffing

Identify all staff members assigned to the RSAT Program. List their names, qualifications, job titles, and percent of time allocated to RSAT. Identify all staff members who are funded by RSAT grant funds, including matching funds.

12. Other Funding Sources

Please provide information regarding any other funding sources that will be utilized to supplement the RSAT funding to support your jail-

⁵ Applicants are strongly encouraged to work with the Local Substance Abuse Authority agency in their area to design and implement both treatment and continuing care/recovery support (aftercare) services. A list of local authority agencies and contact persons is included as Attachment 4.

based substance use disorder treatment program and/or aftercare services.

13. Medicaid/Health Insurance Enrollment

Explain how you will identify and enroll uninsured RSAT participants into Medicaid, or other health insurance through the Health Insurance Marketplace, as well as increase access to and use of primary healthcare and substance use/mental health disorder treatment for newly insured individuals in order to ensure continuity of care and improve recidivism outcomes for RSAT participants after they are released from jail.

14. Sustainability

Please describe how you will sustain your jail-based substance use disorder treatment program after RSAT funds are no longer available.

D. Budget Matrix and Budget Narrative

Please complete the Budget Matrix Form, followed by a Budget Narrative explaining how funding will be expended in each category. Provide detail on how funding amounts were determined and how they are essential to and will benefit the grant program.

Match Requirement: Federal RSAT funds awarded under this program may not cover more than 75 percent of the total costs of the project being funded. The applicant must identify the source of the 25 percent non-federal portion of the budget and how match funds will be used. Applicants may satisfy this match requirement with either cash or in-kind services. Match funds are subject to the same requirements and restrictions as the federal RSAT funds, and must be expended within the grant award period. The formula for calculating the match amount is:

$$\frac{\text{Federal Award Amount}}{\text{Federal Share Percentage}} = \text{Adjusted (Total) Project Cost}$$

$$\text{Required Recipients Share Percentage} \times \text{Adjusted Project Cost} = \text{Required Match}$$

Example: For a federal award amount of \$350,000, match would be calculated as follows:

$$\frac{\$350,000}{75 \text{ percent (0.75)}} = \$466,667 \text{ (Total Project Cost)}$$

$$25 \text{ percent (0.25)} \times \$466,667 = \$116,667 \text{ match}$$

Consultants/Contracts: Persons with specialized skills who are not on the payroll are considered consultants. **When a consultant is known, a resumé listing the consultant’s qualifications and contract must**

accompany the application. However, if the position is vacant and the project receives funding, this information must be forwarded to CCJJ when a contract with the consultant is signed. All procurement transactions, whether negotiated or competitively bid without regard to dollar value, shall be conducted in a manner so as to provide maximum open and free competition. Describe the procedure to be used in acquiring the consultant (i.e., small purchase procedures, competitively sealed bids, non-competitive negotiation, etc.) **Fee justification must be provided in the budget narrative.**

Supplies/Operating: Supplies include general office supplies, cleaning, maintenance costs, training materials, books and subscriptions, research forms, postage stamps, operating expenses, and other expendable materials for the life of the project. All supply purchases covered by this grant must be necessary for the project to achieve its goals and objectives. All procurement transactions, whether negotiated or competitively bid and without regard to dollar value, shall be conducted in a manner so as to provide a maximum open and free competition. Purchases between \$1,000 and \$5,000: Quotes should be obtained (by phone, fax or letter) from at least two vendors. Awards must be made to the vendor submitting the lowest quote meeting the minimum specifications and required delivery date. Purchases exceeding \$5,000: A competitive sealed bid process must be conducted. Sole source contracts must be approved by CCJJ prior to being awarded.

Travel/Training: Grant related travel charges must not exceed the rates allowed by the State of Utah. Organizations whose written travel policies are less restrictive than the State of Utah, or that do not have their own written travel policy, must adhere to the State of Utah travel policy. "Per Diem" includes meals and lodging. Meals provided gratis must be deducted from the per diem rate allowed.

Equipment: Equipment is tangible, nonexpendable personal property having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit. A recipient/subrecipient may use its own definition of equipment provided that such definition would at least include all equipment defined above. All procurement transactions, whether negotiated or competitively bid and without regard to dollar value, shall be conducted in a manner so as to provide a maximum open and free competition. A competitive sealed bid process must be conducted. Sole source contracts must be approved by CCJJ prior to being awarded.

Indirect Costs: The new Federal Uniform Guideline allows for Indirect Costs to be charged by grantees as part of the grant budget. According to the Guideline, one of the following options must be chosen by grantees:

Option One: If a subgrantee has a negotiated Modified Total Direct Cost (MTDC)* rate with the Federal Government, then this Indirect Cost Rate must be applied to the grant application as part of the proposal request. Proof of the negotiated rate must be submitted with the grant application.

Option Two: If a subgrantee does not have a negotiated Modified Total Direct Cost rate with the Federal Government, or if the negotiated rate has lapsed, the Guideline allows the subgrantee to request a minimum MTDC rate of 10%. **Note:** Once this option has been chosen, it must be chosen again on all future grant applications until a subgrantee negotiates a rate with the Federal Government.

Option Three: If a subgrantee's operational costs are fully covered by charging these costs as administrative (direct) costs, or if the subgrantee calculates indirect costs and determines that these costs are immaterial, then the subgrantee may waive any indirect cost reimbursements.

It should be noted that choosing any one of the three options above will neither detract from nor enhance the consideration of the grant proposal.

*Modified Total Direct Costs (MTDC) are defined as all direct salaries and wages, applicable fringe benefits, materials and supplies, services, travel, and up to the first \$25,000 of each subaward (regardless of the period of performance of the subawards under the award). MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs and the portion of each subaward in excess of \$25,000. Other items may only be excluded when necessary to avoid serious inequity in the distribution of indirect costs, and with the approval of the cognizant agency for indirect costs.

A governmental department or agency unit that receives more than \$35 million in direct federal funding must submit its indirect cost rate proposal to its cognizant agency for indirect costs. Other governmental departments or agencies must develop an indirect cost proposal in accordance with the requirements of this Uniform Guide and maintain the proposal and related supporting documentation for audit. These governmental departments or agencies are not required to submit their proposals unless they are specifically requested to do so by the cognizant agency for indirect costs. Where a non-federal entity only receives funds as a subrecipient, the pass-through entity will be responsible for negotiating and/or monitoring the subrecipient's indirect costs.

Supplanting: Federal RSAT funds may be used to implement new programs or expand existing programs, but cannot replace or supplant non-federal funds that have been appropriated for the same purpose. A grant recipient may not use federal funds to pay for programs the recipient is already obligated to pay for or has funded.

Prohibited Uses: RSAT funds shall not be used for land acquisition or construction projects.

Suspension or Termination of Funding: The Utah Commission on Criminal and Juvenile Justice may suspend funding, in whole or in part, terminate funding, or impose other sanctions on a subgrantee for any of the following reasons:

- Failure to substantially comply with the requirements or statutory objectives of 42 U.S.C. §3796 ff -- Residential Substance Abuse Treatment for State Prisoners, program guidelines issued thereunder, or other provisions of Federal law;
- Failure to make satisfactory progress toward the goals or strategies set forth in its application;
- Failure to adhere to grant agreement requirements or special conditions;
- Failure to require urinalysis and/or other forms of alcohol and drug testing of individuals assigned to the residential treatment program;
- Proposing or implementing substantial program changes to the extent that, if originally submitted, the application would not have been funded;
- Failure to submit financial or programmatic reports;
- Filing a false certification in this application or other report or document; and/or
- Other good cause shown.

Prior to the imposition of sanctions, the Commission on Criminal and Juvenile Justice will provide reasonable notice to the grantee of its intent to impose sanctions and will attempt to resolve the problem informally.

E. Grant Assurances, Conditions, Certifications and Requirements
Each applicant must read and sign the Grant Assurances, Conditions, Certifications and Requirements and attach them to their application as Appendix 1.

F. Appendices
Please include the following appendices with your grant application:

Appendix 1 Grant Assurances, Conditions, Certifications and Requirements

Appendix 2 Written Agreements for Coordination with State and/or Local Substance Use Disorder Treatment Programs (if any)

Attachment 1

SUCCESS Initiative

Operational Excellence: Achieving *SUCCESS*

by Steve Cuthbert, Operational Management Executive

What is the goal of Utah state government? Answers to this very basic question can vary widely according to individual perspectives.

Customers are likely to say the goal is to provide quality services. Taxpayers may indicate the goal centers on value for every dollar invested. Lastly, as state employees, we know quality services and value are more likely to be realized when there is an innovative and favorable work environment.

Of course, we know the real answer lies in all three areas. The newly organized Governor's Office of Management and Budget (GOMB) has defined the goal as "delivering continuously improving services at lower costs". It is with this goal in mind that Governor Herbert set an ambitious target to improve state government operations and services by 25 percent over the next four years.

In a recent address to his cabinet, Governor Herbert stated "achieving this target will require a comprehensive approach to operational excellence. From setting clear goals and targets, to systems thinking and root cause analysis, to project management practices—we intend to develop and maintain the nation's gold standard for government." He was also very clear in stating that the 25 percent target is not an exercise in reducing budgets, rather the focus is on improving all aspects of operational performance.

In support of this target, GOMB has developed a comprehensive set of operational excellence tools and principles—called the SUCCESS framework. The SUCCESS framework is grounded in seven fundamentals of high performing organizations. When implemented as a whole, the seven fundamentals can transform organizations into an integrated system with shared goals and the ability to achieve them.

The seven fundamentals are:

- **S**et measurable goals and targets
- **U**se thinking tools
- **C**reate your strategy
- **C**reate your organization
- **E**ngage staff at all levels
- **S**ynchronize policy and projects
- **S**tay focused



Each cabinet agency is currently applying these fundamentals in an effort to work towards Governor Herbert's 25 percent target. Going forward, GOMB will make the SUCCESS training material and tools accessible via the Internet to all state employees for use in improvement efforts.

In addition, GOMB has developed a performance measurement system to track overall progress and recognize results—results that can be used for making better budget decisions. Ultimately, the SUCCESS initiative will keep Utah on top as the best managed state in the nation, continually delivering value to the public as well as each taxpayer dollar.

Look for SUCCESS initiative updates in future editions of the newsletter. [WE](#)

Attachment 2

**NIDA Principles of Drug Abuse Treatment for Criminal Justice Populations:
A Research-Based Guide**

National Institute on Drug Abuse

Principles of Drug Abuse Treatment for Criminal Justice Populations | A Research-Based Guide

NIDA
NATIONAL INSTITUTE
ON DRUG ABUSE



NIH Publication No. 11-5316
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National Institutes of Health
U.S. Department of Health
and Human Services

PRINCIPLES OF DRUG ABUSE TREATMENT FOR CRIMINAL JUSTICE POPULATIONS



1. Drug addiction is a brain disease that affects behavior. Drug addiction has well-recognized cognitive, behavioral, and physiological characteristics that contribute to continued use of drugs despite the harmful consequences. Scientists have also found that chronic drug abuse alters the brain's anatomy and chemistry and that these changes can last for months or years after the individual has stopped using drugs. This transformation may help explain why addicted persons are at a high risk of relapse to drug abuse even after long periods of abstinence and why they persist in seeking drugs despite the consequences.

2. Recovery from drug addiction requires effective treatment, followed by management of the problem over time. Drug addiction is a serious problem that can be treated and managed throughout its course. Effective drug abuse 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. Outcomes for drug abusing offenders in the community can be improved by monitoring drug use and by encouraging continued participation in treatment.

3. Treatment must last long enough to produce stable behavioral changes. In treatment, the drug abuser is taught to break old patterns of thinking and behaving and to learn new skills for avoiding drug use and criminal behavior. Individuals with severe drug problems and co-occurring disorders typically need longer treatment (e.g., a minimum of 3 months) and more

PRINCIPLES

comprehensive services. Early in treatment, the drug abuser begins a therapeutic process of change. In later stages, he or she addresses other problems related to drug abuse and learns how to manage them as well.

4. Assessment is the first step in treatment.

A history of drug or alcohol use may suggest the need to conduct a comprehensive assessment to determine the nature and extent of an individual's drug problems, establish whether problems exist in other areas that may affect recovery, and enable the formulation of an appropriate treatment plan. Personality disorders and other mental health problems are prevalent in offender populations; therefore, comprehensive assessments should include mental health evaluations with treatment planning for these problems.

5. Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.

Individuals differ in terms of age, gender, ethnicity and culture, problem severity, recovery stage, and level of supervision needed. Individuals also respond differently to different treatment approaches and treatment providers. In general, drug treatment should address issues of motivation, problemsolving, and skill-building for resisting drug use and criminal behavior. Lessons aimed at supplanting drug use and criminal activities with constructive activities and at understanding the consequences of one's behavior are also important to include. Tailored treatment interventions can facilitate the development of healthy interpersonal relationships and improve the participant's ability to interact with family, peers, and others in the community.

6. Drug use during treatment should be carefully monitored.

Individuals trying to recover from drug addiction may experience a relapse, or return to drug use. Triggers for drug relapse are varied; common ones include mental stress and associations with peers and social situations linked to drug use. An undetected relapse

can progress to serious drug abuse, but detected use can present opportunities for therapeutic intervention. Monitoring drug 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—determining rewards and sanctions to facilitate change, and modifying treatment plans according to progress.

7. Treatment should target factors that are associated with criminal behavior.

“Criminal thinking” is 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 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. This pattern of thinking often contributes to drug use and criminal behavior. Treatment that provides specific cognitive skills training to help individuals recognize errors in judgment that lead to drug abuse and criminal behavior may improve outcomes.

8. Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.

The coordination of drug abuse treatment with correctional planning can encourage participation in drug abuse treatment and can help treatment providers incorporate correctional requirements as treatment goals. Treatment providers should collaborate with criminal justice staff to evaluate each individual's treatment plan and ensure that it meets correctional supervision requirements, as well as that person's changing needs, which may include housing and child care; medical, psychiatric, and social support services; and vocational and employment assistance. For offenders with drug abuse problems, planning should incorporate the transition to community-based treatment and links to appropriate post-release services to improve the success of drug treatment and re-entry. Abstinence requirements

PRINCIPLES

may necessitate a rapid clinical response, such as more counseling, targeted intervention, or increased medication, to prevent relapse. Ongoing coordination between treatment providers and courts or parole and probation officers is important in addressing the complex needs of these re-entering individuals.

9. Continuity of care is essential for drug abusers re-entering the community. Offenders who complete prison-based treatment and continue with treatment in the community have the best outcomes. Continuing drug abuse treatment helps the recently released offender deal with problems that become relevant after release, 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, resulting in reduced drug use and criminal behavior post-incarceration. Continuing drug treatment in the community is essential to sustaining these gains.

10. A balance of rewards and sanctions encourages pro-social behavior and treatment participation. When providing correctional supervision of individuals participating in drug abuse treatment, it is important to reinforce positive behavior. Nonmonetary “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 from 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.

11. Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach. High rates of mental health problems are found both in offender populations and in those with substance abuse problems. Drug abuse treatment can sometimes

address depression, anxiety, and other mental health problems. Personality, cognitive, and other serious mental disorders can be difficult to treat and may disrupt drug treatment. The presence of co-occurring disorders may require an integrated approach that combines drug abuse treatment with psychiatric treatment, including the use of medication. Individuals with either a substance abuse or mental health problem should be assessed for the presence of the other.

12. Medications are an important part of treatment for many drug abusing offenders.

Medicines such as methadone, buprenorphine, and extended-release naltrexone have been shown to reduce heroin use and should be made available to individuals who could benefit from them. Effective use of medications can also be instrumental in enabling people with co-occurring mental health problems to function successfully in society. Behavioral strategies can increase adherence to medication regimens.

13. Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.

The rates of infectious diseases, such as hepatitis, tuberculosis, and HIV/AIDS, are higher in drug abusers, incarcerated offenders, and offenders under community supervision than in the general population. Infectious diseases affect not just the offender, but also the criminal justice system and the wider community. Consistent with Federal and State laws, drug-involved offenders should be offered testing for infectious diseases and receive counseling on their health status and on ways to modify risk behaviors. Probation and parole officers who monitor offenders with serious medical conditions should link them with appropriate health care services, encourage compliance with medical treatment, and re-establish their eligibility for public health services (e.g., Medicaid, county health departments) before release from prison or jail.

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PREFACE



From the time it was established in 1974, the National Institute on Drug Abuse (NIDA) has supported research on drug abuse treatment for people involved with the criminal justice system.

Findings show unequivocally that providing comprehensive drug abuse treatment to criminal offenders works, reducing both drug abuse and criminal recidivism. The substantial prison population in the United States is attributable in large part to drug-related offenses and is accompanied by high rates of recidivism. As such, it is a matter of public health and safety to make drug abuse treatment a key component of the criminal justice system. Indeed, addressing the treatment needs of substance abusing offenders is critical to reducing overall crime and other drug-related societal burdens, such as lost job productivity and family disintegration.

Scientific research shows that drug abuse treatment can work even when an individual enters it under legal mandate. However, only a small percentage of those who need treatment actually

PREFACE

receive it, and often the treatment provided is inadequate. To be effective, treatment must begin in prison and be sustained after release through participation in community treatment programs. By engaging in a continuing therapeutic process, individuals can learn how to avoid relapse and withdraw from a life of crime.

As reflected in our collaborative Criminal Justice–Drug Abuse Treatment Studies (CJ–DATS) Initiative, NIDA is committed to working across organizational boundaries to improve substance abuse treatment services. Multiple studies from different scientific disciplines have helped us understand the basic neurobiology of addiction, along with what constitutes effective treatment. Now we are at the point where the *implementation* of evidence-based treatment principles is called for within the criminal justice system to improve public health and public safety by reducing both drug use and crime.

This booklet—a complement to NIDA’s *Principles of Drug Addiction Treatment: A Research-Based Guide*—is intended to describe the treatment principles and research findings that have particular relevance to the criminal justice community and to treatment professionals working with drug abusing offenders. It is divided into three main sections: (1) research findings on addicted offenders distilled into 13 essential principles (see pages 1–5), (2) a series of frequently asked questions (FAQs) about drug abuse treatment for those involved with the criminal justice system, and (3) a resource section that provides Web sites for additional information. This booklet and other resources on drug abuse and the criminal justice system are available on NIDA’s Web site at <http://www.drugabuse.gov/drugpages/cj.html>.

With the release of this landmark publication’s revised edition, we are optimistic that correctional agencies have begun to understand how drug treatment programs are helping achieve public health and safety goals for the Nation.

Nora D. Volkow, M.D.
Director
National Institute on Drug Abuse

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INTRODUCTION



The connection between drug abuse and crime is well known.

Drug abuse is implicated in at least three types of drug-related offenses: (1) offenses defined by drug possession or sales, (2) offenses directly related to drug abuse (e.g., stealing to get money for drugs), and (3) offenses related to a lifestyle that predisposes the drug abuser to engage in illegal activity, for example, through association with other offenders or with illicit markets. Individuals who use illicit drugs are more likely to commit crimes, and it is common for many offenses, including violent crimes, to be committed by individuals who had used drugs or alcohol prior to committing the crime, or who were using at the time of the offense.

According to 2008 statistics from the Department of Justice's (DOJ's) Bureau of Justice Statistics (BJS), the total correctional population is estimated to be 7.3 million, with more than 5 million individuals on probation or under parole supervision, and drug law violations accounting for the most common type of criminal offense (Glaze and Bonczar 2009). In a survey of State and Federal prisoners, BJS estimated that about half of the prisoners met *Diagnostic and Statistical Manual for Mental Disorders* (DSM) criteria for drug abuse or dependence, and yet fewer than 20 percent who needed treatment received it (Chandler et al. 2009; Mumola and Karberg 2006). Of those surveyed, 14.8 percent of State and 17.4 percent of Federal prisoners reported having received drug treatment since admission (Mumola and Karberg 2006).

Juvenile justice systems also report high levels of drug abuse.

In 2008, approximately 10 percent of the estimated 2.1 million juvenile arrests were for drug abuse or underage drinking violations (Puzzanchera 2009). As many as two-thirds of detained juveniles may have a substance use disorder (SUD); female juveniles who enter the system generally have higher SUD rates than males (McClelland et al. 2004a).

Although the past several decades have witnessed an increased interest in providing substance abuse treatment services for criminal justice offenders, only a small percentage of offenders has access to adequate services, especially in jails and community correctional facilities (Taxman et al. 2007; Sabol et al. 2010). Not only is there a gap in the availability of these services for offenders, but often there are few choices in the types of services provided. Treatment that is of insufficient quality and intensity or that is not well suited to the needs of offenders may not yield meaningful reductions in drug use and recidivism. Untreated substance abusing offenders are more likely than treated offenders to relapse to drug abuse and return to criminal behavior. This can lead to re-arrest and re-incarceration, jeopardizing public health and public safety and taxing criminal justice system resources. Treatment is the most effective course for interrupting the drug abuse/criminal justice cycle for offenders with drug abuse problems.

Drug abuse treatment can be incorporated into criminal justice settings in a variety of ways. Examples include treatment in prison followed by community-based treatment after release; drug courts that blend judicial monitoring and sanctions with treatment by imposing treatment as a condition of probation; and treatment under parole or probation supervision. Drug abuse treatment can benefit from the cross-agency coordination and collaboration of criminal justice professionals, substance abuse treatment providers, and other social service agencies. By working together, the criminal justice and treatment systems can optimize resources to benefit the health, safety, and well-being of the individuals and communities they serve.

Treatment offers the best alternative for interrupting the drug abuse/criminal justice cycle.

FREQUENTLY ASKED QUESTIONS (FAQS)



1. Why do people involved in the criminal justice system continue abusing drugs?

The answer to this perplexing question spans basic neurobiological, psychological, social, and environmental factors. The repeated use of addictive drugs eventually changes how the brain functions. Resulting brain changes, which accompany the transition from voluntary to compulsive drug use, affect the brain's natural inhibition and reward centers, causing

the addicted person to use drugs in spite of the adverse health, social, and legal consequences (Baler and Volkow 2006; Volkow et al. 2010; and Chandler et al. 2009). Craving for drugs may be triggered by contact with the people, places, and things associated with prior drug use, as well as by stress. Forced

abstinence (when it occurs) is not treatment, and it does not cure addiction. Abstinent individuals must still learn how to avoid relapse, including those who may have been abstinent for a long period of time while incarcerated.

Addictive drugs cause long-lasting changes in the brain



Normal



Cocaine Abuser
(10 days of
abstinence)



Cocaine Abuser
(100 days of
abstinence)

Source: Volkow et al., 1992, 1993.

PET scans showing glucose metabolism in healthy (normal) and cocaine-addicted brains. Even after 100 days of abstinence, glucose metabolism has not returned to normal levels.

FREQUENTLY ASKED QUESTIONS

Potential risk factors for released offenders include pressures from peers and family members to return to drug use and a criminal lifestyle. Tensions of daily life—violent associates, few opportunities for legitimate employment, lack of safe housing, and even the need to comply with correctional supervision conditions—can also create stressful situations that can precipitate a relapse to drug use.

Research on how the brain is affected by drug abuse promises to teach us much more about the mechanics of drug-induced brain changes and their relationship to addiction. Research also reveals that with effective drug abuse treatment, individuals can overcome persistent drug effects and lead healthy, productive lives.

2. Why should drug abuse treatment be provided to offenders?

The case for treating drug abusing offenders is compelling. Drug abuse treatment improves outcomes for drug abusing offenders and has beneficial effects for public health and safety. Effective treatment decreases future drug use and drug-related criminal behavior, can improve the individual's relationships with his or her family, and may improve prospects for employment. In addition, it can save lives: A retrospective study of more than 30,000 Washington State inmates found that during the first 2 weeks after release, the risk of death among former inmates was more than 12 times that among other residents, with drug overdose being the leading cause (Binswanger et al. 2007).

Outcomes for substance abusing individuals can be improved when criminal justice personnel work in tandem with treatment providers on drug abuse treatment needs and supervision requirements. Treatment needs that can be assessed after arrest include substance abuse severity, mental health problems, and physical health. Defense attorneys, prosecutors, and judges need to work together during the prosecution and sentencing phases of the criminal justice process to determine suitable treatment programs that meet the offender's needs. Through drug courts, diversion programs, pretrial release programs that are conditional on treatment, and conditional probation with sanctions, the offender can participate in community-based drug abuse treatment while under criminal justice supervision. In some

instances, the judge may recommend that the offender participate in treatment while serving jail or prison time or require it as part of continuing correctional supervision post-release.

3. How effective is drug abuse treatment for criminal justice-involved individuals?

Treatment is an effective intervention for drug abusers, including those who are involved with the criminal justice system. However, the effectiveness of drug treatment depends on both the individual and the program, and on whether interventions and treatment services are available and appropriate for the individual's needs. To alter attitudes, beliefs, and behaviors that support drug use, the drug abuser must engage in a therapeutic change process, which may include medications to help prevent relapse. Longitudinal outcome studies find that those who participate in community-based drug abuse treatment programs commit fewer crimes than those who do not participate (Prendergast et al. 2002; Butzin et al. 2006; and Kinlock et al. 2009).

Outcomes can be improved when criminal justice personnel work in tandem with treatment providers.

4. Are all drug abusers in the criminal justice system good candidates for treatment?

A history of drug use does not in itself indicate the need for drug abuse treatment. Offenders who meet drug dependence criteria should be given higher priority for treatment than those who do not. Less intensive interventions, such as drug abuse education or self-help group participation, may be appropriate for those not meeting criteria for drug dependence. Services such as family-based interventions for juveniles, psychiatric treatment, or cognitive-behavioral interventions for changing "criminal thinking" may be a higher priority for some offenders, and individuals with mental health problems may require specialized services (see FAQ Nos. 6 and 12).

FREQUENTLY ASKED QUESTIONS

Low motivation to participate in treatment or to end drug abuse should not preclude access to treatment if other criteria are met. Motivational enhancement interventions may be useful in these cases. Examples include motivational interviewing and contingency management techniques, which often provide tangible rewards in exchange for meeting program goals. Legal pressure that encourages abstinence and treatment participation may also help these individuals by improving retention and prompting longer treatment stays.

Drug abuse treatment is also effective for offenders who have a history of serious and violent crime, particularly if they receive intensive, targeted services. The economic benefits in avoided crime costs and those of crime victims (e.g., medical costs, lost earnings, and loss in quality of life) may be substantial for these high-risk offenders. Treating them requires a high degree of coordination between drug abuse treatment providers and criminal justice personnel to ensure that the prisoners receive needed treatment and other services that will help prevent criminal recidivism.

5. Is legally mandated treatment effective?

Often, the criminal justice system can apply legal pressure to encourage offenders to participate in drug abuse treatment; or treatment can be mandated through a drug court or as a condition of pretrial release, probation, or parole. A large percentage of those admitted to drug abuse treatment cite legal pressure as an important reason for seeking treatment. Most studies suggest that outcomes for those who are legally pressured to enter treatment are as good as or better than outcomes for those who entered treatment without legal pressure. Individuals under legal pressure also tend to have higher attendance rates and remain in treatment for longer periods, which can also have a positive impact on treatment outcomes.

Legal pressure can increase treatment attendance and improve retention.

6. Are relapse risk factors different in offender populations? How should drug abuse treatment deal with these risk factors?

Often, drug abusing offenders have problems in other areas. Examples include family difficulties, limited social skills, educational and employment problems, mental health disorders, infectious diseases, and other medical issues. Treatment should take these problems into account, because they can increase the risk of drug relapse and criminal recidivism if left unaddressed.

Stress is often a contributing factor to relapse, and offenders who are re-entering society face many challenges and stressors, including reuniting with family members, securing housing, and complying with criminal justice supervision requirements. Even the many daily decisions that most people face can be stressful for those recently released from a highly controlled prison environment.

Other threats to recovery include a loss of support from family or friends, which incarcerated people may experience. Drug abusers returning to the community may also encounter people from their lives who are still involved in drugs or crime and be enticed to resume a criminal and drug using lifestyle. Returning to environments or activities associated with prior drug use may trigger strong cravings and cause a relapse. A coordinated approach by treatment and criminal justice staff provides the best way to detect and intervene with these and other threats to recovery. In any case, treatment is needed to provide the skills necessary to avoid or cope with situations that could lead to relapse.

Treatment staff should identify the offender's unique relapse risk factors and periodically re-assess and modify the treatment plan as needed. Generally, continuing or re-emerging drug use during treatment requires a clinical response—either increasing the amount or level of treatment, or changing the treatment intervention.

Returning to environments associated with drug use may trigger cravings and cause a relapse.

FREQUENTLY ASKED QUESTIONS

7. What treatment and other health services should be provided to drug abusers involved with the criminal justice system?

One of the goals of treatment planning is to match evidence-based interventions to individual needs at each stage of drug treatment. Over time, various combinations of treatment services may be required. Evidence-based interventions include cognitive-behavioral therapy to help participants learn positive social and coping skills, contingency management approaches to reinforce positive behavioral change, and motivational enhancement to increase treatment engagement and retention. In those addicted to opioid drugs, agonist/partial agonist medications can also help normalize brain function, and antagonist medications can facilitate abstinence. For juvenile offenders, treatments that involve the family and other aspects of the drug abuser's environment have established efficacy.

Drug abuse treatment plans for incarcerated offenders can facilitate successful re-entry into the community by incorporating relevant transition plans and services. Drug abusers often have mental and physical health, family counseling, parenting, educational, and vocational needs, so medical, psychological, and social services are often crucial components of successful treatment. Case management approaches can be used to provide assistance in obtaining and integrating drug abuse treatment with community services.

8. How long should drug abuse treatment last for individuals involved in the criminal justice system?

While individuals progress through drug abuse treatment at different rates, one of the most reliable findings in treatment research is that lasting reductions in criminal activity and drug abuse are related to length of treatment. Generally, better outcomes are associated with treatment that lasts longer than 90 days, with treatment completers achieving the greatest reductions in drug abuse and criminal behavior. Again, legal pressure can improve retention rates.

A longer continuum of treatment may be indicated for individuals with severe or multiple problems. Research has shown that treatment provided in prison and continued in the community after release can reduce the risk of recidivism to criminal behavior as well as relapse to drug use.

Early phases of treatment help the participant stop using drugs and begin a therapeutic process of change. Later stages address other problems related to drug abuse and, importantly, help the individual learn how to self-manage the drug problem.

Because addiction is a chronic disease, drug relapse and return to treatment are common features of recovery. Thus, treatment may need to extend over a long period across multiple episodes of care.

9. How can rewards and sanctions be used effectively with drug-involved offenders in treatment?

The systematic application of behavioral management principles underlying reward and punishment can help individuals reduce their drug use and criminal behavior. Rewards and sanctions are most likely to change behavior when they are certain to follow the targeted behavior, when they follow swiftly, and when they are perceived as fair. It is important to recognize and reinforce progress toward responsible, abstinent behavior. Rewarding positive behavior is more effective in producing long-term positive change than punishing negative behavior. Indeed, punishment alone is an ineffective public health and safety intervention for offenders whose crime is directly related to drug use (Leukefeld et al. 2002). Nonmonetary rewards such as social recognition can be as effective as monetary ones. A graduated range of rewards given for meeting predetermined goals can be an effective strategy.

Contingency management strategies, proven effective in community settings, use voucher-based incentives or rewards, such as bus tokens, to reinforce abstinence (measured by negative drug tests) or to shape progress toward other treatment goals, such as program session attendance or compliance with medication regimens. Contingency management is most effective when the contingent reward closely follows the behavior being monitored. An intervention

FREQUENTLY ASKED QUESTIONS

tested by CJ-DATS researchers, called “Step’n Out,” used a contingency management approach whereby criminal justice staff monitored specific behaviors (e.g., abstinence, employment searches, and counseling attendance) and rewarded individuals who met agreed-upon goals with social acknowledgement (e.g., congratulatory letter from parole supervisor) and small material incentives (e.g., partial payment for clothes for job interviews). This approach improved parolees’ attendance at integrated community parole and addiction treatment sessions, as well as increased use of treatment and individual counseling services (Friedmann et al. 2009).

Graduated sanctions, which invoke less punitive responses for early and less serious noncompliance and increasingly severe sanctions for more serious or continuing problems, can be an effective tool in conjunction with drug testing. The effective use of graduated sanctions involves consistent, predictable, and clear responses to noncompliant behavior.

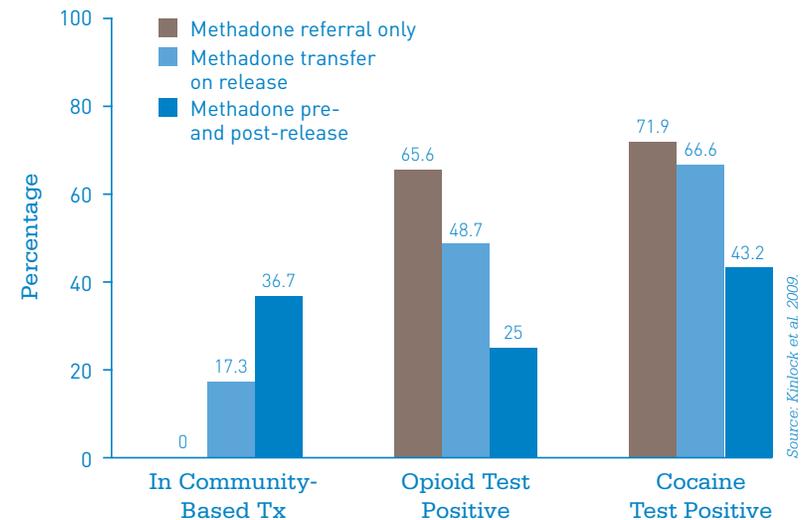
Drug testing can determine when an individual is having difficulties with recovery. The first response to drug use detected through urinalysis should be a clinical one—for example, increasing treatment intensity or switching to an alternative treatment. This often requires coordination between the criminal justice staff and the treatment provider. (Note that more intensive treatment should not be considered a sanction, but rather a routine progression in health care practice when a treatment appears less effective than expected.)

Behavioral contracting can employ both rewards and sanctions. A behavioral contract is an explicit agreement between the participant and the treatment provider or criminal justice monitor (or among all three) that specifies proscribed behaviors and associated sanctions, as well as positive goals and rewards for success.

Behavioral contracting can instill a sense of procedural justice because both the necessary steps toward progress and the sanctions for violating the contract are specified and understood in advance.

It is important to recognize and reinforce progress toward responsible, abstinent behavior.

Methadone treatment before and after release from prison increases treatment retention and reduces drug use



At 12 months post-release, offenders who had received methadone treatment in prison and continued it in the community were significantly more likely to enter and stay in treatment and less likely to test positive for opioid and cocaine use than participants who received counseling and referral to methadone, or those who received counseling with transfer to methadone maintenance upon release.

10. What is the role of medications in treating substance abusing offenders?

Medications can be an important component of effective drug abuse treatment for offenders. By allowing the brain to function more normally, they enable the addicted person to leave behind a life of crime and drug abuse. Although some jurisdictions have found ways to successfully implement medication therapy, addiction medications are underused in the treatment of drug abusers within the criminal justice system, despite evidence of their effectiveness.

FREQUENTLY ASKED QUESTIONS

Effective medications have been developed for treating addiction to opiates/heroin and alcohol:

- **Opiates/Heroin.** Long-term opiate abuse results in a desensitization of the brain's opiate receptors to endorphins, the body's natural opioids. Opioid agonist/partial agonist medications, which act at the same receptors as heroin, morphine, and endorphins, tend to be well tolerated and can help an individual remain in treatment. For example, methadone, an opiate agonist, reduces the craving that otherwise results in compulsive use of heroin or other illicit opiates. Methadone treatment has been shown to be effective in decreasing opiate use, drug-related criminal behavior, and HIV

risk behavior. Buprenorphine is a partial agonist and acts on the same receptors as morphine (a full agonist), but without producing the same level of dependence or withdrawal symptoms. Suboxone is a unique formulation of buprenorphine that contains naloxone, an opioid antagonist that limits diversion by causing severe withdrawal symptoms in addicted users who inject it to get "high." It has no adverse effects

when taken orally, as prescribed.

An alternative approach, in previously detoxified opiate users, is to use an antagonist medication that blocks the effects of opiates. Naltrexone has been available for more than 2 decades, but poor compliance in the face of severe cravings and addiction has undermined its benefits. An extended-release injectable formulation of naltrexone (Vivitrol) was recently approved by the U.S. Food and Drug Administration (FDA) for treating opioid addiction. Vivitrol requires dosing every month rather than daily, which stands to improve treatment adherence.

- **Alcohol.** Disulfiram (also known as Antabuse) is an aversion therapy that induces nausea if alcohol is consumed. Acamprosate, a medication that helps reduce alcohol craving, works by restoring normal balance to the brain's glutamate neurotransmitter system.

Naltrexone (and now Vivitrol), which blocks some of alcohol's pleasurable effects and alcohol craving, is also approved by the FDA for treatment of alcohol abuse.

11. How can the criminal justice and drug abuse treatment systems reduce the spread of HIV/AIDS, hepatitis, and other infectious diseases among drug abusing offenders?

Individuals involved in the criminal justice system have disproportionately high rates of substance use disorders and infectious diseases, including HIV/AIDS. In fact, 14 percent of HIV-infected individuals in this country pass through the criminal justice system each year (Spaulding et al. 2009). Other infectious diseases, such as hepatitis B, hepatitis C, and tuberculosis, also are pervasive in the criminal justice system.

This overrepresentation also provides an opportunity to integrate treatment and improve outcomes for both substance use disorders and infectious diseases. Research shows that treatment for drug abuse can lessen the spread of infectious diseases by reducing high-risk behaviors like needle-sharing and unprotected sex (Metzger et al. 2010).

Identifying those who are HIV+ and starting them on HAART treatment could not only improve their health outcomes but also decrease HIV spread (Montaner et al. 2010).

It is imperative that offenders with infectious diseases be linked with community-based medical care prior to release. Offenders often have difficulty negotiating access to health services and adhering to complex treatment protocols following release from prison and jail. One study found that simply helping HIV-infected inmates complete the paperwork required to get their prescriptions filled upon release significantly diminished treatment interruption, although improvement was still needed, since fewer than half had filled their prescriptions within 2 months of release (Baillargeon et al. 2009).

Medications can be an important component of effective drug abuse treatment for offenders.

The prevalence of AIDS is approximately five times higher among incarcerated offenders than in the general population.

FREQUENTLY ASKED QUESTIONS

Community health, drug treatment, and criminal justice agencies should work together to offer education, screening, counseling, prevention, and treatment programs for HIV/AIDS, hepatitis, and other infectious diseases to offenders returning to the community.

12. What works for offenders with co-occurring substance abuse and mental disorders?

It is important to adequately assess mental disorders and to address them as part of effective drug abuse treatment. Many types of co-occurring mental health problems can be successfully addressed in standard drug abuse treatment programs. However, individuals with serious mental disorders may require an integrated treatment approach designed for treating patients with co-occurring mental and substance use disorders.

Much progress has been made in developing effective medications for treating mental disorders, including a number of antidepressants, antianxiety agents, mood stabilizers, and antipsychotics. These medications may be critical for treatment success with offenders who have co-occurring mental disorders such as depression, anxiety disorders, bipolar disorder, or schizophrenia. Cognitive-behavioral therapy can be effective for treating some mental health problems, particularly when combined with medications. Contingency management can improve adherence to medications, and intensive case management may be useful for linking severely mentally ill individuals with drug abuse treatment, mental health care, and community services. A specialized type of treatment—Modified Therapeutic Communities (MTCs)—incorporates features of traditional Therapeutic Communities with a special focus on addressing co-occurring mental health conditions.

13. Is providing drug abuse treatment to offenders worth the financial investment?

In 2007, it was estimated that the cost to society of drug abuse was \$193 billion (National Drug Intelligence Center [NDIC], 2011), a substantial portion of which—\$113 billion—is associated with drug-

related crime, including criminal justice system costs and costs borne by victims of crime. The cost of treating drug abuse (including health costs, hospitalizations, and government specialty treatment) was estimated to be \$14.6 billion, a fraction of these overall societal costs (NDIC, 2011). Drug abuse treatment is cost effective in reducing drug use and bringing about related savings in health care. Treatment also consistently has been shown to reduce the costs associated with lost productivity, crime, and incarceration across various settings and populations. The largest economic benefit of treatment is seen in avoided costs of crime (incarceration and victimization costs). Providing methadone treatment to opioid-addicted prisoners prior to their release, for example, not only helps to reduce drug use but also avoids the much higher imprisonment costs for drug-related crime (see figure).

Even greater economic benefits result from treating offenders with co-occurring mental health problems and substance use disorders. Residential prison treatment is more cost effective if offenders attend treatment post-release, according to research (Martin et al. 1999; Butzin 2006). Drug courts also convey positive economic benefits,

economic benefit of treatment is seen in avoided costs of crime.

Treating addiction in the criminal justice system is cost-effective



The cost of methadone treatment averages around \$5,000 a year, compared to approximately \$24,000 for State and Federal prisons to keep people confined. Reducing the number of people incarcerated for drug use can net huge savings in economic and social costs.

Sources: Zarbin et al. 2008 and Warren et al. 2008.

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including participant-earned wages and avoided incarceration and future crime costs.

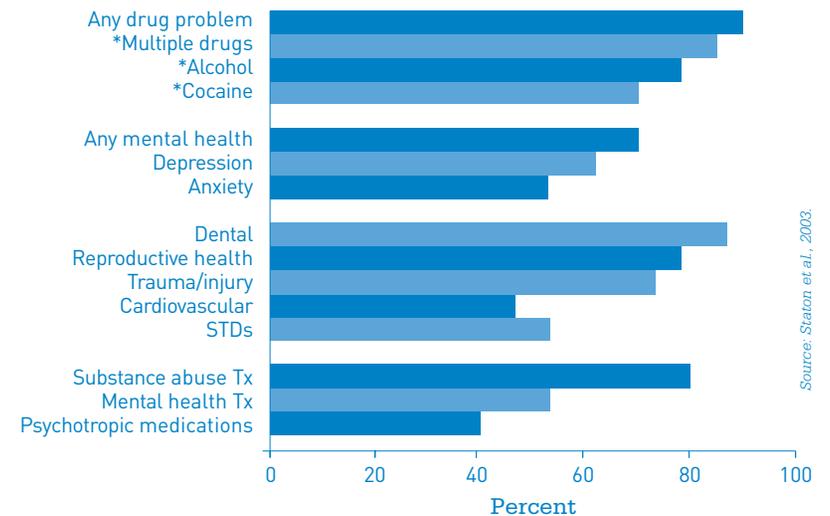
14. What are the unique treatment needs of women in the criminal justice system?

Although women are incarcerated at far lower rates than men, the number and percentage of incarcerated women have grown substantially in recent years. Between 2000 and 2008, the number of men in prisons and jails grew by only 5 percent, while the number of incarcerated women grew by about 15 percent (Sabol et al. 2010). Women in prison are likely to have a different set of problems and needs than men, presenting particular treatment challenges that may call for tailored approaches (Greenfield et al. 2007) (figure).

Incarcerated women in treatment are significantly more likely than incarcerated men to have severe substance abuse histories, co-occurring mental disorders, and high rates of past treatment for both; they also tend to have more physical health problems (Staton et al. 2003; Messina et al. 2006). Approximately 50 percent of female offenders are likely to have histories of physical or sexual abuse, and women are more likely than men to be victims of domestic violence. Past or current victimization can contribute to drug or alcohol abuse, depression, post-traumatic stress disorder, and criminal activity.

Treatment programs serving both men and women can provide effective treatment for their female patients. However, gender-specific programs may be more effective for female offenders, particularly those with histories of trauma and abuse (Pelissier et al. 2003). Female offenders are more likely to need medical and mental health services, child care services, and assistance in finding housing and employment. Following a comprehensive assessment, women with mental health disorders should receive appropriate treatment and case management, including victim services as needed. For female offenders with children, parental responsibilities can conflict with their ability to participate in drug treatment. Regaining or retaining custody of their children can also motivate mothers to participate in treatment. Treatment programs may improve retention by offering child care services and parenting classes.

Incarcerated women have high rates of substance abuse, mental disorders, and other health problems



Source: Staton et al., 2003.

*Note: Graph shows lifetime percentages except for multiple drugs, alcohol, and cocaine, which are the percentage reporting use in the 30 days prior to incarceration. (N=60)

15. What are the unique treatment needs of juveniles in the criminal justice system?

The U.S. Department of Justice's Office of Justice Programs reports a high rate of drug use among juvenile detainees. One study, for example, found that 77 percent of criminal justice-involved youth reported substance use (mainly marijuana) in the past 6 months, and nearly half of male and female juvenile detainees had a substance use disorder (McClelland et al. 2004a; McClelland et al. 2004b).

Arrest rates for drug-related crimes also remain high among juveniles. A recent report showed that of the estimated 2.1 million juvenile arrests in 2008, approximately 10 percent were for drug abuse or underage drinking violations (Puzzanchera 2009).

Juveniles entering the criminal justice system can bring a number of serious problems with them—substance abuse, academic failure,

FREQUENTLY ASKED QUESTIONS

emotional disturbances, physical health issues, family problems, and a history of physical or sexual abuse. Girls make up nearly one-third of juvenile arrests, a high percentage of whom report some form of emotional, physical, or sexual abuse. Effectively addressing these problems requires their gaining access to

comprehensive assessment, treatment, case management, and support services appropriate for their age and developmental stage. Assessment is particularly important, because not all adolescents who have used drugs need treatment. For those who do, there are several points in the juvenile justice continuum where treatment has been integrated, including juvenile

drug courts, community-based supervision, juvenile detention, and community re-entry.

Families play an important role in the recovery of substance abusing juveniles, but this influence can be either positive or negative. Parental substance abuse or criminal involvement, physical or sexual abuse by family members, and lack of parental involvement or supervision are all risk factors for adolescent substance abuse and delinquent behavior. Thus, the effective treatment of juvenile substance abusers

often requires a family-based treatment model that targets family functioning and the increased involvement of family members. Effective adolescent treatment approaches include multisystemic therapy, multidimensional family therapy, and functional family therapy. These

interventions show promise in strengthening families and decreasing juvenile substance abuse and delinquent behavior.

Effective treatment of juvenile substance abusers often requires a family-based treatment model.

Juvenile offenders

Virtually every juvenile offender should be screened for drug abuse and mental disorders, and receive an intervention:

- Treatment for those who are dependent on alcohol or drugs, or mentally ill.
- Drug abuse prevention for those who are not.
- HIV prevention or treatment as needed.

RESOURCES



Many resources are available on the Internet. The following are useful links:

General Information

NIDA Web site: www.drugabuse.gov

General Inquiries: NIDA Public Information Office 301-443-1124

Federal Resources

Bureau of Justice Assistance (BJA) Substance Abuse Programs	www.ojp.usdoj.gov/bja/programs/substance_abu.html
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Bureau of Justice Statistics (BJS) Statistics on Drugs and Crime	http://bjs.ojp.usdoj.gov/content/dcf/contents.cfm
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Center for Substance Abuse Treatment (CSAT) Substance Abuse and Mental Health Services Administration (SAMHSA)	http://www.samhsa.gov/about/csata.aspx
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Federal Resources (continued)

Federal Bureau of Prisons (BOP) Substance Abuse Treatment	www.bop.gov/inmate_programs/substance.jsp
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National Criminal Justice Reference Service (NCJRS)	www.ncjrs.gov
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National Institute on Alcohol Abuse and Alcoholism (NIAAA)	www.niaaa.nih.gov
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National Institute of Corrections (NIC)	www.nicic.org
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National Institute of Justice (NIJ)	www.ojp.usdoj.gov/nij
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National Institute of Mental Health (NIMH)	www.nimh.nih.gov
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Office of Applied Studies (OAS) Substance Abuse and Mental Health Services Administration (SAMHSA)	www.samhsa.gov/data
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Office of Justice Programs (OJP)	www.ojp.usdoj.gov
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Office of Juvenile Justice and Delinquency Prevention (OJJDP)	www.ojjdp.ncjrs.org
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REFERENCES



Baler, R.D., and Volkow, N.D. Drug addiction: The neurobiology of disrupted self-control. *Trends Mol Med* 12(12):559–566, 2006.

Baillargeon, J.; Giordano, T.P.; Rich, J.D.; Wu, Z.H.; Wells, K.; Pollock, B.H.; and Paar, D.P. Accessing antiretroviral therapy following release from prison. *JAMA* 301(8):848–857, 2009.

Binswanger, I.A.; Stern, M.F.; Deyo, R.A.; Heagerty, P.J.; Cheadle, A.; Elmore, J.G.; and Koepsell, T.D. Release from prison—a high risk of death for former inmates. *New Engl J Med* 356(2):157–165, 2007.

Butzin, C.A., O’Connell, D.J., Martin, S.S., and Inciardi, J.A. Effect of drug treatment during work release on new arrests and incarcerations. *J Crim Justice* 34(5):557–565, 2006.

Chandler, R.K.; Fletcher, B.W.; and Volkow, N.D. Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *JAMA* 301(2):183–190, 2009.

Cooper, M.; Sabol, W.J.; and West, H.C. *Prisoners in 2008*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2010. Accessed at <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1763>, June 2011.

Friedmann, P.D.; Rhodes, A.G.; and Taxman, F.S.; for the Step’n Out Research Group of CJ-DATS. Collaborative behavioral management: integration and intensification of parole and outpatient addiction treatment services in the Step’n Out study. *J Exp Criminol* 5(3):227–243, 2009.

Glaze, L.E., and Bonczar, T.P. *Probation and Parole in the United States, 2008*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2009.

Greenfield, S.F., Brooks, A.J., Gordon, S.M., Green, C.A., Kropp, F., McHugh, R.K., Lincoln, M., Hien, D., and Miele, G.M. Substance abuse treatment entry, retention, and outcome in women: a review of the literature. *Drug Alcohol Depend* 86:1–21, 2007.

Karberg, J.C., and Mumola, C.J. *Drug Use and Dependence, State and Federal Prisoners, 2004*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2006.

Kinlock, T.W., Gordon, M.S., Schwartz, R.P., Fitzgerald, T.T., and O’Grady, K.E. A randomized clinical trial of methadone maintenance for prisoners: Results at 12 months post-release. *J Subst Abuse Treat* 37(3):277–285, 2009.

Leukefeld, C.G.; Tims, F.; and Farabee, D., Eds. *Treatment of Drug Offenders: Policies and Issues*. NY, NY: Springer, 2002.

Martin, S.S.; Butzin, C.A.; Saum, C.A.; and Inciardi, J.A. Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware: From prison to work release to aftercare. *The Prison Journal* 79(3):294–320, 1999.

McClelland, G.M., Elkington, K.S., Teplin, L.A., and Abram, K.M. Multiple substance use disorders in juvenile detainees. *J Am Acad Child Adolesc Psychiatry* 43(10):1215–1224, 2004a.

McClelland, G.M.; Teplin, L.A.; and Abram, K.M. *Detection and prevalence of substance use among juvenile detainees*. Juvenile Justice Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 2004b.

Messina, N.; Burdon, W.; Hagopian, G.; and Prendergast, M. Predictors of prison-based treatment outcomes: A comparison of men and women participants. *Am J Drug Alcohol Abuse* 32:7–28, 2006.

Metzger, D.S.; Woody, G.E.; and O’Brien, C.P. Drug treatment as HIV prevention: A research update. *J Acquir Immune Defic Syndr* 55(suppl. 1):S32–S36, 2010.

Montaner, J.S.; Wood, E.; Kerr, T.; Lima, V.; Barrios, R.; Shannon, K.; Harrigan, R.; and Hogg, R. Expanded highly active antiretroviral therapy coverage among HIV-positive drug users to improve individual and public health outcomes. *J Acquir Immune Defic Syndr* 55(suppl. 1):S5–S9, 2010.

National Drug Intelligence Center. *The Economic Impact of Illicit Drug Use on American Society*. Washington, DC: United States Department of Justice, 2011.

Pelissier, B.M., Camp, S.D., Gaes, G.G., Saylor, W.G., and Rhodes, W. Gender differences in outcomes from prison-based residential treatment. *J Subst Abuse Treat* 24(2), 149–160, 2003.

Prendergast, M.L., Podus, D., Change, E., and Urada, D. The effectiveness of drug abuse treatment: A meta-analysis of comparison group studies. *Drug Alcohol Depend* 67(1):53–72, 2002.

Puzzanchera, C. *Juvenile Arrests 2008*. Juvenile Justice Bulletin. Washington DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 2009.

Sabol, W.J., West, H.C., and Cooper, M. *Prisoners in 2008*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2010.

Spaulding, A.C., Seals, R.M., Page, M.J., Brzozowski, A.K., Rhodes, W., and Hammett, T.M. HIV/AIDS among inmates of and releases from U.S. correctional facilities, 2006: Declining share of epidemic but persistent public health opportunity. *PLoS One* 4(11):e7558, 2009.

Staton, M.; Leukefeld, C.; and Webster, J.M. Substance use, health, and mental health: Problems and service utilization among incarcerated women. *Int J Offender Ther Comp Criminol* 47(2):224–239, 2003.

Taxman, F.S.; Perdoni, M.L.; and Harrison, L.D. Drug treatment services for adult offenders: The state of the state. *J Subst Abuse Treat* 32(3):239–254, 2007.

Volkow, N.D., Wang, G.J., Fowler, J.S., Tomasi, D., Telang, F., and Baler, R. Addiction: decreased reward sensitivity and increased expectation sensitivity conspire to overwhelm the brain's control circuit. *Bioessays* 32(9):748–755, 2010.

Warren, J.; Gelb, A; Horowitz, J; and Riordan, J. *One in 100: Behind Bars in America 2008*. Washington, DC: The Pew Center on the States, The Pew Charitable Trusts, 2008.

Zarkin, G.A.; Dunlap, L.J.; Wedehase, B.; and Cowell, A.J. The effect of alternative staff time data collection methods on drug treatment service cost estimates. *Evaluation and Program Planning* 31:427–435, 2008.

For More Information

For more information about other research-based publications on drug abuse and addiction, visit NIDA's Web site at www.drugabuse.gov, or contact the *DrugPubs* Research Dissemination Center at 877–NIDA-NIH (877-643-2644; TTY/TDD: 240-645-0228).

Attachment 3

Criminogenic Risk and Need Factors

Risk and Criminogenic Needs

Andrews and Bonta (2010, p. 58-60) have identified eight criminogenic risk and need factors. Risk factors should be used to determine the level of treatment and criminogenic needs should be the focus of treatment where the goal is to reduce the risk of future criminal behavior and involvement in the criminal/juvenile justice system. These risk and need factors are often labeled the 'Central Eight,' with the first four, or 'Big Four,' having the greatest impact on recidivism, and the second four, or 'Moderate Four,' have a slightly less, but still impactful relationship with future criminal behavior.

Risk and Need Factors

1. History of Antisocial Behavior. For this risk factor, the dynamic need to be targeted is "building on new noncriminal behaviors in high-risk situations and build self-efficacy for beliefs supporting reform." *Example interventions include:*
 - a. Learning and identifying high-risk situations that lead to illegal behavior.
 - b. Writing 'high-risk avoidance plan' and practice plan.
 - c. Learn and practice (to habit) new skills, behaviors to use in high-risk situations.
2. Antisocial Personality Pattern. This is described as "impulsive, adventurous pleasure-seeking, generalized trouble (multiple persons, multiple settings), restless aggressive, callous disregard for others." For this risk factor, the dynamic need to be targeted is "weak self-control, weak anger management skills, and poor problem solving skills." *Example interventions include:*
 - a. Teach and practice (role-play to habit) self-control strategies (awareness, motivation, plan, reward, practice to habit, depletion, delay gratification).
 - b. Teach and practice (role-play to habit) anger control (handout).
 - c. Teach and practice (role-play to habit) social skills (i.e., keeping out of fights).
3. Antisocial Cognition. This includes, "attitudes, values, beliefs, rationalizations, and a personal identity that is favorable to crime." For this risk factor, the dynamic need to be targeted is, "reduction of antisocial thinking and feeling and through building and practicing less risky thought and feelings." *Example interventions include:*
 - a. Teaching commonly used thinking errors (self-centered, minimizing/mislabeling, assuming the worst, blaming others).
 - b. Teach and practice (to habit) how to identify and correct thinking errors.
 - c. Teach and practice correction (role-play to habit) of hostile interpretations.
4. Antisocial Associates. This includes "both association with procriminal others and relative isolation from anticriminal others." For this risk factor, the dynamic need to be targeted is, "reduce association with procriminal others and enhance association and [prosocial] others." *Example interventions include:*
 - a. Motivational Interviewing (MI) skills to increase desire to avoid antisocial peers.
 - b. Increase time spend in prosocial structured & supervised activities (clubs, sports).
 - c. Use behavior contracting and monitoring to reduce contact with antisocial peers.

5. Family/marital circumstances. This includes, “poor-quality relationships in combination with neutral expectations with regard to crime and procriminal expectations. For this risk factor, the dynamic need to be targeted is, “Strong nurturance and caring in combination with strong monitoring and supervision.” *Example interventions include:*
 - a. Practice parental modeling of prosocial attitudes and behaviors.
 - b. Create behavioral plan that includes frequent rewards (and consequences) for complying with parent requests, chores, homework, etc.
 - c. Improve family relationships (Think attachment! Decrease negative comments & increase positive, increase touch and connectedness, identify positives).
 - d. Teach and practice (role-play to habit) social skills (i.e., making a complaint, understanding the feelings of others, dealing w/ someone else’s anger, expressing affection, etc). Plan and increase frequency of family leisure activities.
6. School/Work. This includes “low levels of performance and involvement and low levels of rewards and satisfactions.” For this risk factor, the dynamic need to be targeted is, “Enhance performance, involvement, and rewards and satisfactions.” *Example interventions include:*
 - a. Identify deficits (for accommodations) & increase & focus on strengths.
 - b. Assist in identifying & encourage enrollment (empower family) in training.
 - c. Teach and practice (role-play to habit) social skills needed at work (i.e., getting ready for a difficult conversation, dealing with accusations, etc.)
7. Leisure/Recreation. This includes, “Low levels of involvement and satisfactory in anticriminal leisure pursuits.” For this risk factor, the dynamic need to be targeted is, “Enhance involvement and rewards and satisfactions.” *Example interventions include:*
 - a. Use MI skills enhance motivation/desire to engage in prosocial activities.
 - b. Identify and encourage participation to engage in prosocial activities.
 - c. Teach and practice (role-play to habit) skills needed to engage in these activities.
8. Substance Abuse (SA). This includes “problems with alcohol and/or drugs. For this risk factor, the dynamic need to be targeted is, “Reducing SA, reduce personal and interpersonal supports for substance-oriented behavior, enhance alternatives to SA.” *Example interventions include:*
 - a. Use MI skills enhance motivation/desire to abstain from SA.
 - b. Identify high-risk circumstances and teach avoidance strategies as well as teach and practice (role-play to the point of habit) new behavioral and coping skills to use when high-risk situations cannot be avoided.
 - c. Refer to SA treatment if necessary.

Reference:

Andrews, D., & Bonta, J. (Eds.). (2010). *The Psychology of Criminal Conduct* (5th Edition ed.). New Providence, NJ: Matthew Bender & Company, Inc., LexisNexis Group.

Attachment 4

Local Substance Abuse Authority Agencies

UTAH LOCAL SUBSTANCE ABUSE AUTHORITY AGENCIES

Agency Contact	Counties Served	Agency/Address	Phone and E-Mail
Brock Alder, Director	Box Elder, Cache and Rich Counties	Bear River Health Department Division of Substance Abuse 655 East 1300 North Logan, UT 84321	435-792-6421 E-Mail: balder@brhd.org
Kevin Eastman, Executive Director	Weber and Morgan Counties	Weber Human Services 237 26 th Street Ogden, UT 84401	801-625-3601 or 801-625-3700 E-Mail: kevine@weberhs.org
Brandon Hatch, Director	Davis County	Davis Behavioral Health 934 South Main Layton, UT 84041	801-773-7060 E-Mail: brandonh@dbh Utah.org
Tim Whalen, Director	Salt Lake County	Salt Lake County Division of Behavioral Health Services Salt Lake County Government Center 2001 South State Street, Suite S-2300 Salt Lake City, UT 84190	801-468-4727 E-Mail: twhalen@slco.org
Gary Larcenaire, Executive Director	Tooele County	Valley Behavioral Health/Tooele County 100 South 1000 West Tooele, UT 84074	E-Mail: garyl@vmh.com
	Summit County	Valley Behavioral Health/Summit County 1753 Sidewinder Drive Park City, UT 84060-7322	
Juergen Korbanka, Executive Director	Wasatch County	Wasatch Mental Health 750 North 200 West, #300 Provo, UT 84601	801-852-4703 E-Mail: korbanka@wasatch.org
Richard Nance, Director	Utah County	Utah County Department of Drug and Alcohol Prevention and Treatment 151 South University Avenue, Suite 3200 Provo, UT 84601	801-851-7127 E-Mail: richardn@utahcounty.gov
Brian Whipple, Director	Juab, Millard, Piute, Sanpete, Sevier and Wayne Counties	Central Utah Counseling and Substance Abuse Center 152 North 400 West Ephraim, UT 84627	435-283-8400 E-Mail: brianw@cucc.us
Mike Deal, Executive Director	Beaver, Garfield, Kane, Iron and Washington Counties	Southwest Behavioral Health Center 474 West 200 North, Suite 300 St. George, UT 84770	435-634-5614 E-Mail: mdeal@sbhcutah.org
Karen Dolan, Director	Carbon, Emery and Grand Counties	Four Corners Community Behavioral Health 105 West 100 North, PO Box 867 Price, UT 84501	435-637-7200 E-Mail: kdolan@fourcorners.ws
Jed Lyman, Director	San Juan County	San Juan Counseling Center 356 South Main Blanding, UT 84511	435-678-2992 E-Mail: jlyman@sanjuancc.org
Kyle Snow, Director	Daggett, Duchesne and Uintah Counties	Northeastern Counseling Center 285 West 800 South Roosevelt, UT 84066	435-789-6300 E-Mail: kyles@nccutah.org